A Practical Approach to Managing Socially Complex Patients in Acute Care

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>> HELLO, EVERYONE. WELCOME TO PHYSICALTHERAPY.COM. OUR COURSE TITLE TODAY IS A A PRACTICAL APPROACH TO MANAGING SOCIALLY COMPLEX PATIENTS IN ACUTE CARE. MY NAME IS CALISTA KELLY. I WILL BE YOUR MODERATOR THROUGHOUT TODAY'S COURSE. TODAY IS OUR FIRST DAY OF OUR VIRTUAL CONFERENCE ON ACUTE CARE TOPICS AND WE'D LIKE TO GIVE A SPECIAL THANKS TO DR. SHARON GORMAN FOR ARRANGING THE CONFERENCE AND THE SPEAKERS THIS WEEK. SO, BEFORE WE GET STARTED TODAY, THERE ARE A FEW THINGS WE NEED TO GO THROUGH. AS FAR AS OUR CLASSROOM TOOLS AND PROCEDURES, IF YOU ARE HAVING ANY DIFFICULTIES WITH OUR SOUND OR VISUAL DISPLAY THROUGHOUT THE PRESENTATION TODAY, YOU MAY REACH US AT 866-782-6258 YOU CAN E-MAIL US AT CUSTOMERSERVICE@PHYSICALTHERAPY.COM, OR USE OUR QUESTION AND ANSWER POD TODAY.

THAT QUESTION AND ANSWER POD IS LOCATED BELOW THE POWERPOINT. SO, USE THAT. PLACE YOUR CURSER IN THE OPEN TEXT FIELD AND THEN TYPE YOUR ISSUE AND HIT THE SEND BUTTON. THE QUESTION/ANSWER POD IS A WAY TO INTERACT WITH THE PRESENTER THROUGHOUT THE PRESENTATION. IF YOU HAVE QUESTIONS FOR HER, PLACE THAT QUESTION IN THE QUESTION/ANSWER POD AND HIT THE SEND BUTTON. TO EARN CEUS FOR THIS COURSE YOU WILL NEED TO BE LOGGED IN THE ENTIRE' TIME. WAIT 15 MINUTES FOR THE ATTENDANCE REPORTS TO CLEAR AND LOG BACK INTO PHYSICALS THIS THERAPY.COM AND ACCESS YOUR PERSONAL ACCOUNT. PARTICIPANTS MUCH EARN 80 OR HIGHER TO EARN CEUS. YOU WILL BE GIVEN TWO ATTEMPTS TO GET A PASSING SCORE AND MUST TAKE THE EXAM IN THE NEXT SEVEN DAYS. IF YOU HAVE NOT DONE SO ALREADY, THERE'S A HANDOUT

TO DOWNLOAD AND FOLLOW ALONG WITH TODAY'S COURSE. TO DOWNLOAD, AS SHOWN IN THE TOP, CLICK DOWNLOAD FILE. ONE MORE ANNOUNCEMENT. I SEE SOME PEOPLE LOGGED IN MORE THAN ONCE. YOU MAY BE HEARING MY VOICE IN AN ECHO CURRENTLY. IF YOU ARE HEARING AN ECHO, LOOK AROUND AND CLOSE OUT OF AN EXTRA WINDOW IN THE CLASSROOM BECAUSE CHANCES ARE YOU ARE LOGGED IN MORE THAN ONCE. AT THIS TIME, I'M GOING TO TAKE A BRIEF PAUSE. WHEN I RETURN TO THE CLASSROOM, I WILL INTRODUCE TODAY'S PRESENTER AND WE WILL GET STARTED. IT'S MY PLEASURE TO WELCOME MONA WONG FROM PHYSICALTHERAPY.COM. SHE RECEIVED HER DOCTORATE AND ACUTE CARE PHYSICAL THERAPIST FOR TEN YEARS AND PROVIDING CARE TO PARENTS WITH VARYING MEDICAL AND SOCIAL COMPLEXITIES. DURING HER TENURE AS A STAFF THERAPIST, SHE HAS ASSISTED IN MENTORING NEW STUDENTS AND THERAPISTS WITH A DEVELOPMENT OF CLINICAL MANAGEMENT SKILLS. SHE'S BEEN INVOLVED IN LEADERSHIP ROLES WITHIN THE LOCAL DISTRICT LEVEL AND SERVED AS A STATE DELEGATE TO THE HOUSE OF DELEGATES. THANK YOU TO MUCH, MONA, FOR BEING PART OF OUR VIRTUAL CONFERENCE THIS WEEK AND PRESENTING FOR US TODAY. AT THIS TIME, I'M GOING TO TURN THE MICROPHONE OVER TO YOU.

>> HI. GOOD MORNING, EVERYONE. THANK YOU FOR PARTICIPATING IN I HOPE YOU WILL BE FORGIVING IN ME DOING THIS FOR THE FIRST TIME. I'M A LITTLE NERVOUS. SO BEAR WITH ME. LET'S GO TO THE NEXT SLIDE. I WILL TALK ABOUT THE BACKGROUND. YOU KNOW, WORKING IN AN ACUTE CARE HOSPITAL IS THE MOST DIFFICULT DECISIONS ARE TREATING SOME OF THESE PATIENTS WHO ARE VERY COMPLICATED IN THEIR SOCIAL SITUATIONS. MAKING A DISCHARGE RECOMMENDATION, IT INVOLVES CONSIDERATION FOR SO MANY DIFFERENT THINGS AND SOME OF THE MOST IMPORTANT ONES ARE THE ENVIRONMENT OR THE LACK OF SOCIAL SUPPORT AND FEELING GOOD ABOUT

THE DISCHARGE OR MAYBE FEELING OKAY ABOUT THE DISCHARGE. SO, THE OTHER BACKGROUND ON THIS IS PART OF THE REASON I WAS ASKED TO PRESENT THIS SUBJECT IS BECAUSE WHEN I'M DEALING WITH THESE SITUATIONS, IT'S ALMOST A DAILY OCCURRENCE AND SOME OF OUR NEW GRADS OR NEW THERAPISTS WHO ARE NOT JUST NEW GRADS BUT MAYBE NEW TO OUR POPULATION AND THE FACILITY THAT I WORK IN, THEY OFTEN NEED A LOT MORE GUIDANCE AND MENTORING THROUGH THOSE SITUATIONS. I WAS ABLE TO DO A LOT OF THAT THROUGH THE YEARS. MOST OF THE INFORMATION THAT I HAVE PUT IN THIS POWERPOINT IS THE EDUCATION THAT I PROVIDED AS A CI. SO THIS IS A LITTLE MORE ORGANIZED AND HOPEFULLY EASY TO FOLLOW. AND MAYBE NOT SO CONFUSING.

SO I WOULD ALSO LIKE TO FIND OUT MORE ABOUT THE PARTICIPANTS AND WHO'S LISTENING IN OR WANTING TO KNOW MORE INFORMATION ABOUT THIS. I'M GOING TO ASK A FEW QUESTIONS TO GET A SURVEY OF THE GROUP. THE FIRST ONE -- LET'S SEE. WHAT SETTING DO YOU GUYS PRACTICE IN? IF YOU COULD GIVE ME SOME INFORMATION. WE HAVE A LOT OF PARTICIPANTS TODAY. SO I'M EXPECTING MANY OF YOU ARE GOING TO PUT IN ALL SORTS OF DIFFERENT THINGS. I ASSUME MOST OF YOU HAVE SOMETHING TO DO WITH ACUTE CARE BECAUSE THIS IS AN ACUTE CARE WEBINAR. ALL RIGHT. I'M SEEING EVERYBODY KIND OF FILTER IN HERE. LOOKS LIKE MOST OF YOU ARE EITHER ACUTE CARE, HOME HEALTH OR SNFS. GOOD TO KNOW. LET ME ASK THE SECOND QUESTION, WHERE DO MOST OF YOU PRACTICE? ARE YOU IN AN URBAN CENTER, SUBURBAN OR RURAL AREA? JUST WAITING AS EVERYBODY ANSWERS. HOPEFULLY THIS IS INTERACTIVE FOR EVERYONE AND YOU ARE NOT GOING TO GET TOO BORED. OKAY. LOOKS LIKE MOST PEOPLE HAVE ANSWERED AND GOOD AMOUNT OF YOU ARE IN A SUBURBAN AREA. OKAY. THEN THE LAST QUESTION, JUST TO KIND OF TAKE A SURVEY HERE, HOW MANY OF YOU DEAL WITH SOCIALLY COMPLEX PATIENTS? JUST LOOKING. WE WILL

BROADCAST THOSE RESULTS SO EVERYBODY CAN SEE. WE ARE TEETERING BETWEEN OFTEN AND OCCASIONALLY.

SO JUST TO GIVE YOU A BACKGROUND WHERE I WORK, I WORK IN AN URBAN CENTER. IT'S A TEACHING HOSPITAL. MOST OF OUR PATIENT POPULATION IS MEDICAL -- MEDICAID FOR THOSE THAT DON'T LIVE IN CALIFORNIA AND WITHOUT INSURANCE. WE ARE THE SAFETY NET OF THE COMMUNITY IN TERMS OF THE VULNERABLE POPULATION THAT LIVE IN THE AREA. ALL RIGHT.

GO TO THE NEXT SLIDE. SO, THE LEARNING OUTCOMES FOR THIS WEBINAR IS DEFINING SOCIAL DETERMINANTS OF HEALTH, IDENTIFYING AT LEAST TWO ROLES OF THE PHYSICAL THERAPIST AND THE MANAGEMENT OF SOCIALLY COMPLEX PATIENTS, IDENTIFY AT LEAST THREE BARRIERS TO PATIENT PHYSICAL THERAPY DISCHARGE RECOMMENDATIONS AND IDENTIFY AT LEAST FOUR POTENTIAL PROVIDERS OR SERVICES AVAILABLE TO ASSIST WITH DISCHARGE RECOMMENDATIONS.

LET'S START BY DETERMINING OUR SOCIAL DETERMINANTS OF HEALTH. THESE ARE OTHER THINGS THAT IMPACT ONE'S HEALTH OUTCOMES OTHER THAN JUST EXERCISE, NUTRITION, IMMUNIZATIONS AND SEEING A PHYSICIAN WHEN WE ARE SICK. THE SOCIAL DETERMINANTS OF HEALTH WERE INITIALLY ACKNOWLEDGED BY THE WORLD HEALTH ORGANIZATION IN 2003. ACCORDING TO THE OFFICE OF DISEASE PREVENTION AND HEALTH PROMOTION, THE DEFINITION IS CONDITIONS IN THE ENVIRONMENTS IN WHICH PEOPLE ARE BORN, LIVE, LEARN, WORK, PLAY, WORSHIP AND AGE THAT AFFECT A WIDE RANGE OF HEALTH FUNCTIONING AND QUALITY OF LIFE OUTCOMES AND RISKS. SO, WHAT ARE THOSE CONDITIONS? THEY ARE DEFINED AS SOCIAL, ECONOMIC AND PHYSICAL. AND THEN WHAT ARE ENVIRONMENTS? THE ENVIRONMENTS ARE SCHOOL, CHURCH, WORKPLACE AND NEIGHBORHOOD.

TO GIVE YOU AN EXAMPLE OF WHAT THAT MIGHT LOOK LIKE, IT WOULD BE -- LET'S SAY THE CONDITION OF A HOMELESS CHILD IN THE ENVIRONMENT OF

SCHOOL CAN AFFECT THEIR HEALTH OUTCOMES. WE WILL PROBABLY -- WE WILL GO OVER THAT IN A LITTLE BIT. SO, HOW DO YOU ADDRESS THE SOCIAL DETERMINANTS OF HEALTH? ACCORDING TO THE HEALTHY PEOPLE 2020, WHICH IS A PART OF THE OFFICE OF DISEASE PREVENTION AND HEALTH PROMOTION, THEY CAME UP WITH A PLACE SPACE FRAMEWORK, WHICH ARE ECONOMIC STABILITY, EDUCATION, SOCIAL AND COMMUNITY CONTEXTS, HEALTH AND HEALTHCARE, NEIGHBORHOOD AND BUILT ENVIRONMENT. SO, IF WE TAKE THE EXAMPLE OF THE HOMELESS CHILD GOING TO SCHOOL, ONE, THE ECONOMIC STABILITY, WHICH WOULD BE HOUSING STABILITY, HOW DOES THAT NECESSARILY AFFECT THAT CHILD'S OUTCOMES IN HEALTH? WELL, THAT CHILD IS LIKELY GOING TO STRESS OVER WHERE TO SLEEP AT NIGHT, MAYBE EVEN SHOWERING AND DOING SOME BASIC ADL.

SO THAT STRESS WILL LEAD TO OTHER THINGS AND NOT NECESSARILY THEIR LEARNING. THEY ARE JUST WORRIED ABOUT SO MUCH MORE THAN WHAT A NORMAL CHILD WHO WOULD HAVE STABLE HOUSING. NUMBER TWO, EDUCATION. SO, THEY WOULD HAVE PROBABLY A DECREASED TIME WITH HOMEWORK OR HELP MAYBE EVEN DECREASED TIME TO DO THEIR HOMEWORK, SAY IF THEY ARE HOMELESS LIVING IN A CAR WITH THEIR FAMILY THEY MAY NOT HAVE LIGHTING UNTIL AFTER DARK. SO THE TIME TO BE ABLE TO DO HOMEWORK, WHICH I BELIEVE MOST CHILDREN DO IS GOING TO BE DECREASED. SO THEY MAY NOT BE ABLE TO SPEND AS MUCH TIME ON THEIR HOMEWORK AND THEY MAY NOT HAVE ACCESS TO RESOURCES LIKE COMPUTERS. I HAVE A SMALL CHILD IN ELEMENTARY SCHOOL AND A LOT OF THE CURRICULUM IS TURNING TOWARDS COMPUTER-BASED LEARNING. SO, WHO MAY NOT HAVE THOSE RESOURCES IS GOING TO HAVE ADDED STRESS IN THEIR LIFE. OKAY. WE WILL TALK ABOUT SOCIAL AND COMMUNITY CONTEXT. THERE COULD BE DISCRIMINATION FROM OTHER KIDS IF THEY FIND OUT THE CHILD IS HOMELESS OR SOMETHING AS SIMPLE AS NOT BEING ABLE TO TAKE A

SHOWER THE NEXT NIGHT. THEY MIGHT BE AFRAID THAT OTHER KIDS WILL MAKE FUN OF THEM. FOUR, HEALTH AND HEALTHCARE. PARENTS MAY NOT UNDERSTAND HEALTH LITERACY OR HAVE HEALTH LITERACY AND UNDERSTAND WHEN TO TAKE A CHILD TO THE PHYSICIAN WHEN THEY ARE SICK OR HAVE ACCESS TO HEALTH INSURANCE THAT MAY PAY FOR THEIR HEALTHCARE TO SEE A PHYSICIAN AND THEN NOT CHOOSE TO SEE A PHYSICIAN WHEN THEIR CHILD IS SICK. THE LAST ONE, THE NEIGHBORHOOD AND BUILT ENVIRONMENT. CONSTANTLY WORRYING ABOUT A SAFE ENVIRONMENT TO SLEEP EVERY NIGHT OR ACCESS TO HEALTHY FOOD IN THAT AREA CAN AFFECT THE CHILD'S HEALTH. THIS IS ONE SOCIAL DETERMINANT OF HEALTH THAT CAN AFFECT THE OUTCOME OF SOMEBODY'S HEALTH. IN THIS ONE IT IS A CHILD BUT THERE ARE PROBABLY MANY MORE SCENARIOS AND MAYBE NOT EVERY AREA WILL BE TOUCHED ON WITH OTHER EXAMPLES BUT YOU CAN KIND OF SEE WHERE THIS IS GOING.

IF YOU WANT MORE INFORMATION, OR A BETTER UNDERSTANDING OF THE SOCIAL DETERMINANTS OF HEALTH, YOU CAN FIND IT AT HEALTHYPEOPLE.GOV AT THEIR WEBSITE. OKAY. SO, WHEN WE ARE TALKING ABOUT SOCIALLY COMPLEX PATIENTS, WE'RE USUALLY TALKING ABOUT A VULNERABLE POPULATION. I USUALLY SEE THIS KIND OF VULNERABLE POPULATION WITHIN THE FACILITY I WORK IN. THIS IS A HOMELESS POPULATION, EVEN GERIATRIC POPULATION OR ORPHANED POPULATION. WHAT DOES IT MEAN BY "ORPHANED"? USUALLY SOMEONE WITHOUT SUPPORT, LEFT TO LIVE ON THEIR OWN AND NOT ABLE TO CARE FOR THEMSELVES OR MARGINALLY CARE FOR THEMSELVES. THE NEXT SLIDE WILL FOCUS ON SKILLS THAT WE MIGHT NEED AS AN ACUTE CARE THERAPIST THAT WOULD HELP TO KIND OF ADDRESS SOCIALLY COMPLEX PATIENTS. THIS IS TAKEN FROM THE ACADEMY OF ACUTE CARE PHYSICAL THERAPY AND THEIR CORE COMPETENCIES FOR ENTRY-LEVEL PRACTICE IN ACUTE CARE PHYSICAL THERAPY. SO, THIS DOCUMENT WAS

CREATED BY THE MINIMUM SKILLS TASK FORCE IN 2015. THERE'S FIVE SECTIONS THAT THEY DETERMINED WOULD BE IMPORTANT SKILLS FOR AN ENTRY-LEVEL THERAPIST IN ACUTE CARE. THAT WOULD BE CLINICAL DECISION MAKING, COMMUNICATION, SAFETY, PATIENT MANAGEMENT, AND DISCHARGE PLANNING.

THERE ARE FIVE SECTIONS WITH DETAILED CHARACTERISTICS FOR EACH SECTIONS. I'M JUST CHOOSING TO HIGHLIGHT A FEW CHARACTERISTICS FROM THE CLINICAL DECISION-MAKING SECTION. I WOULD ACTUALLY SUGGEST GOING TO THE ACADEMY OF ACUTE CARE PHYSICAL THERAPY WEBSITE AND YOU CAN GO TO THEIR EDUCATION TAB. IT WILL LIST CORE COMPETENCIES AND YOU CAN DOWNLOAD THE DOCUMENT TO GIVE YOU A MORE COMPREHENSIVE GUIDE.

SO CLINICAL DECISION MAKING -- I'VE JUST PICKED OUT A FEW THAT I THOUGHT WERE SOMEWHAT IMPORTANT. BEING OBSERVANT TO THE DETAILS OF THE PATIENT'S HISTORY, PHYSICAL EXAMINATION AND COMPLEX ENVIRONMENT. SOMETIMES WHEN YOU DO A CHART REVIEW, IT DOESN'T GIVE THE WHOLE PICTURE OF THE PATIENT. SO WHEN YOU ARE ACTUALLY DOING AN EXAMPLE NATION, YOU NEED TO BE KEYING IN ON SEEING AND TAKING IN SOME DETAILS ABOUT THE PATIENT WHILE YOU ARE DOING THE EVALUATION. NUMBER TWO, PREDICT PATIENT PRESENTATION AND ANTICIPATE NEEDS AND RESOURCES. THREE, SCREEN THE MEDICAL RECORDS TO DETERMINE WHETHER THE PATIENT WILL BENEFIT FROM PHYSICAL THERAPY SERVICES AT THE POINT IN TIME, AND THEN CLEARLY COMMUNICATE THE CLINICAL RATIONALE TO THE MEDICAL TEAM POST ASSESSMENT. SO, KNOWING WHETHER YOUR PHYSICAL THERAPY INTERVENTION WILL APPROVE THEIR ACUTE CARE CONDITION MAY HELP IN TERMS OF SCREENING FOR THIS PATIENT. IDENTIFY AND DIFFERENTIATE UNDERLYING CONDITIONS AND, BODY SYSTEM

IMPAIRMENTS, CONTEXTUAL FACTORS, ACTIVITY LIMITATIONS AND PARTICIPATION RESTRICTIONS. WHAT DOES THIS MEAN? CRITICALLY REFLECT ON INFORMATION, KNOWLEDGE, EXPERIENCE AND EVIDENCE TO CREATE A COMPREHENSIVE PHYSICAL THERAPY PLAN OF CARE THAT'S INDIVIDUALIZED AND FOCUSED ON PATIENT AND CAREGIVER GOALS AND CIRCUMSTANCES. THIS IS PROBABLY ONE OF THE HARDEST THINGS TO DO. YOU ARE TRYING TO SYNTHESIZE ALL OF THE INFORMATION YOU HAVE GATHERED AND CREATE A REALISTIC PLAN OF CARE. ALL RIGHT. SO, IN MY FACILITY, WE HAVE A DEDICATED SOCIAL MEDICINE SERVICE THAT IS FAIRLY NEW, LIKE WITHIN THE LAST THREE YEARS. THERE HAVE BEEN MULTIPLE ITERATIONS OF THIS SERVICE IN THE PAST. TRYING TO DETERMINE WHO SHOULD BE INVOLVED. IT WILL PROBABLY CONTINUE TO EVOLVE BUT AS OF NOW ITS FUNCTION IS TO BE THE PRIMARY TEAM FOR PATIENTS WHO ARE ADMITTED WITH A SOCIAL SITUATION THAT PREVENTS THEM FROM RETURNING OR DISCHARGING HOME SAFELY. THE SOCIAL MEDICINE SERVICE ALSO COORDINATES CARE AMONGST VARIOUS PROVIDERS, AS NEEDED. USUALLY THE TEAM IS MADE UP OF A PHYSICIAN, UTILIZATION MANAGEMENT OR PATIENT CARE COORDINATOR AND MEDICAL SOCIAL WORKER.

SO, THIS TEAM WILL USUALLY CONSULT ANCILLARY PROVIDERS, AS NECESSARY. IT DEPENDS ON THE INDIVIDUAL PATIENT SITUATION. A LOT OF TIMES PHYSICAL THERAPY AND OCCUPATIONAL THERAPY WILL BE CONSULTED.

OKAY. SO NOW WE'RE AT THE PART OF WHAT ARE YOU GOING TO ACTUALLY START DOING. THE NEXT FEW SLIDES I TRIED TO LAY OUT STEP BY STEP KIND OF A GUIDELINE. IT'S BY NO MEANS A COOKBOOK AND A RECIPE THAT YOU HAVE TO FOLLOW EXACTLY, BUT JUST A GUIDELINE FOR YOU TO USE AS APPROPRIATELY. SO, IF YOU HAVE A COMPLICATED PATIENT, OR SOCIALLY COMPLICATED PATIENT, WHERE DO YOU REALLY START? FIRST OF ALL, WE WILL

START WITH THE CHART REVIEW. THAT SEEMS PRETTY STANDARD AND BASIC. I THINK EVERYBODY SHOULD BE OR IS DOING THAT BEFORE THEIR EVALUATION. YOU KNOW, WHY PUT THE CHART REVIEW AS IMPORTANT IS BECAUSE SOMETIMES YOU MIGHT NOT BE GETTING A FULL PICTURE JUST BY READING THE MOST CURRENT CHART REVIEW. YOU MAY HAVE TO LOOK TO SEE IF THERE'S ANY PAST ADMISSIONS TO GET MORE OF A COMPREHENSIVE IDEA OF A PATIENT'S SITUATION. YOU CAN SOMETIMES FIND PREVIOUS DOCUMENTED PHYSICAL ENVIRONMENTS, FUNCTION, AND COGNITION. IN MY FACILITY, THERE HAVE BEEN MANY TIMES WHERE THE CURRENT ADMISSION IS NOT THE FIRST ADMISSION. THERE WILL BE MAYBE MULTIPLE ADMISSIONS AND EVEN SOMETIMES AN ALTERNATE MRN THAT HASN'T BEEN COLLATED WITH THE CURRENT MRN. SO DOING A THOROUGH CHART REVIEW AND REALLY TRYING TO FIND OUT ABOUT THE PATIENT AND GET A VERY GOOD IMPRESSION OF WHAT THEIR LIFE IS LIKE IS IMPORTANT.

AND THEN THE NEXT THING YOU SHOULD DO IS TO HAVE A GUIDELINE OF WHAT YOU ARE LIKELY GOING TO DO WITH YOUR TIME WITH THAT PATIENT. YOU MAY HAVE TO MAKE SOME INITIAL ASSUMPTIONS ABOUT THE PATIENT. YOU KNOW, WHAT DOES THIS REALLY MEAN, AN IDEA OF WHAT INFORMATION YOU WILL NEED TO FIND OUT. AND HOW YOU MAY CONDUCT YOUR OBJECTIVE EXAM. YOU MAY MAKE SOME ASSUMPTIONS OF WHAT WILL HAPPEN, BUT YOU WILL ALSO NEED TO HAVE A CONTINGENCY PLAN IF THESE ASSUMPTIONS DON'T WORK OUT. SO, HAVING A ROUGH GUIDELINE OF HOW YOU SEE THE TIME WITH THE PATIENT IS KIND OF IMPORTANT. THINGS CAN QUICKLY CHANGE FROM MOMENT TO MOMENT. OKAY. YOU ALSO NEED TO UNDERSTAND WHAT WILL YOU BRING TO THE TABLE AS A PHYSICAL THERAPIST? WHAT TREATMENT IDEAS WILL YOU HAVE THAT CAN HELP UNCOVER SOME OF THE INFORMATION OR HELP WITH THE PATIENT'S FUNCTION OR SITUATION? AND THEN THE NEXT PART WILL BE ACTUALLY DOING THE EVALUATION. AGAIN, WITH YOUR EVALUATION,

YOU ARE GOING TO BE FILLING IN THE BLANKS WITH YOUR SUBJECTIVE QUESTIONS. YOU MAY NOT GET ALL OF THE INFORMATION FROM YOUR CHART REVIEW. SO, FILLING IN THOSE BLANKS, LIKE MAYBE YOU KNOW THE PATIENT LIVES ALONE. DO YOU KNOW WHETHER THEY HAVE STAIRS? IF THEY ARE LIVING ALONE, ARE THEY FUNCTIONING MARGINALLY. DO THEY HAVE ANY ASSISTANCE? WHAT'S THE DAY LIKE FOR THE PATIENT? FOR EXAMPLE, MAYBE THE PATIENT LIVES ALONE. THEY ARE MAYBE WALKING MINIMALLY BUT ABLE TO WALK TO THE CORNER MARKET EVERY DAY TO GET FOOD. ALL RIGHT? AND THEN YOU ARE GOING TO DO YOUR OBJECTIVE EXAM TO GIVE YOU OBJECTIVE FINDINGS FOR THEIR PHYSICAL FUNCTION.

SO AS YOU ARE DOING YOUR EVALUATION, A LOT OF THINGS ARE GOING THROUGH YOUR MIND. SOME OF THE CONSIDERATIONS THAT YOU SHOULD HAVE IN THE BACK OF YOUR HEAD AS YOU ARE DOING YOUR EVALUATION, YOU KNOW, THE FIRST TIER, WHAT I COULD CONSIDER THAT I'M RUNNING THROUGH AS I'M DOING MY EVALUATION IS WHAT IS THEIR MEDICAL ACUITY? WE'RE AN ACUTE CARE HOSPITAL. THEY ARE HERE FOR A REASON. USUALLY IT'S BECAUSE THERE'S SOME MEDICAL SITUATION HAPPENING. MAYBE THERE'S NOT.

THAT'S WHERE WE GET INTO SOME OF THE PLAY WITH THE SOCIALLY COMPLEX PATIENTS. DOES THE PATIENT ACTUALLY HAVE ANY FUNCTIONAL DEFICITS, NEW, OLD OR EVEN ANY. THIS MAY SEEM LIKE A FUNNY QUESTION, BUT SOMETIMES PHYSICIANS CAN CONSULT PHYSICAL THERAPY WITHOUT EVEN REALLY ASKING THE QUESTION TO THE PATIENT. SO, IT WILL BE OUR JOB TO DETERMINE IF THERE ARE FUNCTIONAL DEFICITS THAT WE CAN TREAT. IS THE PATIENT'S REPORTED BASELINE WORSE NOW, OR IS IT THE SAME? WILL THEY BENEFIT FROM A SKILLED PHYSICAL THERAPY INTERVENTION TO RETURN TO THEIR BASELINE FUNCTION IF THEY ARE WORSE? SO, I ASK THIS FULL KNOWING

PROGNOSTICATION IS NOT EASY, BUT AT LEAST START TO ASK THE QUESTION AS YOU ARE EVALUATING THE PATIENT. SOME OF THOSE THINGS THAT ALSO COME WITH ASKING THIS QUESTION IS, YOU KNOW, IS A PHYSICAL THERAPY INTERVENTION GOING TO BE THE BEST INTERVENTION FOR THIS PATIENT TO RETURN TO THEIR BASELINE, OR IS IT GOING TO BE A MEDICAL INTERVENTION BECAUSE THERE'S SOME MEDICAL ACUITY FOR THEM BEING IN THE HOSPITAL. WILL IT BE TIME OR WILL IT BE GENERAL MOBILITY OR RESTORATIVE PROGRAM THAT IS PROVIDED AS AN UNSKILLED INTERVENTION? AND THEN ALSO, WHAT ENVIRONMENT WILL THE PATIENT NEED TO NEGOTIATE WHEN THEY RETURN HOME? SO, MY SECOND TIER OF CONSIDERATIONS THAT I HAVE GOING ON IN THE BACK OF MY MIND AS I'M EVALUATING A PATIENT WOULD BE THEIR BEHAVIOR. IS THEIR BEHAVIOR GOING TO AFFECT THE TREATMENT OR RECOMMENDATION?

WHAT DOES THAT REALLY MEAN? FOR EXAMPLE, ARE THEY AMENABLE TO THE EDUCATION I WILL BE PROVIDING? WILL THEY BE COMPLIANT WITH THAT EDUCATION AND RECOMMENDATION? MAYBE THERE ARE OTHER FACTORS MORE IMPORTANT THAN FOLLOWING THROUGH WITH OUR PLAN OF CARE OR OUR HOME EXERCISE PROGRAM THAT THE PATIENT IS WORRIED ABOUT. EXAMPLES MIGHT BE THEY ARE MORE WORRIED ABOUT HAVING HOUSING AND A SAFE PLACE TO LIVE, OR MAYBE IT'S ABOUT FOOD. THAT SEEMS TO BE MORE IMPORTANT THAN FOLLOWING THROUGH WITH THE PLAN OF CARE WE SET UP FOR THE PATIENT SOMETIMES.

ALL RIGHT. DO THEY LIVE IN THE COUNTY OR LOCAL AREA? THE REASON WHY I THINK ABOUT THIS IS WHAT SERVICES ARE AVAILABLE WITHIN THE COUNTY THAT MAY BE THEIR INSURANCE IS MANAGED THROUGH AND ARE THEY ABLE TO COME BACK FOR FOLLOWUP APPOINTMENTS? WHAT RESOURCES ARE AVAILABLE POST DISCHARGE? AGAIN, THIS WILL DEPEND ON

THE ABOVE WITH INSURANCE AND COUNTY SERVICES THAT ARE AVAILABLE TO THEM. AND THEN I PUT HERE, HEALTH SYSTEM POLITICS. THIS ONE'S KIND OF HARD. EVERY FACILITY IS DIFFERENT BUT, FOR EXAMPLE, WE HAVE A LOT OF PATIENTS WAITING FOR LONG-TERM PLACEMENT. OUR HEALTH SYSTEM DOESN'T HAVE ENOUGH RESOURCES FOR A CUSTODIAL BED. SO, THERE'S USUALLY A SIX-MONTH WAITING LIST WITHIN OUR COUNTY TO GET ONE OF THESE CUSTODIAL BEDS, BUT THAT HAS TO BE WEIGHED AGAINST THE COST OF STAYING IN AN ACUTE CARE BED. THOSE ARE THE HEALTH SYSTEM POLITICS THAT MY FACILITY USUALLY DEALS
THEN IS THE PATIENT A FREQUENT FLYER? DOES THE PATIENT HAVE MULTIPLE ADMITS FOR THE SAME REASON IN A SHORT AMOUNT OF TIME, AND ARE THEY CONSISTENTLY COMING IN FOR THE SAME REASON? OKAY. YOU MAY ASK WHAT OUTCOME MEASURES ONE SHOULD USE WHEN YOU'RE EVALUATING A PATIENT.

AS MOST PHYSICAL THERAPY STUDENTS HATE TO HEAR, IT DEPENDS. YOU'LL NEED TO DETERMINE THE RIGHT TOOLS FOR THE SPECIFIC SITUATION AND PATIENT THAT WILL BE IN FRONT OF YOU, WHETHER THAT IS AN OUTCOME MEASURE, HIGHLIGHTING THE PHYSICAL OR COGNITIVE OR QUALITY OF LIFE DEFICITS. AND OF COURSE DOCUMENTATION OF THESE OUTCOME MEASURES MAY HELP TO SUPPORT YOUR RECOMMENDATION AND ASSESSMENT. HOW TO DETERMINE GOALS. I KNOW THIS IS PROBABLY ONE OF THE HARDEST THINGS AS A NEW THERAPIST TO GRASP WHEN YOU ARE IN AN ACUTE CARE HOSPITAL BECAUSE THINGS GO BY SO QUICKLY AND THERE'S SO MUCH INFORMATION TO SYNTHESIZE AT ONCE. SO FIRST, YOU SHOULD ASK WHAT ARE THE PATIENT'S GOALS? AND THEN YOU'LL NEED TO CONSIDER WHAT ARE THE PHYSICIAN'S GOALS. I PUT THIS HERE BECAUSE SOMETIMES THE PHYSICIAN'S GOALS MAY NOT BE IN LINE WITH THE PATIENT'S OR YOUR GOALS FOR THE PATIENT. AND THEN WHAT IS A REALISTIC GOAL IN A SPECIFIC TIME FRAME THAT YOU HAVE IN

MIND? DOES IT MATCH THE PATIENT'S GOALS? DOES IT MATCH THE ENVIRONMENT THEY WILL RETURN TO?

ALL RIGHT. SO, I THINK THIS SLIDE MIGHT BE SLIGHTLY CONFUSING. I APOLOGIZE IF IT IS. FEEL FREE TO ASK ANY QUESTIONS. BUT IF YOU HAVE DETERMINED A GOAL YOU ARE LIKELY TO BE RECOMMENDING SOME FORM OF THERAPY. ONCE YOU HAVE DETERMINED A REALISTIC GOAL, YOU WANT TO DETERMINE THE FREQUENCY AND DURATION AND WHY THIS IS IMPORTANT IS BECAUSE THEN YOU ARE GOING TO LIKELY SLOT IN A RECOMMENDATION FOR ONE OF THESE LEVELS OF REHAB. SO, WHAT LEVEL OF REHABILITATION DOES THE PATIENT NEED TO REACH THE GOALS THAT YOU HAVE DETERMINED? I THINK MOST PEOPLE UNDERSTAND WHAT ALL OF THESE ARE BUT WE WILL RUN THROUGH THEM QUICKLY, ACUTE REHAB, INTENSIVE DAILY THERAPY, AT LEAST THREE TO FIVE HOURS A DAY. SNF REHAB IS DAILY THERAPY BUT NOT AS INTENSE I HAVE, A RESTORATIVE PROGRAM IN A CUSTODIAL ENVIRONMENT, LIKE A BOARDING CARE OR SUBACUTE.

I THINK MOST PEOPLE KNOW WHAT A RESTORATIVE PROGRAM IS, BUT IF YOU DON'T, A RESTORATIVE PROGRAM CAN USUALLY BE CARRIED OUT BY A NON-SKILLED PHYSICAL THERAPIST, OR THERAPIST, BUT MANY PLACES I KNOW THE THERAPIST WILL DO THE EVALUATION AND IT WILL BE CARRIED OUT BY EITHER A NURSING ASSISTANT OR A REHAB TECH. AND THEN THERE WILL BE HOME HEALTH REHAB, OUTPATIENT REHAB, WHICH WILL BE DETERMINED BY THAT OUTPATIENT THERAPIST. I WOULD SAY THAT IS NOT AS OFTEN AS DAILY. IT MAY BE EVEN ANYWHERE FROM THREE TIMES A WEEK TO ONCE A MONTH. AND THEN NO REHAB IS ANOTHER OPTION. SO, WHEN I SAY "NO REHAB," IT MAY BE THAT THE PATIENT DOESN'T NEED ANY REHAB OR ONLY NEEDED A ONE-TIME EDUCATION DURING YOUR EVALUATION. OKAY. SO, WHAT IS THE PT'S ROLE? CERTAIN PT CONSULTS THAT COME IN MAY NOT MAKE IT CLEAR WHAT OUR

ROLE IS IN THE PATIENT'S CARE. ONE MIGHT ASSUME IF WE WERE CONSULTED, THE PHYSICIAN OR THE TEAM HAS ALREADY DETERMINED THAT WE HAVE A ROLE TO PLAY, BUT IT MAY JUST BE A CONSULT BECAUSE THEY NEEDED ANOTHER SET OF EYES TO HELP THEM MAKE SOME DECISIONS. SO, WHEN I SAY WHAT IS THE PT'S ROLE, I THINK THIS IS WHAT OUR ROLE SHOULD BE. IT IS DETERMINING THE FUNCTIONING LEVEL AND RECONCILING IT WITH WHATEVER AVAILABLE RESOURCES THERE ARE TO THE PATIENT. DETERMINING ADDED OR NEEDED ASSISTANCE THAT THE PATIENT DOESN'T HAVE AVAILABLE CURRENTLY, OR EVEN REHABILITATIVE PROGNOSTICATION. CAN THE PATIENT IMPROVE FOR SAFE DISCHARGE THROUGH A REHABILITATIVE PROGRAM? SO, BARRIERS TO DISCHARGE THAT WE SHOULD BE THINKING ABOUT AS WE'RE TAKING IN ALL OF OUR INFORMATION. FIRST THING I USUALLY THINK ABOUT IS THE ENVIRONMENT.

YOU KNOW, NOT EVERYBODY HAS A VERY NICE RANCH HOME WITH NO STAIRS TO GET IN AND MULTIPLE FAMILY MEMBERS TO HELP. THE SOCIALLY COMPLEX PATIENTS USUALLY DON'T HAVE ANY OF THAT. A LOT OF TIMES, YOU KNOW, THEY MAY HAVE MULTIPLE SET OF STAIRS OR LIVE ON A HILL, JUST TO EVEN GET INTO THEIR SMALL APARTMENT, WHICH MAY NOT ALWAYS HAVE A BATHROOM OR SHOWER IN THEIR ROOM. SOME PATIENTS MAY LIVE IN THEIR VEHICLES, NOT JUST IS THERE A VEHICLE IN ORDER TO GET HOME. PATIENTS MAY HAVE UNSTABLE OR EVEN NO HOUSING. SO SOMETHING LIKE COUCH SURFING. IF YOU DON'T KNOW WHAT COUCH SURFING IS, IT'S, YOU KNOW, SLEEPING ON ONE PERSON'S COUCH ONE NIGHT AND MAYBE SLEEPING ON ANOTHER PERSON'S COUCH ANOTHER NIGHT. SO, THEY ARE JUST CONSTANTLY MOVING FROM ONE ENVIRONMENT TO ANOTHER. A TENT, SOME OF THE PATIENTS I SEE WILL LIVE IN TENTS. SOMETIMES THOSE TENTS NEED TO BE PACKED UP AND MOVED. AND SOMETIMES THEY ARE SOMEWHAT STABLE FOR A SHORT PERIOD OF TIME. AND THEN JUST THE PLAIN STREET, THE SIDEWALK THAT PEOPLE,

THAT PATIENTS WILL BE SLEEPING IN. IT MAY NOT EVEN BE A COVERED AREA OF THE STREET, IN AN ALCOVE. IT MIGHT BE JUST AN OPEN AREA. ARE THEY UNSUPPORTED? DO THEY HAVE A LACK OF SUPPORT IN TERMS OF WHEN THEY GO HOME? DO THEY HAVE ANYBODY TO ASSIST THEM WITH ANYTHING, EVEN JUST GETTING A MEAL, MAYBE BEING ABLE TO CALL THE HOSPITAL OR PHYSICIAN TO SET UP APPOINTMENTS, OR DO THEY HAVE POOR SUPPORT? MAYBE THEY HAVE FAMILY, BUT THEIR FAMILY IS NOT REALLY ABLE TO HELP TO TAKE CARE OF THEM BECAUSE THEIR FAMILY IS WORKING OR THEY HAVE THEIR OWN LIVES OR MAYBE THEIR FAMILY CAN ONLY HELP ONCE IN A WHILE. AND THEN ANOTHER BARRIER MIGHT BE THEIR COGNITION OR THEIR CAPACITY. MAYBE THE PATIENT IS PHYSICALLY FUNCTIONING FINE, BUT THEIR COGNITION IS THEY DON'T HAVE ANY INSIGHT INTO THEIR DEFICITS OR EVEN THEIR OWN SAFETY AWARENESS. THESE MIGHT BE PATIENTS WHO HAVE HAD PREVIOUS TBIS AND LIVING ON THEIR OWN WITHOUT ANY SUPPORT AND UNFORTUNATELY, THEIR SITUATION IS THAT THEY HAVE JUST BEEN LIVING OUT THERE MARGINALLY AND DEALING WITH SOMETHING DAY TO DAY, BUT THEY PROBABLY SHOULDN'T BE LIVING ALONE. OKAY.

SO, I'VE LISTED SOME DISCHARGE DESTINATIONS THAT ARE AVAILABLE IN MY COMMUNITY. THIS IS NOT AN EXHAUSTIVE LIST, BUT IT GIVES YOU AN IDEA OF AVAILABLE RESOURCES TO KIND OF CHECK WITHIN YOUR OWN COMMUNITY WHAT IS AVAILABLE. I WILL GO THROUGH SOME OF THESE. SOME MIGHT BE FAMILIAR, SOME MAY NOT BE FAMILIAR, DEPENDING ON WHERE YOU PRACTICE. SO, WE ALL KNOW REHABILITATION. YOU KNOW THERE'S ACUTE REHAB, SNF REHAB, HOME HEALTH REHAB AND OUTPATIENT REHAB. SKILLED NURSING FACILITY, MAYBE THERE'S REHAB AVAILABLE BUT MAYBE THE PATIENT'S MAIN REASON FOR GOING TO A SKILLED NURSING FACILITY MIGHT BE WOUND CARE OR IV ANTIBIOTICS, AND AT THESE FACILITIES THEY CAN GET REHABILITATION OR EVEN A RESTORATIVE PROGRAM. A LONG-TERM ACUTE CARE OR SUBACUTE

FACILITY, A BOARDING CARE, WHICH IS ALSO -- WE HAVE PSYCH BOARDING CARES IN OUR COMMUNITY. SO THIS IS A PLACE WHERE MOST OF THE PATIENTS ARE INDEPENDENT IN THEIR FUNCTIONING, BUT THEY MAY NEED TO LIVE WITHIN THE BOARDING CARE TO HAVE SOME SUPERVISION TO HELP WITH MEDICAL MANAGEMENT OR SOCIAL MANAGEMENT. THERE'S ALSO ADULT DAY HEALTH PROGRAMS WHERE IF YOU HAVE FAMILY BUT THEY ARE NOT ABLE TO TAKE CARE OF THE PATIENT DURING THE DAY AND THE PATIENT NEEDS MORE SUPERVISION, THEIR FAMILIES CAN SIGN PATIENT UP FOR ADULT DAY HEALTH. IT IS ALMOST LIKE DAY CARE AND THEN THEY CAN PICK THEM UP OR HAVE THE PATIENT TRANSPORTED BACK HOME TO WHEN THE FAMILY IS AVAILABLE TO TAKE CARE OF THEM IN THE EVENING. RESPITE.

RESPITE IS ACTUALLY MEDICALLY FOCUSED BEDS IN A SHELTER ENVIRONMENT. SO, THERE'S A PHYSICIAN MONITORING THESE PATIENTS. HOWEVER, IN RESPITE, THE PATIENT MUST BE INDEPENDENT WITH THEIR FUNCTIONING AND WITH THEIR ADLS. SO EVEN IF YOU WERE TO SAY THE PATIENT NEEDED SUPERVISION JUST TO BECOME COMPLIANT WITH THEIR WEIGHT-BEARING STATUS, MOST OF THE RESPITE BEDS WILL SAY, YEAH, WE'RE NOT REALLY ABLE TO PROVIDE THAT BECAUSE WE'VE GOT OTHER PATIENTS IN MULTIPLE BEDS HERE THAT WE CAN'T ALWAYS KEEP SUPERVISION FOR THE PATIENT. SO, SHELTER IS DIFFERENT. SHELTER IS USUALLY PATIENTS HAVE TO LEAVE DURING THE DAY. AND THEN THEY HAVE TO COME BACK IN THE EVENING AND LINE UP IN ORDER TO GET A BED. SO, SOME OF THE EXCEPTIONS ARE THE PHYSICIAN CAN ASK FOR A REST AND RECLINE. MEANING WHILE THE PATIENT MAY NOT BE RESPITE OR MAYBE THERE IS NOT A RESPITE BED AVAILABLE, THAT THEY CAN STAY IN THE SHELTER WITHOUT HAVING TO LEAVE. THIS WILL DEPEND ON WHETHER THE SHELTER HAS THE ABILITY TO ALLOW FOR THE REST AND RECLINE. A LOT OF SHELTERS ALSO IN OUR COMMUNITY ARE 90-DAY BEDS. SO, THE PATIENT CAN BE DISCHARGED TO A SHELTER AND KEEP THAT BED FOR

90 DAYS, BUT THEN IF THEY WERE -- IF THE PATIENT WERE TO LEAVE THE SHELTER AND NOT COME BACK, THEY MIGHT HAVE A TIME LIMIT IN WHICH THAT PATIENT WOULD LOSE THAT 90-DAY BED. NAVIGATION CENTER. SO, THIS IS SOMETHING THAT IS FAIRLY NEW IN MY COMMUNITY. IT IS TEMPORARY HOUSING, SOMEWHAT LIKE A SHELTER BUT THERE'S CASE MANAGEMENT THERE TO GET THEM PLUGGED INTO OTHER HOUSING. DETOX CENTERS, WE'RE TALKING ABOUT MAYBE ALCOHOLICS, WHEN SOMEONE IS IN ALCOHOL WITHDRAWAL AND THEY CAN GO TO A DETOX CENTER. MOST OF PATIENTS NEED TO BE INDEPENDENT. WE HAVE IN HOME SUPPORTIVE CARE SERVICE GIVERS. THIS RESOURCE IS FOR PATIENTS WHO QUALIFY, USUALLY THROUGH OUR FACILITY IT IS THROUGH MEDI-CAL.

I DON'T KNOW IF MEDICAID HAS IT AVAILABLE, BUT THE PATIENT IS ABLE TO APPLY FOR AN IHHS CAREGIVER TO COME AND HELP WITH CERTAIN THINGS, MAYBE LIKE INSTRUMENTAL ADLS, COOKING, CLEANING OR EVEN SUPERVISION. DEPENDING ON THAT CASE, IT WILL BE DETERMINED HOW MANY HOURS THE PATIENT WILL GET. THEN THERE IS ALSO IN-PATIENT PSYCH FACILITIES. OTHER DISCHARGE DESTINATIONS WOULD BE HOME HOSPICE, JAIL, A STABILIZATION ROOM IS USUALLY JUST A HOTEL ROOM. OUR COMMUNITY HAS BEEN ABLE TO OFFER THESE EVER SO OFTEN.

THEY ARE USUALLY LIKE ONE OR TWO NIGHTS JUST TO HELP THE PATIENT GET TAPPED INTO RESOURCES. SOMETIMES OUR PATIENTS GO WITH FAMILY AND FRIENDS, AND NOT EVERYBODY HAS THIS. SOMETIMES THE PATIENTS ARE REACHING OUT TO DISTANT FAMILY AND, YOU KNOW, ACQUAINTANCES RATHER THAN GOOD FRIENDS. AND THEN SOME UNUSUAL SITUATIONS FOR DISCHARGE ARE MAYBE AN AIRPLANE OR A BUS. WE HAVE A PROGRAM CALLED HOMEWARD BOUND. IF A PATIENT IS OUT OF STATE AND WISHES TO RETURN TO THEIR HOME STATE, THEY CAN GET THIS RESOURCE TO HELP THEM GET A BUS

TICKET HOME. SO, IT LOOKS LIKE THERE'S A COUPLE OF QUESTIONS OR A COUPLE OF COMMENTS. ALLISON ASKS, IS BOARDING CARE TEMPORARY OR LONG-TERM HOUSING? BOARDING CARE IS USUALLY A LONG-TERM HOUSING SITUATION. WHAT WILL HAPPEN IS IF, FOR EXAMPLE, IF A PATIENT IS NOT ABLE TO CARE FOR THEMSELVES OR HAS MAYBE SOME COGNITIVE DEFICITS AND THE FAMILY IS UNABLE TO CARE FOR THE PATIENT, THEY WILL FIND BOARDING CARE. AGAIN, BOARDING CARE, THE PRICE WILL DEPEND ON THE BOARDING CARE AND SOMETIMES INSURANCE CAN HELP TO COVER THOSE COSTS, BUT IT IS ESSENTIALLY A PLACE FOR A PATIENT TO LIVE. THERE WILL BE SOME SUPPORT. THERE WON'T BE A PHYSICIAN THERE BUT THERE WILL BE SOME NURSING ASSISTANT TYPES OR EVEN A NURSE THAT IS AVAILABLE TO HELP THE PATIENT MAYBE WITH MEDICINE -- EXCUSE ME, THEIR MED MANAGEMENT, MEDICATIONS THAT THEY TAKE, TAKING THEM TO APPOINTMENTS.

A LOT OF TIMES THESE BOARDING CARES, THE PATIENTS ARE ABLE TO KIND OF LIVE THEIR OWN LIFE FREELY, LIKE LEAVE THE BOARDING CARE AND COME BACK FOR A MEAL AND HAVE A PLACE TO SLEEP AND SOMEONE'S HELPING THEM. SHARELY MARR. HOPEFULLY I'M NOT SAYING YOUR NAME WRONG. HOW ABOUT INSURANCE GOALS? INSURANCE HAS SOME GOALS AND THAT IS TRICKY. THAT IS SOMETHING WE HAVE TO KEEP IN THE BACK OF OUR MIND BUT ALSO NOT LET IT DICTATE OUR OWN PLAN OF CARE. DOES ANYBODY ELSE HAVE ANY QUESTIONS? IT SEEMS LIKE, YOU KNOW, I MIGHT HAVE BEEN BLOWING THROUGH A LOT OF THIS AND I REALLY APOLOGIZE. IT LOOKS LIKE THE TIME IS -- WE'RE AT ALMOST 45 MINUTES HERE. SO DOES ANYONE HAVE ANY QUESTIONS ON WHAT I'VE GONE OVER TO FAR BEFORE WE MOVE ON? OKAY. HOPEFULLY THIS IS NOT CLEAR AS MUD. ALL RIGHT.

SO NOW YOU HAVE DONE ALL OF THIS MENTAL GYMNASTICS WHILE YOU HAVE BEEN EVALUATING THE PATIENT AND I SAY MENTAL GYMNASTICS BECAUSE THAT IS REALISTICALLY WHAT IT IS. IF YOU THINK OF AN ALGORITHM, I FEEL LIKE

MY HEAD IS CONSTANTLY DOING AN ALGORITHM WHEN I AM SEEING PATIENTS AND CONSTANTLY GOING THROUGH A FLOWCHART LIKE IF THAN THAT, AND THEN MOVING THROUGH. IT'S DECISION MAKING TIME. NOW WHAT DO YOU DO WITH ALL OF THIS INFORMATION? ALL RIGHT. AS YOU ARE COMING UP WITH RECOMMENDATIONS, FIRST, THINK ABOUT WHAT'S REALLY BEST FOR THE PATIENT'S REGARDS TO REHABILITATION? I SAY THIS BECAUSE OUR ROLE AS THE PHYSICAL THERAPIST IS TO REALLY LOOK AT A PATIENT'S FUNCTION AND THEIR REHABILITATION. WE CAN GET BOGGED DOWN BY ALL OF THE SOCIAL ISSUES AND ALL OF THE OTHER COMPLEXITY OF THE PATIENTS OR OUR PATIENTS. SO YOU REALLY HAVE TO SIMPLIFY THIS. WHAT'S MY ROLE? WHAT'S MY RECOMMENDATION GOING TO BE? LET'S FOCUS ON THE FIRST THING. WHAT IS BEST FOR THE PATIENT IF THEY ARE NEEDING REHABILITATION? THE SECOND ONE WOULD BE, WHAT ARE THE PATIENT'S AND FAMILY'S GOALS. AGAIN, THESE THINGS MAY NOT ALWAYS LINE UP TOGETHER, OKAY? YOU KNOW, YOU WANT TO CONSIDER WHETHER OR NOT THE PATIENT OR FAMILY'S GOALS ARE EVEN REALISTIC. FOR EXAMPLE, A PATIENT GOING HOME ON HOSPICE.

WHEN YOU HEAR THAT, YOU ARE USUALLY THINKING END OF LIFE CARE, RIGHT? BUT SOMETIMES THE GOALS MAY INCLUDE CAREGIVER TRAINING EDUCATION TO REDUCE THE BURDEN OF CARE OR DME REGS, WHAT DURABLE MEDICAL EQUIPMENT WILL THEY NEED TO SUPPORT THE PATIENT AT HOME? AND WHAT LEVEL OF REHAB IS MOST IMPORTANT AND APPROPRIATE FOR THAT KIND OF TRAINING? IF YOU ARE GOING TO BE DOING THIS TYPE OF TRAINING, IS IT GOING TO BE MORE APPROPRIATE TO DO THE TRAINING IN SNF? IS IT GOING TO BE MORE IMPORTANT AT HOME? OR IS IT GOING TO BE MOST APPROPRIATE TO DO AN OUTPATIENT? I KNOW THAT SOUNDS WEIRD IF SOMEONE IS GOING HOME ON HOSPICE BUT MANY PATIENTS GO HOME ON HOSPICE MAY STILL HAVE A FAIR AMOUNT OF TIME. SO UNDERSTANDING WHAT THE FAMILY AND

PATIENT'S GOALS ARE ARE IMPORTANT. WE HAVE A COUPLE OF OTHER QUESTIONS HERE. TAKE A LOOK. OR COMMENTS, SORRY. YOU GUYS ARE REALLY NICE. THANK YOU FOR YOUR SUPPORTIVE COMMENTS. OKAY. STEVEN, WHEN YOU ARE GOING OVER THE ROLE OF PT, NONE OF THE OPTIONS ON THE TEST WERE ONES YOU MENTIONED. OKAY. I WILL HAVE TO LOOK AT THAT TEST AFTER WE ARE DONE, AND THEN I WILL TRY TO COME BACK TO THAT. LET'S KEEP THAT ONE IN THE QUEUE. OKAY.

>> COMMUNICATION, ONCE YOU HAVE DETERMINED RECOMMENDATION AND YOUR REASONING FOR THOSE RECOMMENDATIONS, YOU'LL WANT TO UNDERSTAND COMMUNICATION. IT'S VERY KEY TO COMMUNICATE WHAT THOSE RECOMMENDATIONS ARE. SO, PEOPLE I FEEL LIKE ARE IMPORTANT TO INFORM ARE DEFINITELY THE PRIMARY TEAM MEMBERS, WHICH ARE PHYSICIANS. AND THEN MAYBE OTHER REHABILITATIVE PROVIDERS WHO ARE INVOLVED IN THAT PATIENT'S CARE, MAYBE OT OR SPEECH, THE SOCIAL WORKER, UTILIZATION MANAGEMENT OR PATIENT CARE COORDINATOR. I DON'T KNOW IF EVERYBODY HAS EXPERIENCE WITH UTILIZATION MANAGEMENT OR PATIENT CARE COORDINATOR.

THESE ARE USUALLY NURSES WHO ARE KIND OF MANAGING THE STAY IN THE ACUTE CARE HOSPITAL OF THE PATIENT. THEY HAVE CRITERIA THAT THEY ARE CONSTANTLY LOOKING AT FOR THE ADMISSION OF THE PATIENT AND ALSO HELPING TO DETERMINE WHERE PATIENTS ARE GOING. THEY MAY NOT MAKE THE RECOMMENDATIONS FOR THE DISCHARGE. THEY WILL COME TO YOU FOR THAT, BUT THEY ARE KIND OF LOOKING AT ALL OF THE AVAILABLE RESOURCES AS TO MOVE THE PATIENT THROUGH THE SYSTEM. OKAY. ALSO, COMMUNICATING WITH THE NURSE. SOMETIMES THE NURSE IS THE FIRST TO KNOW. AND SOMETIMES THE NURSE IS THE LAST TO KNOW. ALWAYS KEEPING THE NURSE INFORMED IS VERY HELPFUL. AND THEN HOW YOU COMMUNICATE.

IT WILL DEPEND ON THE WORK FLOW THAT'S ESTABLISHED IN YOUR FACILITY. IF IT'S A VERY COMPLICATED SITUATION THAT REQUIRES A MORE NUANCED THAN THE DOCUMENTATION IN THE CHART, I WILL USUALLY CALL AND HAVE A DISCUSSION WITH THE PHYSICIAN OR IF YOU HAVE ROUNDS AVAILABLE THAN I WOULD HAVE THAT DISCUSSION IN ROUNDS. USUALLY IN OUR FACILITY, WE HAVE SERVICES AND MOST OF OUR SERVICES HAVE CONSISTENT ROUNDING WITH THE TEAM. SO, IF IT'S LIKE THE MEDICINE SERVICE, WE USUALLY HAVE DAILY ROUNDS TO SPEAK WITH THE TEAM. ALL RIGHT. MORE COMMUNICATION. SO HERE'S SOME OTHER PROVIDERS THAT MAY BENEFIT FROM KNOWING YOUR RECOMMENDATIONS AND MIGHT INFLUENCE THEIR OWN CARE WITH THE PATIENT. SPECIALTY TEAMS, FOR EXAMPLE LET'S SAY YOU HAVE A PATIENT WITH A CVA. SO THE PRIMARY TEAM WOULD BE NEUROLOGY AND SAY THEY HAVE MRS, YOU MIGHT RECOMMEND ACUTE REHAB. IT COULD AFFECT THE INFECTIOUS DISEASE SPECIALTY TEAM WITH THEIR RECOMMENDATIONS AND COURSE OF ANTIBIOTICS IN THE ACUTE CARE FACILITY, VERSUS IF YOUR RECOMMENDATION WAS FOR THE PATIENT TO GO HOME WITH HOME PT. THEIR TREATMENT MIGHT BE DIFFERENT BASED ON WHERE THE PATIENT IS GOING. PSYCH LIAISON NURSING.

I'M NOT SURE IF THAT IS JUST A SERVICE THAT IS VERY SPECIFIC TO OUR FACILITY, BUT THESE ARE USUALLY NURSES WHO HELP WITH PATIENTS AND FAMILIES COPING WITH THEIR HOSPITALIZATION. ELIGIBILITY, THIS DEPARTMENT USUALLY IS DEALING WITH THE INSURANCE AND MAKING SURE PATIENTS HAVE INSURANCE OR HELPING TO SET UP PAYMENTS FOR THEIR STAY IN THE ACUTE CARE HOSPITAL. WE HAVE A LONG-TERM PLACEMENT TEAM. THIS IS A SPECIALTY TEAM THAT IF THE PATIENT IS DEEMED TO NEED SOME TYPE OF LONG-TERM PLACEMENT, THEY REFER TO THIS TEAM TO HELP FIND RESOURCES IN THE COMMUNITY FOR THAT LONG-TERM PLACEMENT. A NEURO PSYCHOLOGIST, IF THE PATIENT -- THE TEAM IS THINKING THE PATIENT MAY

HAVE SOME CAPACITY QUESTIONS, A NEUROPSYCHOLOGIST MAY COME IN AND DO AN EVALUATION AND THEY MAY LOOK AT YOUR RECOMMENDATIONS TO KIND OF UNDERSTAND WHAT THE PATIENT IS ABLE TO DO OR NOT DO. AND THEN ALSO, WE HAVE AN ADDICTION SPECIALIST TEAM WHICH IS FAIRLY NEW TO OUR FACILITY. IF THE PATIENT HAVE SUBSTANCE USE AND THEY ARE LOOKING TO SEEK TREATMENT, SOMETIMES THIS TEAM LIKES TO KNOW WHAT OUR RECOMMENDATIONS ARE SO THEY CAN SET UP THEIR PLAN OF CARE TO HELP PATIENTS DETOX OR MANAGE THEIR ADDICTION. OKAY. SO, WHEN YOU ARE TREATING PATIENTS WITH THESE SOCIALLY COMPLEX BACKGROUNDS, THERE CAN BE SOME UNINTENDED CONSEQUENCES. YOU MAY FIND YOU ARE MITIGATING SOME ETHICAL DILEMMAS OR STRESSES WHILE TREATING OR EVALUATING THESE PATIENTS. SO YOU WILL HAVE TO KEEP SOME ETHICAL CONSIDERATIONS IN MIND. THIS IS PROBABLY A TOPIC UNTO ITSELF AND CAN GET EXTREMELY COMPLICATED. SO AT THIS TIME, I'D JUST MAKE SOME SUGGESTIONS.

FOR EXAMPLE, IF YOU HAVE A RISK MANAGEMENT DEPARTMENT, YOU CAN REACH OUT TO THEM. IF YOU HAVE SOME ETHICAL DILEMMAS OR DISTRESSES THAT YOU NEED TO DISCUSS IN TERMS OF GIVING THE BEST CARE TO THE PATIENT. YOU CAN REFER TO THE CODE OF ETHICS TO GIVE GUIDANCE AND YOU WILL WANT TO CONSIDER YOUR STATE LICENSURE BOARD. ANOTHER UNINTENDED CONSEQUENCE OF DEALING WITH SOCIALLY COMPLEX PATIENTS IS BURNOUT. THESE SITUATIONS CAN BE EXTREMELY TRICKY AND CAN WEIGH ON YOU HEAVILY DAY IN AND OUT. SOMETIMES THERAPISTS THAT I KNOW OR EVEN OTHER PROVIDERS CAN TAKE HOME SOME OF THESE SITUATIONS. IT'S REALLY IMPORTANT TO THINK ABOUT SELF CARE BEHAVIORS. THAT CAN BE ANYTHING FOR YOU. SOME PEOPLE, YOU KNOW, COME HOME AND WATCH TV OR WATCH MOVIES TO DESTRESS, MAYBE MEDITATION, MAYBE WORKING OUT. WHATEVER WORKS BEST FOR YOU TO HELP REDUCE THE AMOUNT OF

BURNOUT IS GOING TO HELP. THE OTHER THING IS REALLY GET SUPPORT WHEREVER YOU CAN FIND IT. I KNOW THAT FOR ME A LOT OF MY CO-WORKERS, I FIND SUPPORT BECAUSE WE ALL DEAL WITH THIS ON A DAILY BASIS AND WE DISCUSS IT AND WE COME UP WITH WAYS TO COPE AND HELP EACH OTHER. SO THERE'S ACTUALLY ON FRIDAY GOING TO BE A WEBINAR ON BURNOUT. SO, THAT MIGHT BE SOMETHING TO LOOK INTO. OKAY. ALL RIGHT. SO I THINK I HAVE GONE OVER THE BULK OF KIND OF HOW TO APPROACH SOME OF THESE PATIENTS. LET ME GO BACK HERE AND TAKE A LOOK -- HOLD ON ONE SECOND -- AT SOME OF THESE QUESTIONS AND COMMENTS AND TRY TO ADDRESS THEM. AGAIN, IF YOU HAVE QUESTIONS OR COMMENTS, MAYBE THIS IS A GOOD TIME TO PUT THEM IN BEFORE WE START THE CASE STUDIES. OKAY. GIVE ME A SECOND HERE. SO, STEVEN, I'M GOING TO ADDRESS YOUR QUESTION ABOUT THE POST TEST. LET'S SEE.

SO, I GUESS, STEVEN, I THINK YOUR QUESTION IS NUMBER ONE, WHAT IS THE ROLE OF THE PHYSICAL THERAPIST IN AN ACUTE CARE HOSPITAL SETTING FOR SOCIALLY COMPLEX PATIENTS? WITHOUT GIVING YOU THE ANSWER, I WOULD SAY -- HOW SHOULD I -- I DON'T WANT TO GIVE YOU THE ANSWER. I'M TRYING TO THINK ABOUT HOW TO ADDRESS YOUR QUESTION THERE. THERE'S DEFINITELY ONE OF THE ANSWERS THAT I DID TALK ABOUT. THE OTHER ONES ARE ANSWERS THAT I DID NOT TOUCH ON. SO MAYBE THAT WILL GIVE YOU A HINT ABOUT WHAT THE ANSWER MIGHT BE. OKAY. I SEE SOME TECHNICAL COMMENTS HERE. ALBERT, I'M GOING TO READ YOURS OUT LOUD. OFTEN CASE MANAGERS DON'T TAKE ACCOUNT OF SOCIAL FACTORS. I HAVE HAD A FEW TELL ME THAT ACTUALLY DON'T TAKE SOCIAL HARDSHIPS IN TO ACCOUNT WITH PT PLANNING. WE OFTEN SIDE STEP THIS BY COMPLETING -- SOMETHING HAPPENED HERE. WE OFTEN SIDE STEP THIS BY COMPLETING DC PLANNING AS EARLY AS POSSIBLE BUT WONDER IF YOU HAVE ANY ADVICE ON THIS. SO, THIS IS THE PART THAT GETS REALLY ETHICALLY TRICKY. A LOT OF TIMES YOU ARE

GOING TO DO SOMETHING SIMILAR TO WHAT YOU ALREADY ARE DOING, WHICH IS MAKING YOUR RECOMMENDATION AS EARLY AS POSSIBLE. THE UNFORTUNATE PART ABOUT THIS IS THAT, YOU KNOW, YOU MAKE YOUR RECOMMENDATIONS AS BEST YOU CAN WITH THE PATIENT IN MIND. WHETHER SOMEBODY ELSE IS GOING TO FOLLOW THROUGH WITH THAT IS ANOTHER STORY, RIGHT? THERE ARE MANY TIMES THIS DOES HAPPEN. IT DOESN'T FEEL GOOD. IT WEIGHS ON YOU. I WOULD CONTINUE TO JUST STATE YOUR RECOMMENDATION AND YOUR REASONS WHY, AND DOCUMENT THAT THOROUGHLY IN THE CHART SO THAT NOBODY CAN QUESTION WHAT YOUR -- WHY YOU ARE RECOMMENDING THOSE THINGS. IF IT IS NOT FOLLOWED THROUGH -- I HATE TO SAY IT IS NOT ON YOU BUT ON THEM AND IT IS LIKE KICKING THE CAN DOWN THE ROAD BUT IF YOU WANT TO CONTINUE TO ADVOCATE FOR THE PATIENT, ONE THING I WOULD SUGGEST IS IF YOU HAVE A PATIENT'S ADVOCATE OFFICE TO GO TO THEM AND REALLY STATE WHY YOU ARE RECOMMENDING SOMETHING THAT IS NOT BEING FOLLOWED THROUGH.

ALSO TALKING TO THE SOCIAL WORKER IF THE SOCIAL WORKER IS DIFFERENCE FROM THE INSURANCE CASE MANAGER AND TALKING TO THE PHYSICIAN. SOMETIMES -- A LOT OF OUR SOCIAL WORKERS ARE VERY VERSED IN THE RESOURCES WE HAVE WITHIN OUR COMMUNITY, BUT SOME OF THEM AREN'T. I'VE, FROM TIME TO TIME, HAVE HEARD OF SOMETHING THAT A SOCIAL WORKER MAY NOT BE AWARE OF AND IF THEY ARE ABLE TO KIND OF HUNT SOME OF THAT DOWN THEY MIGHT BE ABLE TO FIND OTHER RESOURCES OUT THERE. SORRY, THAT'S NOT A GREAT ANSWER, BUT I THINK THAT'S THE BEST I CAN DO. AGAIN, THE ETHICAL CONSIDERATIONS WHEN DEALING WITH SOME OF THESE PATIENTS CAN BE THE BIGGER PROBLEM.

OKAY. A GOOD EXAMPLE OF REALLY JUST GIVING YOUR MOBILITY RECOMMENDATIONS AND HAVING THE TEAM KIND OF TAKE THAT INTO ACCOUNT INTO WHAT THEY ARE DOING. DEBBIE, LET'S SEE. DO YOU HAVE ANY SUGGESTIONS FOR STARTING A RESTORATIVE PROGRAM IN ACUTE CARE FOR PATIENTS WHO DO NOT HAVE A SAFETY SEAT PLAN AND END UP STAYING IN ACUTE CARE? YES. ONE OF THE THINGS THAT A RESTORATIVE PROGRAM CAN DO IS THINGS THAT I'VE DONE IS I WILL GO IN. I WILL EVALUATE THE PATIENT. I WILL SET UP A PLAN OF CARE THAT WOULD BE, JUST DAILY MOBILIZATION. I WILL USUALLY SAY SOMETHING LIKE MOBILIZE THREE TIMES A DAY WITH HOUSE STAFF. AFTER EVERY MEAL -- YOU CAN BE AS SPECIFIC OR AS GENERAL BUT YOU CAN WRITE THOSE DOWN AND THEN YOU CAN ALSO PRINT OUT THOSE THINGS OR WRITE IT ON THE WHITE BOARD IN THE PATIENT'S ROOM. AND THEN YOU NEED TO FOLLOWUP WITH THE NURSING STAFF. SOMETIMES THE HANDOFF FROM NURSE TO NURSE MAY NOT BE GREAT, BUT THE OTHER THING THAT YOU CAN DO IS ALSO TELL THE PHYSICIAN. THE PHYSICIAN CAN WRITE AN ORDER FOR THE MOBILITY TO HAPPEN, AND IT CAN BE VERY SPECIFIC AS TO WHO'S DOING THAT.

SO, THAT'S ONE WAY TO DO A RESTORATIVE PROGRAM. THEN YOU CAN WRITE YOUR FREQUENCY AND DURATION FOR SOMETHING LIKE THAT, MAYBE WILL FOLLOW ONCE A WEEK FOR, YOU KNOW, SAY THREE OR FOUR WEEKS, DEPENDING ON HOW LONG YOU ANTICIPATE THE PATIENT WILL NEED THE RESTORATIVE PROGRAM FOR. I WOULD HESITATE TO MAKE THE DURATION FOR HOW LONG YOU THINK THE PATIENT WILL STAY. I WOULD MAKE THE DURATION MORE ABOUT HOW LONG YOU THINK THE PATIENT WILL BENEFIT FROM THAT RESTORATIVE PROGRAM. BECAUSE YOU NEVER KNOW. SOMETIMES THE PATIENT MAY LEAVE IN TWO WEEKS, THEY MIGHT LEAVE IN SIX MONTHS, RIGHT? KIM, WOULD IT BE OKAY TO REFER A PATIENT TO MY CHURCH FOR ASSIST WITH PAYING THEIR RENT DURING THEIR RECOVERY? I MAY NOT BE SOMETHING SO

DETAILED AS RECOMMENDATION TO THE CHURCH. I MIGHT WRITE IT MORE OF A VAGUE DESCRIPTION OF WHAT THAT CHURCH IS. SO, RECOMMEND SUPPORT FOR MANAGING ASSETS AND ABILITY TO DO IADLS. AND THEN WHAT I WOULD DO -- SO THAT'S KIND OF THE THING THAT'S GOING TO BE IN THE DOCUMENTATION, WHICH SOMEONE WILL LOOK AT. A LOT OF TIMES, THESE UTILIZATION MANAGEMENT OR PATIENT CARE COORDINATORS THEY DON'T LIKE THOSE SPECIFIC THINGS BECAUSE THEY ARE LIKE I DON'T KNOW THAT CHURCH. I DON'T KNOW ANYBODY THERE. HOW CAN I POSSIBLY MAKE THAT HAPPEN? IF YOU WRITE A DESCRIPTION OF WHAT KIND OF SERVICES THAT THAT CHURCH MAY PROVIDE AND THEN TALK TO THE SOCIAL WORKER ABOUT HELPING THAT PATIENT ACCESS THAT RESOURCE IS HOW I WOULD PROBABLY GO ABOUT IT.

OKAY. KELLY, HOW ARE WE ABLE TO SEE THE TEST? OH, THERE IS A TEST THAT CAN BE PREVIEWED. MORE OF A TECHNICAL QUESTION. I THINK IT IS AVAILABLE TO BE PREVIEWED ON THE WEBSITE. OKAY. SUSAN, ANY SUGGESTIONS ON GETTING A PATIENT MOTIVATED WHILE IN ACUTE CARE WHO HAS NO INTEREST IN PT? OH, VERY, VERY TOUGH. SO, WHEN YOU HAVE A PATIENT WHO HAS NO DESIRE TO GET OUT OF BED, TO PARTICIPATE IN ANY TYPE OF MOBILITY OR THERAPY, THE ONLY THING YOU CAN REALLY DO IS YOU GO IN THERE AND YOU MIGHT HAVE TO TAKE A FEW TIMES. IT MIGHT NOT JUST BE THE ONE DAY YOU GET THE PATIENT ON BOARD BUT BUILD A RELATIONSHIP WITH THE PATIENT. NO EASY TASK WITH SOME PATIENTS, BUT THEN GIVING THEM AS MUCH EDUCATION AS YOU CAN ABOUT WHY PHYSICAL THERAPY WOULD HELP THEM. YOU NEED TO GIVE THEM AS MUCH GOOD INFORMATION FOR THEM TO MAKE THE BEST DECISION. IF THEY CONTINUE TO NOT WANT PHYSICAL THERAPY AND NOT BE AMENABLE TO MOBILITY, YOU CAN'T FORCE THEM INTO DOING IT. EVERYBODY HAS A RIGHT TO MAKE THEIR OWN BAD DECISIONS, BUT THEY SHOULD HAVE THE BEST INFORMATION AND GOOD

INFORMATION TO MAKE A BAD DECISION, IF THAT MAKES SENSE. ANY SUGGESTIONS FOR HOME HEALTH THERAPIST THAT IS SEEING PATIENTS IN THE SOCIALLY COMPLEXION PATIENTS, HALFWAY HOMES, POVERTY, MENTAL HEALTH SYSTEMS, UNSAFE ENVIRONMENTS AS FAR AS GETTING IN TOUCH WITH ACUTE CARE SIDE AND THOSE RECOMMENDATIONS MADE IN THERE?
>> WENDY, I'D SAY IF YOUR HOME HEALTH AGENCY HAS ANY ABILITY TO ACCESS DOCUMENTATION EITHER THRU AN EMR OR -- I DON'T KNOW IF YOU HAVE SUPPORT STAFF AT THE HOME HEALTH AGENCY THAT YOU ARE WORKING WITH TO GET THE DOCUMENTATION FROM THE HOSPITAL PRIOR TO SEEING THE PATIENT MIGHT BE HELPFUL TO SEE WHAT AN ACUTE CARE THERAPIST'S RECOMMENDATIONS HAVE BEEN.

OTHERWISE, YOU MAY HAVE TO JUST DO YOUR OWN EVALUATION AND GO THROUGH THESE STEPS WHILE YOU ARE IN THE HOME HEALTH SETTING. AND THEN FIND WAYS TO TAP THESE OVER RESOURCES. I SOMETIMES FEEL -- I'M SORRY, I HAVEN'T DONE HOME HEALTH BEFORE. I'M NOT SURE HOW AVAILABLE RESOURCES ARE TO YOU IN THE HOME HEALTH SETTING. YOU MIGHT HAVE TO DO YOUR OWN INVESTIGATION AND HELP GUIDE YOUR -- I WOULD GUESS THE PRIMARY CARE PHYSICIAN IN HELPING PATIENTS ACCESS RESOURCES IN THE COMMUNITY AFTER THEY HAVE GONE HOME. OKAY. I THINK THOSE ARE ALL OF THE QUESTIONS THAT I SEE UP HERE.

ALL RIGHT. I'M GOING TO TAKE A DRINK OF WATER. WE WILL MOVE ON TO CASE STUDIES. I'VE LAID OUT FIVE CASE STUDIES. WE CAN GO AS QUICKLY OR AS SLOWLY THROUGH THEM. THEY ARE VERY, VERY GENERAL, OKAY. JUST MY LITTLE DISCLOSURE HERE. CASE STUDIES ARE LOOSELY BASED ON REAL LIFE SCENARIOS AND DETAILS HAVE BEEN MADE TO MAINTAIN PATIENT CONFIDENTIALITY. ALL RIGHT. AGAIN, MY CASE STUDIES ARE VERY GENERAL. YOU GUYS MAY HAVE SOME QUESTIONS AND MAY WANT MORE INFORMATION. I

FIGURED OUT THAT THIS SHOULD BE VERY INTERACTIVE. I KNOW IF I WERE ON THE OPPOSITE SIDE OF CASE STUDIES I WOULD HAVE WAY MORE QUESTIONS THAT WOULD NEED TO BE ADDRESSED BEFORE UNDERSTANDING THEM. THESE ARE JUST THINGS THAT WE CAN GO THROUGH. DON'T AFRAID TO ASK QUESTIONS. THIS IS JUST PURELY A DISCUSSION ON DIFFERENT SCENARIOS. SO, THE FIRST CASE STUDY IS A 50-YEAR-OLD MALE WITH A HISTORY OF A CVA AND A RESIDUAL LEFT UPPER EXTREMITY AND LOWER EXTREMITY WEAKNESS AND ALSO HOMELESS. CURRENT ADMISSION IS FOR ALCOHOL WITHDRAWAL. OKAY. SO, FIRST OF ALL, HOW WOULD I EVEN GO ABOUT ADDRESSING THIS? ONE, I'M LOOKING AT THE ADMISSION DIAGNOSIS, WHICH IS ALCOHOL WITHDRAWAL. I USUALLY SEE THIS A LOT IN MY FACILITY. SOME ASSUMPTIONS I'M GOING TO MAKE IS, ONE, IF THEY ARE IN ALCOHOL WITHDRAWAL, THE PATIENT MAY NOT NECESSARILY BE IN THE BEST PLACE FOR DOING MOBILITY. THEY MAY HAVE -- THEY PROBABLY WILL HAVE SOME DYSFUNCTION. THEY WILL DEFINITELY BE -- THESE ARE ASSUMPTIONS I'M MAKING. THEY ARE NOT ALWAYS TRUE. ONE OF THE QUESTIONS I ALREADY HAVE IS, IS THE PATIENT DONE WITH THEIR WITHDRAWAL?

OKAY. SO AMY IS ASKING, YOU WANT TO KNOW HIS FAMILY SUPPORT AND PRIOR LIVING SITUATION. OKAY. SO, THIS PATIENT HAS NO SUPPORT WHATSOEVER. AND THEY ARE HOMELESS. THEY HAVE BEEN HOMELESS FOR QUITE A FEW YEARS. THEY HAVE BEEN LIVING OUT ON THE STREETS. THERE'S NO FAMILY AND NO REAL FRIENDS. WHAT'S HIS BASELINE FUNCTION? SO, HE IS INDEPENDENT IN WHEELCHAIR MOBILITY AND WHEELCHAIR TRANSFERS. AT LEAST YOU ARE GOING TO PRESUME THAT SINCE HE'S LIVING ON THE STREET AND IS IN A WHEELCHAIR. OKAY. SO, BEFORE I EVEN DO AN EVALUATION, AGAIN, I'M ASKING, IS THIS PATIENT DONE WITH THEIR ALCOHOL WITHDRAWAL? WHY I WOULD ASK THIS QUESTION IS, YOU KNOW, YOU ARE GOING TO SEE SOME DYSFUNCTION. AGAIN, YOU ARE LIKELY GOING TO SEE SOME -- AND

YOUR EVALUATION WILL BE MUDDIED. YOU MAY NOT BE ABLE TO GET A CLEAR PICTURE OF WHAT HIS NEUROLOGICAL DYSFUNCTION IS VERSUS HOW MUCH THE ALCOHOL WITHDRAWAL IS AFFECTING HIS FUNCTION. SO A LOT OF TIMES WE WILL SEE THESE PATIENTS AND WE WILL SAY, OKAY, ARE THEY IN WITHDRAWAL? ARE THEY STILL IN WITHDRAWAL? MANY TIMES THE PHYSICIAN WILL SAY ACTUALLY NO. SO, THEY WILL USUALLY HOLD A PHYSICAL THERAPY EVALUATION NEED UNTIL THE PATIENT IS DONE WITHDRAWING. AT THAT TIME YOU CAN LOOK AT WHAT THE PATIENT IS ABLE TO DO IF YOU STILL DEEM IT NECESSARY TO DO AN EVALUATION. BECAUSE YOU ARE ESSENTIALLY SCREENING THE PATIENT RIGHT NOW. WHEN THE PATIENT IS DONE WITH THEIR WITHDRAWAL SYMPTOMS, AGAIN, YOU WILL BE ABLE TO HAVE A BETTER IDEA WHAT THEIR DYSFUNCTION TRULY IS. IF THE PATIENT -- IF A LOT OF TIMES WHEN -- LET'S SAY MY HAND HAS BEEN FORCED TO SEE THIS PATIENT BECAUSE MAYBE THEY DO WANT TO PUT THE PATIENT INTO AN ALCOHOL DETOX PROGRAM AND THEY NEED TO KNOW IF THEY ARE INDEPENDENT AND ABLE TO GET INTO THEIR WHEELCHAIR TO GO TO THE DETOX PROGRAM, YOU CAN KIND OF GO AND SEE WHAT THEY ARE ABLE TO DO.

NOW, IF IT LOOKS LIKE THEY ARE ABLE TO DO ALL OF THOSE THINGS AT BASELINE, THEN YOU ALREADY KNOW THAT, YEAH, THIS PATIENT DOESN'T NECESSARILY NEED REHABILITATION. THEY ARE LIKELY GOING TO BENEFIT MORE FROM GOING TO THEIR DETOX PROGRAM. THAT'S IF THE PATIENT WANTS TO DETOX. THAT'S ALSO TAKING INTO ACCOUNT THE PATIENT'S GOALS. DO THEY WANT TO DETOX? A LOT OF TIMES, PATIENTS MAY NOT NECESSARILY WANT THAT. SO AT THIS POINT, AGAIN, IF THE PATIENT IS ALREADY AT THEIR BASELINE, NOW YOU ARE LOOKING AT WHAT DOES THE PATIENT WANT? WHAT ARE THEIR GOALS? AND THEN IF THEIR GOAL IS I WANT TO RETURN TO THE STREET, OKAY. WELL, IS THAT PATIENT ABLE TO ADEQUATELY TAKE CARE OF HIMSELF? YOU KNOW, KNOWING SOME HISTORY ABOUT HOW THE PATIENT

CAME IN MAY HELP TO ANSWER THAT AS WELL. YOU HEAR READING SOME OF THE CHART AND IT SAYS PATIENT CAME IN DISHEVELED, MAYBE THEY HAD LICE OR WERE FOUND WITH FECES OR URINE ALL OVER THEIR WHEELCHAIR. YOU ARE GETTING MORE OF AN UNDERSTANDING THAT, YEAH, MAYBE THEY ARE ABLE TO PUSH THEMSELVES AROUND OUT ON THE STREET AND TRANSFER, BUT MAYBE THEY ARE NOT ABLE TO DO THEIR ADLS WELL. SO, YOU MIGHT THEN ASK FOR AN OT TO COME IN AND DO AN EVALUATION TO SEE HOW MUCH THE PATIENT IS ACTUALLY ABLE TO PERFORM THOSE ADLS. AND CONFER WITH THE OT ABOUT WHAT YOU THINK MIGHT BE BEST. AGAIN, THIS MAY NOT BE -- THIS MIGHT NOT BE IN LINE WITH WHAT THE PATIENT WANTS. SO YOU WILL HAVE TO KEEP THAT IN MIND. A LOT OF TIMES SHELTER OR EVEN A RESPITE BED MIGHT BE BEST IF THERE NEEDS TO BE SOME KIND OF MEDICAL CARE, MAYBE MEDICATIONS NEED TO BE MANAGED.

WE CAN SOMETIMES DO THIS IN RESPITE. OTHERWISE A SHELTER BED. THEN IF YOU ARE LOOKING A SHELTER BED, YOU ARE GOING TO WANT TO LOOK AT, OR KEEP IN MIND WHAT KIND OF BED IT IS. IS IT GOING TO BE A BUNK BED? WILL THE PATIENT NEED TO BE ABLE TO CLIMB INTO THE TOP OF THE BUNK BED? OR CAN -- YOU MIGHT WRITE A RECOMMENDATION LIKE PATIENT WILL NEED TO ACCESS BED AT A NORMAL HEIGHT LEVEL AND UNABLE TO CLIMB A LADDER. DOES ANYBODY HAVE ANY QUESTIONS REGARDING THIS CASE STUDY? JUSTIN, YOU HAVE ONLY ADMITTED FOR ALCOHOL-RELATED ISSUES, CAN YOU ADDRESS PRIOR HISTORY WITHOUT FURTHER PHYSICIAN REFERRAL? TRYING TO UNDERSTAND YOUR QUESTION HERE. CAN YOU ADDRESS THE CVA DYSFUNCTION WITHOUT THE PHYSICIAN REFERRAL? WELL, USUALLY IN ACUTE CARE, IF THE PHYSICIAN HAS REFERRED OR HAS PUT IN A CONSULT FOR PHYSICAL THERAPY, YOU CAN ADDRESS ANYTHING THAT YOU SEE BEFORE YOU. IF THE PATIENT IS DONE WITHDRAWING AND YOU CAN ASSESS THAT THEIR RESIDUAL DEFICITS ARE FROM HIS OLD CVA AND THERE MIGHT BE SOME

EDUCATION OR SOME KIND OF TREATMENT YOU CAN PROVIDE TO THAT PATIENT BECAUSE OF THOSE DEFICITS, EVEN IF THEY ARE LONG STANDING, YES, YOU CAN ADDRESS THOSE. SAY THE PATIENT WAS NOT ABLE TO DO THEIR TRANSFERS OR WHEELCHAIR MOBILITY INDEPENDENTLY, THEN YOU CAN ADDRESS AND SAY THE PATIENT AT BASELINE WAS ABLE TO DO THESE THINGS. WE CAN NOW WORK ON GETTING HIM FROM TRANSFERS TO GETTING BACK TO HIS BASELINE OF INDEPENDENT TRANSFERS. KRISTIN. LET'S SEE. OH, CONSIDERING TIME OF YEAR, ICE, SNOW, ET CETERA. YES. IT DEPENDS ON THE PATIENTS. SOMETIMES YOU WILL HAVE A PATIENT THAT SAYS IT DOESN'T MATTER IF IT IS COLD, I FEEL SAFEST.

IF THAT IS THE CASE AND THERE'S -- IT'S EXTREMELY COLD OUTSIDE, ASKING THE PATIENT IF THEY HAVE ANY ACCESS OR DESIRE TO ACCESS ANY BLANKETS OR SLEEPING BAGS OR SOMETIMES WE HAVE CHURCHES THAT PROVIDE SOME OF THESE THINGS FOR PATIENTS IF THEY ARE UNWILLING TO STAY IN A SHELTER. OUR FACILITY HAS A VOLUNTEER CLOSET WHERE PEOPLE HAVE BROUGHT IN EXTRA CLOTHES THAT THEY DONATE, EXTRA CLOTHES THEY DON'T WANT TO BE GIVEN TO PATIENTS AT ANY TIME. THERE HAVE BEEN TIMES WHERE I HAVE BROUGHT STUFF FROM HOME TO GIVE TO A PATIENT LIKE AN OLD SLEEPING BAG THAT I PERSONALLY AM NO LONGER USING AND DONATE IT TO THE PATIENT. JUST COMING UP WITH THINGS. IT DEPENDS ON HOW FAR YOU WANT TO GO WITH THAT AND HOW PERSONALLY -- AND IF YOU DON'T FEEL COMFORTABLE PERSONALLY DOING THAT, FINDING IF THERE ARE ANY RESOURCES IN YOUR COMMUNITY THAT DO HAVE DONATIONS LIKE THAT, IF THE PATIENT IS JUST NOT WILLING TO SEEK SHELTER AND REALLY WANTS TO GO BACK TO THE STREET FOR WHATEVER REASON. OKAY. AMY ASKS, WOULD YOU WANT TO KNOW IF HE HAS FAMILY SUPPORT? I THINK WE ANSWERED THAT. SO HE DOES NOT HAVE FAMILY SUPPORT. LAURA, YES. KNOWING WHAT HIS

BASELINE WAS AND IF IT WOULD BENEFIT FROM SKILLED THERAPY, OKAY. ANY OTHER QUESTIONS?

I HOPE THAT WAS SOMEWHAT CLEAR. I THINK THAT ONE GOT A LITTLE TRICKY. SO SORRY ABOUT THAT. CASE TWO, NOW YOU HAVE A 62-YEAR-OLD FEMALE VISITING FROM ANOTHER COUNTRY ADMITTED SECONDARY TO A PEDESTRIAN VERSUS AUTO, SUSTAINING A RIGHT TIBIAL PLATEAU FRACTURE, LEFT DISTAL RADIUS FRACTURE, MULTIPLE RIB FRACTURES AND A SMALL HEMATOMA. RIGHT AWAY, THIS PATIENT WILL LIKELY NEED SKILLED REHABILITATION. THERE'S SOME TREATMENT TO PROVIDE AND EDUCATION TO PROVIDE, RIGHT? THE BIGGER QUESTION ABOUT THIS CASE STUDY IS WHAT'S THE PATIENT OR FAMILY'S PLAN FOR RETURNING HOME? SOME OF THE QUESTIONS THAT COME UP ARE WILL THEY REHAB HERE IN THIS COUNTRY, OR WILL THEY GO HOME TO REHAB?

SOMETIMES YOU CAN HAVE ACUTE TO ACUTE TRANSFER AND MEDEVAC MIGHT BE AVAILABLE FOR THE PATIENT TO RETURN HOME. OR DO THEY STAY AND WHAT LEVEL DO -- WHAT LEVEL OF FUNCTION DO THEY NEED TO BE AT IN ORDER TO RETURN HOME? OTHER QUESTIONS THAT COME UP MAY BE WILL THIS PATIENT GO TO A HOTEL OR FAMILY PRIOR TO FLYING HOME, WILL THEY FLY HOME RIGHT AWAY. WHAT CLASS CABIN OR AIRFARE TICKET ARE THEY ABLE TO PURCHASE, WHAT ASSIST WILL THEY HAVE AVAILABLE TO THEM IF THEY ARE TO FLY BACK HOME AND WHAT ABOUT GETTING HOME ONCE THEY LAND IN THEIR HOME COUNTRY? MAYBE IT'S A SHORT DRIVE, MAYBE IT'S A LONG DRIVE FROM THE AIRPORT, MAYBE THEY HAVE TO NEGOTIATE OTHER FORMS OF TRANSPORTATION IN ORDER TO GO HOME. MARK, YOU ARE ASKING WHAT COUNTRY ARE THEY FROM? I GUESS WE COULD TALK -- IT DOESN'T MATTER IN MANY WAYS, BUT LET'S JUST SAY SWEDEN. SO, DEPENDING ON THE COUNTRY THEY ARE FROM, YOU MIGHT HAVE TO THINK ABOUT OR ASK IF THEY

HAVE FAMILY OR IF THEY HAVE THE ABILITY TO ANSWER SOME OF THESE CLARIFYING QUESTIONS ABOUT WHAT THEY WILL NEED TO NEGOTIATE WHEN THEY GET HOME THAT'S KIND OF MORE THE IMPORTANT QUESTIONS ABOUT GOING HOME RATHER THAN WHAT COUNTRY. EVERY COUNTRY IS DIFFERENT, RIGHT? YOU KNOW, THAILAND MIGHT HAVE DIFFERENT TRANSPORTATION AND SWEDEN MAY HAVE A CAR. YOU NEED TO ANSWER THE QUESTIONS AND TRY TO FIGURE THEM OUT BEFORE THE PATIENT IS DISCHARGED. DC TO AIRPLANE, YES. CONTINUED SKILLED PT IN ANOTHER COUNTRY, YES. THESE ARE OTHER THINGS -- I KNOW THAT SEEMS VERY STRANGE, BUT I HAVE HAD INSTANCES WHERE I HAVE HAD TO THINK OF A PATIENT WANTING TO DC FROM THE HOSPITAL TO THE AIRPORT AND GETTING ON THE PLANE RIGHT AWAY AND GOING HOME AND THEN THEM SETTING UP THEIR OWN REHAB IN THEIR HOME COUNTRY THAT HAS HAPPENED.

SO WHEN YOU THINK OF DCING TO THE AIRPORT AND THE AIRPLANE, YOU HAVE TO GO THROUGH EVERY OBSTACLE FROM WHEN THE PATIENT IS LEAVING THE HOSPITAL TO THE POINT OF ALL THE WAY WHEN THEY GET BACK TO THEIR COUNTRIES. SO, LET'S TALK ABOUT THAT. THE PATIENT IN OUR FACILITY IS USUALLY WHEELCHAIRED DOWN OUT OF THE HOSPITAL. FIRST OF ALL, I'D NEED TO MAKE SURE THAT A PATIENT IS EVEN ABLE TO TRANSFER INTO A WHEELCHAIR AND SUSTAIN SITTING FOR WHATEVER LENGTH OF TIME THEY ARE GOING TO NEED WHILE THEY ARE ON A AIRPLANE. SO, IF I FEEL LIKE THEY ARE ABLE TO DO THAT, THAN I WILL SAY, OKAY. THEY ARE GOING TO BE WHEELCHAIRED DOWN, THEY WILL CAR TRANSFER INTO, LET'S SAY A TAXI. WHEN THEY GET TO THE AIRPORT, THEY ARE GOING TO BE TRANSFERRED BACK INTO A HOSPITAL CHAIR AT THE AIRPORT. OR A WHEELCHAIR. AND THEN THEY ARE GOING TO BE TRANSFERRED INTO YET ANOTHER TYPE OF TRANSPORT CHAIR THAT CAN FIT IN THE AISLES OF THE AIRPLANE. LIKELY WITH NO ARMRESTS, RIGHT? FROM THAT POINT, ARE THEY SITTING IN ECONOMY,

BUSINESS, FIRST CLASS? USUALLY WHAT WE HAVE DONE IS RECOMMENDED AT LEAST BUSINESS CLASS SO THAT THERE'S ENOUGH ROOM. I HAVE GONE TO THE MEASURE OF WHAT THE LAYOUT OF THE PLANE IS, IT IS AVAILABLE ON-LINE. AND SETTING UP THAT ENVIRONMENT OF A TRANSFER IN THE PLANE AS MUCH AS YOU CAN WHILE THE PATIENT IS STILL IN THE HOSPITAL. ONCE THEY ARE ABLE TO DO THAT, THEN YOU ARE LOOKING AT, OKAY, WHEN YOU GET BACK TO YOUR OWN COUNTRY AND YOU LAND IN THAT AIRPORT, WILL YOU HAVE -- YOU'LL LIKELY HAVE ANOTHER WHEELCHAIR TRANSPORT OFF THE PLANE, OKAY. AND THEN IS THE PATIENT'S FAMILY OR FRIENDS OR WHATEVER THEY HAVE SET UP ON THE OTHER SIDE, ARE THEY DRIVING HOME? IS IT A LONG -- IS IT A LONG DRIVE HOME?

IF SO, WHAT KIND OF VEHICLE WILL THEY BE GETTING INTO? WILL THEY HAVE THE ABILITY TO LIE DOWN? IF NOT, IF THEY ARE GOING STRAIGHT TO A REHAB FACILITY, IN THEIR OWN COUNTRY, WILL AN AMBULANCE OR SOME EMS BE TRANSPORTING THEM? WHAT IS A TRANSPORT GOING TO THEIR NEXT REHAB FACILITY? OR WILL THE FAMILY HAVE TO DRIVE THEM THERE OR WILL THEY HAVE TO NEGOTIATE SOME KIND OF OTHER PUBLIC TRANSPORT? USUALLY, IF SOMEBODY IS GOING TO ANOTHER FACILITY IN THEIR HOME COUNTRY, THEY WILL ALSO HAVE A PHYSICIAN ON THE OTHER SIDE THAT WILL BE TAKING ON THEIR CARE. LIKELY ANOTHER HOSPITAL WILL BE TAKING OVER SO THEY WILL HAVE SOME SORT OF TRANSPORT AVAILABLE. IF NOTHING, USUALLY TRY TO SUGGEST TO HELP THE FAMILY SET UP A CAR TRANSPORT RATHER THAN GETTING ON A SUBWAY OR A BUS. AND THEN, YOU KNOW, IF THE PATIENT IS GOING HOME IN THEIR HOME COUNTRY, YOU WANT TO KNOW WHAT THEIR HOME ENVIRONMENT IS LIKE, RIGHT? WHEN THEY GET HOME, IS THEIR DRIVEWAY STEEP? WILL THEY HAVE TO NEGOTIATE STAIRS TO GET IN? WHAT KIND OF BED ARE THEY ON? ALL OF THOSE THINGS. OKAY. JUSTIN, YOU ARE ASKING DOES HE HAVE ASSISTANCE WITH TRANSPORTATION SUCH AS HELP ON

PLANE, WHAT ABOUT EDEMA RELATED FRACTURE, AND SEATED POSITION PREVENTING DVTS. YES, YOU NEED TO FIND OUT IF THE PATIENT HAS ASSISTANCE. IT CAN BE PROVIDED BY FAMILY. IN THIS CASE, THIS PATIENT HAD FAMILY THAT WAS ABLE TO HELP THEM WHILE THEY WERE ON THE AIRPLANE AND THEY DID FIT IN BUSINESS CLASS. OTHER PATIENTS HAVE BEEN ABLE, THROUGH TRAVEL INSURANCE OR THEIR OWN MEDICAL INSURANCE FROM THEIR COUNTRY TO HAVE A NURSE COME FROM THAT COUNTRY AND PROVIDE ASSISTANCE. THE MEDICAL TEAM HAS TO CLEAR THE PATIENT TO FLY. IN ORDER TO PREVENT SOME OF THESE THINGS YOU WILL LIKELY GIVE THEM A HOME EXERCISE PROGRAM.

WHILE THEY ARE ON THE PLANE TO MINIMIZE THOSE RISKS OF DVT AND SWELLING. IT'S NOT A PERFECT WORLD, BUT LET'S JUST SAY BECAUSE THE PATIENT HAS BASICALLY CHOSEN THIS ROUTE TO GO HOME. CONSIDER AN RV WITH PDA IF THEY CAN RIDE WITH ASSISTANCE. MOST PEOPLE FORGET THAT YES, THAT IS ANOTHER OPTION. KATHY, MAY NEED TO THINK OF FAMILY TRAINING TO ASSIST PATIENT WHEN TRAVELING.

YES. A LOT OF TIMES THERE'S BEEN ANOTHER PATIENT WHO NEEDED TO HAVE FAMILY ASSIST THEIR RETURN TO A FOREIGN COUNTRY, AND THEY ACTUALLY HAD TO LEARN HOW TO MANAGE A BAG. SO NURSING WILL DO SOME OF THOSE THINGS TO HELP THE FAMILY IN EDUCATION. AGAIN, YOUR HOME EXERCISE PROGRAM IF YOU ARE TRYING TO MITIGATE EDEMA AND DVTS BECAUSE OF THESE INJURIES, YOU ARE GOING TO TEACH THE FAMILY ABOUT THEM, AS WELL SO THAT THEY CAN HELP THE PATIENT PERFORM THEM DURING THE TRIP. AGAIN, YOU KNOW, THIS IS ALL DEPENDENT ON THE MEDICAL TEAM CLEARING THE PATIENT TO BE ABLE TO FLY FOR WHATEVER LENGTH OF TIME THE PATIENT WILL NEED TO FLY FOR. CHERYL, WE DO A LOT OF FAMILY TRAINING, AS WELL OF TRAVELING VIA CAR AND PLANE. YES. JUSTIN, CAN YOU

PREVENT THEM FROM LEAVING THE COUNTRY IF YOU ARE NOT RECOMMENDING DC? IF THEY ARE GOING HOME REGARDLESS OF YOUR DC. JUSTIN, YOU CAN NOT PREVENT A PATIENT FROM LEAVING. WHAT YOU CAN SAY IS IF YOU BELIEVE THE PATIENT WILL BE COMPLETELY UNSAFE IN LEAVING AND THEY STILL WANT TO DO THAT, THE PHYSICIAN WILL LIKELY YOU WILL HAVE A DISCUSSION WITH THE PHYSICIAN AND IF THE PHYSICIAN AGREES WITH YOU THEY WILL LIKELY HAVE THE PATIENT SIGN PAPERWORK STATING THEY ARE LEAVING AGAINST MEDICAL ADVICE. YOU CAN'T NECESSARILY PREVENT THEM FROM LEAVING. MOST OF THE PATIENTS AND THEIR FAMILIES THEY DON'T WANT TO RISK THEIR PATIENT'S LIVES. SO THEY WILL USUALLY FOLLOW ALONG AND GO ALONG WITH THE BEST PLAN FOR THE PATIENT.

A LOT OF TIMES EVEN THE PATIENT'S FAMILY WANTS THEIR FAMILY MEMBER TO STAY IN THE HOSPITAL UNTIL THEY ARE ALMOST COMPLETELY INDEPENDENT PRIOR TO FLYING BACK HOME, BUT THAT'S NOT ALWAYS THE CASE EITHER. STACEY, IS PROLONGED FLIGHT WITH A SUB DERMAL HEMATOMA SAFE OR IS THERE A PERIOD OF TIME BEFORE THE FLIGHT AGAIN, EVERY SUBDERMAL HEMATOMA IS DIFFERENT. THIS ONE IS SMALL. SO WE ARE ASSUMING THE NEUROSURGEON HAS ALREADY CLEARED THE PATIENT TO FLY HOME. THEY HAVE DETERMINED WHETHER THAT IS SAFE OR NOT.

ANY OTHER QUESTIONS ON THIS CASE? SO YOU CAN SEE THE AMOUNT OF FORETHOUGHT YOU WILL NEED AND THINGS YOU WILL HAVE TO KEEP IN MIND FOR SOMEONE LIKE THIS LEAVING FOR ANOTHER COUNTRY. THERE'S A LOT OF THINGS THAT YOU MAY HAVE TO DO ON YOUR OWN TO FIGURE OUT. SOCIAL WORK MAY NOT BE ABLE TO HELP CLEAR UP ANY OF THOSE QUESTIONS. AGAIN, I THINK THIS ONE IS MORE COMPLICATED IN A SENSE THAT I'VE ACTUALLY HAD TO FIGURE OUT WHAT FLIGHT THEY ARE ON, WHAT AIRPLANE THEY ARE GOING TO BE IN, GETTING A SCHEMATIC OF THE AIRPLANE, LOOKING

AT PICTURES OF HOW THE SEAT IS SET UP, UNDERSTANDING WHERE THE BATHROOM IS, WHAT SIZE THE BATHROOM IS. THIS IS -- THIS DOES TAKE TIME. IT IS THE MANAGEMENT OF THE PATIENT, BUT YOU ARE ESSENTIALLY TRYING TO FIGURE OUT ALL OF THE BARRIERS THIS PATIENT WILL NEED TO OVERCOME IN ORDER TO GET ON THAT PLANE AND GO HOME. ALL RIGHT.

OKAY. CASE 3. SO A 56-YEAR-OLD MALE ADMITTED FOR COPD EXACERBATION LIVING ON THE THIRD FLOOR OF A SINGLE-ROOM OCCUPANCY HOTEL WITH NO ELEVATOR. IF YOU DON'T KNOW WHAT A SINGLE ROOM OCCUPANCY HOTEL IS, IT IS USUALLY A ROOM IN A HOTEL, BUT THERE'S NO BATHROOM, NO SHOWER IN THEIR ROOM. IT'S JUST A ROOM, PROBABLY BIG ENOUGH TO HAVE A TWIN BED, A CLOSET AND A FEW THINGS. AND MAYBE A SINK. OTHERWISE, THE BATHROOM AND THE SHOWER ARE DOWN THE HALL AND THEY ARE SHARED BY EVERYBODY ON THAT FLOOR. DO ANY OF YOU HAVE ANY QUESTIONS TO START OFF WITH? I PROBABLY LOST A FEW OF YOU. SORRY ABOUT THAT. IS THE PATIENT GOING HOME WITH O2?

YES. THEY CAN GO HOME WITH O2. PRIOR LEVEL OF FUNCTION? THE PRIOR LEVEL OF FUNCTION OF THE PATIENT IS THAT HE WAS INDEPENDENT WITH A SINGLE-POINT CANE AND HE WAS ABLE TO CLIMB THREE FLIGHTS OF STAIRS TO GET INTO HIS APARTMENT. HE DID NEED SOME EXTRA TIME TO DO THAT WHERE HE WOULD REST AND THEN GO UP A FEW STEPS AND REST AND THEN GO UP A FEW STEPS. YES. SO, AGAIN, ACCESS AND ENDURANCE, YES. HE DIDN'T HAVE ENDURANCE TO DO ALL THREE FLIGHTS AT THE SAME TIME. CAN HE REQUEST A FIRST OR SECOND FLOOR? UNFORTUNATELY, NO. BECAUSE THE HOTEL IS ALREADY AT MAX CAPACITY AND EVERYONE HAS ALREADY SET UP THEIR HOME IN THESE ROOMS IT'S VERY DIFFICULT TO REQUEST A FIRST OR SECOND FLOOR. THAT DOESN'T MEAN YOU CAN'T CALL THE CASE MANAGER IN THAT BUILDING TO HAVE THEM, YOU KNOW, TO REQUEST THAT TO SEE IF ANYBODY'S WILLING

TO TRADE, BUT FOR THE IMMEDIATE TIME BEING THIS PATIENT WILL HAVE TO BE ABLE TO CLIMB THOSE THREE FLIGHTS OF STAIRS AGAIN. ARE THERE LANDINGS IN BETWEEN THE FLIGHTS OF STAIRS? YES. THERE WILL BE A LANDING AT EACH FLOOR. IS THERE FAMILY OR FRIENDS HE CAN STAY WITH? NO. THERE ARE NO FAMILY OR FRIENDS THAT HE HAS. OKAY. WILL THE HOTEL ACCEPT HIM BACK WITH HIS CURRENT MEDICAL CONDITION? YES. THE HOTEL WILL ACCEPT HIM BACK. THEY DON'T NECESSARILY HAVE RESTRICTIONS ON WHEN AND HOW PATIENTS COME BACK HOME. THERE MIGHT BE A CASE MANAGER THAT MIGHT BE HAVING CONCERNS AND BRINGING UP THOSE CONCERNS AND MAKING SURE THE PATIENT IS ABLE TO GET BACK IN THEIR HOME. BUT THERE'S NO WAY TO DENY THAT PATIENT ACCESS BACK INTO THEIR HOME BECAUSE OF HIS CONDITION. AGAIN, NO, NOT AT THE TIME BEING CAN THEY MOVE TO A DOWNSTAIRS ROOM. THE BATHROOM IS ON THE SAME FLOOR, BUT IT IS DOWN THE HALL.

YOU ARE TALKING AT LEAST 200 FEET DOWN THE HALL. REHAB TO TOLERATE STAIR AND THEN BACK HOME. I WILL ADDRESS THAT. YOU WILL NEED TO ASSESS WHETHER THE PATIENT HAS A SKILLED PT INTERVENTION OR WHETHER IT IS TIME THAT WILL HELP IMPROVE THE PATIENT'S ABILITY TO CLIMB THOSE STAIRS. SO, WHAT SKILLED INTERVENTION WILL YOU BE PROVIDING TO THIS PATIENT IN ORDER TO CLIMB THOSE STAIRS? NOW, YOU KNOW HE ALREADY KNOWS HOW TO CLIMB THEM BASED ON THE ABILITY TO DO THAT PREVIOUSLY. SO HE KNOWS HOW TO CLIMB THE STAIRS, BUT HE MAY NOT HAVE THE ENDURANCE TO DO SO. SO, WITH THE COPD EXACERBATION, WILL IT BE TIME TO ALLEVIATE THE EXACERBATION AND HAVE IT UNDER CONTROL, AND WHILE HE IS IN SNF, IN THE SNF REHAB, WILL YOUR TREATMENT MAKE THAT HAPPEN FASTER OR HAVE NO BEARING OR BE LIMITED IN THE ABILITY TO PROVIDE A SKILLED INTERVENTION FOR HIM TO BE ABLE TO CLIMB THOSE STAIRS FASTER? THAT'S SOMETHING TO THINK ABOUT. IF YOU BELIEVE THAT YOU HAVE AN

INTERVENTION OR AN INTERVENTION THAT CAN BE PROVIDED IN SKILLED REHAB, WILL HELP HIM TO GET HOME FASTER THAN IF YOU LET NORMAL TIME TAKE ITS COURSE, THAN I'D SAY SURE. SNF REHAB WOULD BE ACCEPTABLE. IF YOU FEEL THAT THERE MAY NOT BE MUCH OF A DIFFERENCE BETWEEN THAT, THAN IF YOU ARE MAKING THE RECOMMENDATION FOR SNF, YOU HAVE TO THINK ABOUT ARE YOU TAKING A RESOURCE, A LIMITED RESOURCE UNFORTUNATELY IN MY COMMUNITY AWAY FROM ANOTHER PATIENT WHO MAY BENEFIT FROM SNF REHAB MORE?

SO THOSE ARE THINGS THAT ARE GOING ON IN THE BACK OF MY MIND. I KNOW THAT'S A LOT TO TAKE ON. OKAY. I'M TRYING TO GET THROUGH THE QUESTIONS. YOU GUYS ARE WRITING THEM FURIOUSLY. LET'S SEE. UNFORTUNATELY FOR THIS PERSON, THOSE THAT HAVE WRITTEN STAYING SOMEWHERE ELSE. HE DOESN'T HAVE ANY OPTIONS TO STAY ANYWHERE ELSE. NO FAMILY AND FRIENDS. WHERE ARE THE SHOWERS? THE SHOWERS ARE ON THE SAME FLOOR. HOWEVER, THEY ARE GOING TO BE DOWN THE HALL ABOUT 200 FEET. CAN HE CLIMB A FULL FLIGHT AT ONCE?

NO. BILATERAL RAILS HE CAN REACH SIMULTANEOUSLY? THERE ARE RAILS ON BOTH SIDES, BUT HE CANNOT REACH THEM WITH BOTH HANDS, THE STAIRCASE IS TOO WIDE TO DO THAT SAFELY. MELINDA, BECAUSE HE MAY GET TRAPPED ON THE THIRD FLOOR. THIS IS A CONCERN. IF THE PATIENT GETS DISCHARGED HOME AND IS ABLE TO CLIMB THREE FLIGHTS BUT IT TAKES A REALLY LONG TIME FOR HIM TO DO THAT. NOW HE IS UP ON THE THIRD FLOOR AND STUCK. HE MAY NOT WANT TO GO OUT BUT MAYBE HE DOES OR MAYBE HE HAS TO. ONE THING YOU NEED TO THINK ABOUT IS LET'S SAY THERE IS A FIRE IN THIS BUILDING, THAT WOULD BE A REALLY BAD STROKE OF LUCK, BUT IS HE GOING TO BE ABLE TO GET OUT OF THE BUILDING? GOING DOWNSTAIRS WILL PROBABLY NOT TAX HIM AS MUCH AS GOING UP THE STAIRS BUT ANOTHER WAY

TO ALSO DO SOME KIND OF TRAINING FOR HIM BEFORE HE LEAVES MIGHT BE TO DO WHAT WE CALL BUMPING UP AND DOWN THE STAIRS, MEANING SLIDING DOWN ON YOUR BUTT IN CASE OF AN EMERGENCY. I'VE DONE THAT KIND OF TRAINING FOR PATIENTS WHO ARE IN THIS SITUATION SOMETIMES. DO THE STAIRS HAVE A HANDRAIL TO HOLD ON? YES, THERE ARE HANDRAILS. STACEY, CAN HE GO SKILLED NURSING FACILITY TO WORK ON LEVEL FUNCTION IF NO LONGER ACUTE EXACERBATION? YES. HE CAN AS LONG AS YOU ARE ABLE TO DOCUMENT THAT THERE IS A SKILLED INTERVENTION THAT HE WOULD BENEFIT FROM. IS THE HOTEL A CHAIN THAT WOULD SEND HIM TO ANOTHER HOTEL? NO, THE HOTEL IS NOT A CHAIN.

IT IS LIKE A CITY OR COUNTY RESOURCE IN WHICH THE SINGLE-ROOM OCCUPANCY HOTEL IS ESSENTIALLY THEIR APARTMENT, BUT THEY CALL IT A SINGLE-OCCUPANCY ROOM HOTEL BECAUSE THEY THINK OF THE NATURE OF HOW THE BUILDING WAS BUILT NEAR YEARS AGO. HOME HEALTH, YES. HOME HEALTH IS A VIABLE OPTION. USUALLY WITH HOME HEALTH, IN OUR COMMUNITY HOME HEALTH CRITERIA IS A PATIENT HAS TO BE STUCK IN THEIR ROOM. SO THE INABILITY TO MAYBE DO THE STAIRS AT ONCE OR NEEDING EXTRA TIME. YES, YOU CAN HAVE HOME HEALTH GO IN THERE AND THEY CAN DO A HOME SAFETY EVAL. THAT MIGHT HELP TO BRIDGE OR FEEL SAFER FOR HIM TO GO HOME. OKAY. TALK TO PATIENT ABOUT MOVING -- YES. OKAY. SO SHOWER CHAIR, STEPHANIE, YOU ASKED IS A SHOWER CHAIR AVAILABLE AND CAN HE TOLERATE A SHOWER? THAT IS SOMETHING TO TALK TO THE PATIENT ABOUT. SOME PATIENTS MAY SAY I'M NOT GOING TO TAKE A SHOWER UNTIL THIS IS BETTER. YOU CAN TALK ABOUT POTENTIALLY DOING A SPONGE BATH IF HE HAS A SINK IN HIS ROOM. A SHOWER CHAIR IS SOMETIMES AVAILABLE BUT, AGAIN, SOME OF THE TRICKIER SITUATIONS ARE, YES, WE CAN SEND HIM HOME WITH A SHOWER CHAIR BUT THERE'S NO GUARANTEE THAT THAT SHOWER CHAIR WILL STAY IN THAT SHARED SHOWER. IT MIGHT DISAPPEAR. ELLEN, THIS

IS A LONG-TERM SITUATION FOR A PATIENT WITH COPD. WHAT'S NEXT? MANAGEMENT OF HIS COPD IS LIKELY THE FIRST THING TO THINK ABOUT AND THEN LOOKING AND EDUCATING HIM ON TRYING TO GET -- HAVE SOMEBODY HELP HIM MOVE TO A DIFFERENT HOUSING SITUATION WHERE HE WOULD NOT HAVE TO OVERCOME SO MANY STAIRS. YES, ALLISON, ENERGY CONSERVATION TECHNIQUES AND EDUCATION, YES. THAT'S EXTREMELY IMPORTANT. YES, KATHY, VERY GOOD COMMENTS HERE. TRAINING HIM ON HOW TO SIT AND STEP TO REST AND THEN TURN AROUND AND KEEP CLIMBING, YES. YES. ANDY, CAN A CHAIR BE PLACED AT EACH LANDING? THIS IS SOMETHING WE WOULD EITHER NEED TO ASK THE PATIENT IF THAT IS POSSIBLE, ASK THEIR CASE MANAGER IF THEY HAVE ONE OR CALL THE BUILDING MANAGER TO SEE IF THAT IS POSSIBLE. IS THE COST OF AN EXTENDED HOSPITAL MORE EXPENSIVE THAN SNF IF HE IS NOT ABLE TO GO HOME? THIS IS A GREAT QUESTION.

USUALLY ADMINISTRATION WILL OR UTILIZATION MANAGEMENT WILL BRING THIS UP. SO, AS A THERAPIST, YOU WILL NEED TO FIGURE OUT DO YOU WANT TO RECOMMEND SNF REHAB OR FOR HIM TO GO TO IN ORDER TO IMPROVE THEIR ENDURANCE WITH SOME SKILLED INTERVENTION THAT YOU KNOW IS THE BEST TREATMENT FOR HIM, OR YOU ARE GOING TO KIND OF WEIGH THAT WITH SOME OTHER INSTITUTIONAL OR HEALTH SYSTEM FACTORS. THAT IS A VERY, VERY TRICKY QUESTION. AND SOMETIMES COMES UP. AS LONG AS YOU ARE DOCUMENTING EXACTLY THE REASON WHY YOU ARE MAKING THE RECOMMENDATION YOU DO AND HIGHLIGHTING THE DYSFUNCTION AND THE NEED FOR REHAB, I THINK YOU WILL BE OKAY. BUT, AGAIN, THAT HAS TO BE VERY CLEAR. HOW IS FINANCIAL STATUS AND WILL HOTEL ALLOW ANY MODIFICATIONS LIKE A STAIR LIFT? THE FINANCIAL STATUS IS A PATIENT LIKE THIS IS GETTING SOME KIND OF AN ALLOWANCE AND USING THAT ALLOWANCE TO PAY FOR THIS HOTEL ROOM ON A MONTHLY BASIS LIKE AN APARTMENT. NO, THE HOTEL WOULD NOT ALLOW A STAIR LIFT. IF WE WANTED TO PURSUE THAT,

THAT WOULD BE KIND OF A BIGGER SYSTEMS ISSUE THAT WOULD REQUIRE A LOT OF BUREAUCRACY TO GET THROUGH. AMY, YES. SET UP LIFE ALERT IS A GOOD IDEA. IS HE READY TO PAY FOR THE STAIR LIFT? LIKELY THE PATIENT DOES NOT HAVE ENOUGH FUNDS TO PAY FOR THE STAIR LIFT. YES, JOHN, WE TALKED ABOUT FIRE SAFETY, GETTING IN AND OUT. SO WITH COPD EXACERBATION, WE WANT TO THINK OF -- HE'S BEEN ABLE TO GO UP AND DOWN THE STAIRS PREVIOUSLY INDEPENDENTLY WITH A CANE. SO, IS THAT EXACERBATION SHOULD NOT BE LASTING FOR AN EXTENDED PERIOD OF TIME. ONCE HIS EXACERBATION IS MANAGED AND HE RETURNS TO HIS BASELINE RESPIRATORY FUNCTION, HE SHOULD BE ALSO ABLE TO RETURN BACK TO HIS PHYSICAL FUNCTION. OKAY.

IN MOST OF THESE QUESTIONS ARE KIND OF GONE OVER. SUSAN -- YOU ARE NOT NECESSARILY RELATED TO THIS CASE BUT AS FAR AS POVERTY GOES, WHAT CHANGES IN THE COMMUNITY RESOURCES DO YOU THINK WOULD BE MOST BENEFICIAL FOR YOUR PATIENTS TO EXPERIENCE? BIG PICTURE QUESTIONS. YOU KNOW, HAVING THE AMOUNT OF RESOURCES AVAILABLE FOR THE COMMUNITY THAT YOU SERVE WOULD BE VERY HELPFUL. SOMETIMES FINDING OTHER ORGANIZATIONS THAT ARE INVESTED IN HELPING TO GET SOME OF THESE RESOURCES AVAILABLE TO PATIENTS CAN BE A START. I WOULD SAY THERE ARE A LOT OF ORGANIZATIONS WITHIN MY COMMUNITY THAT ARE LOOKING AT THESE TYPE OF SOCIAL PROBLEMS AND TRYING TO HAVE AS MANY RESOURCES AVAILABLE TO PATIENTS, BUT IT IS A VERY, VERY DIFFICULT THING TO NEGOTIATE BECAUSE I BELIEVE WE HAVE A LARGER POPULATION THAN THE RESOURCES WE HAVE AVAILABLE. WE HAVE ABOUT TEN MINUTES LEFT AND THERE ARE TWO MORE CASES. I'M JUST GOING TO TRY TO GO THROUGH THEM. AND I WILL GO OVER THEM KIND OF QUICKLY. IF WE HAVE MORE QUESTIONS, WE CAN ASK THEM AT THE END. WITH CASE FOUR, 86-YEAR-OLD FEMALE RECENTLY PAROLED FROM JAIL WITH A HISTORY OF DEMENTIA INITIALLY TO BE

REPATRIATED TO HER ORIGINAL EUROPEAN COUNTRY BY A FEDERAL AGENCY BUT UNABLE TO COMPLETE THIS PLAN. SO ESSENTIALLY THIS PATIENT WAS DROPPED OFF AT THE HOSPITAL IN THE ED. THE PATIENT SPENT OVER 30 YEARS IN JAIL. AND UNFORTUNATELY, NOT ABLE TO REPATRIATE THE PERSON BACK UNDER THIS ORIGINAL PLAN THAT WAS SET UP PRIOR TO THEIR PAROLE. SO THE PATIENT HAS DEMENTIA. SO THEY WILL HAVE SOME COGNITIVE DEFICITS, POOR INSIGHT INTO THEIR COGNITIVE DEFICITS AND DECREASED SAFETY. PATIENT IS ABLE TO MOBILIZE WITH CLOSE SUPERVISION. THE PATIENT ACTUALLY DID NOT HAVE ANY FAMILY MEMBERS IN THEIR ORIGINAL -- IN THE COUNTRY THEY WERE SUPPOSED TO BE REPATRIATED. NOBODY WAS WILLING TO TAKE THE PATIENT BACK.

AND THEN THERE MIGHT HAVE BEEN A FAMILY MEMBER BUT WAS NOT INVOLVED AND DID NOT REALLY WANT TO BE INVOLVED. SO, BECAUSE OF THEIR COGNITIVE OR LACK OF COGNITIVE CAPACITY, THEY NEEDED TO HAVE -- THEY NEEDED TO HAVE A GUARDIAN MAKE MEDICAL DECISIONS. THAT NEEDED TO HAPPEN FIRST. EVENTUALLY, PHYSICAL THERAPY WAS CONSULTED. THE REASON THEY WERE CONSULTED AND THE ROLE WE HAD TO PLAY IS DETERMINE THEIR FUNCTIONAL LEVEL, THEIR REAL FUNCTIONAL LEVEL. WHILE THERE WERE JAIL NOTES THAT HIGHLIGHTED WHAT THEY WERE ABLE TO DO -- AND YOU CAN MAKE SOME ASSUMPTIONS SINCE THEY WERE IN GENERAL POPULATION, TO HAVE A VERY DETAILED UNDERSTANDING OF THEIR MOBILITY AND MAYBE THEIR COGNITIVE ABILITY TO BE SAFE IN THAT MOBILITY NEEDED TO BE DOCUMENTED THROUGH A PHYSICAL THERAPY EVALUATION. SO, DETERMINING THEIR LEVEL OF MOBILITY AND KIND OF LETTING THE TEAM KNOW WHAT THEIR FUNK WAS SO THEY COULD FIND AVAILABLE RESOURCES WHERE THAT MOBILITY COULD BE HANDLED. SO THAT PATIENT ENDED UP GOING TO LONG-TERM CARE, BOARDING CARE SINCE THEY WERE CONTACT CARE, CLOSE SUPERVISION. SOME BOARDING CARES WILL TAKE PATIENTS LIKE

THAT AND SOME WILL NOT. SO, IT WAS UP TO THE PATIENT CARE COORDINATOR AND UTILIZATION MANAGEMENT TO FIND THE RIGHT BOARDING CARE THAT CAN HANDLE THE FUNCTION OF THAT PATIENT. OKAY. I WILL MOVE QUICKLY THROUGH CASE FIVE. THIS IS A 9-YEAR-OLD FEMALE ADMITTED FOR SECONDARY SYNCOPAL FALL WITH HISTORY OF AFIB AND DIABETES. PATIENT LIVES ALONE IN AN APARTMENT WITH ELEVATOR ACCESS. SHE HAS AN IN-HOME SUPPORTIVE SERVICE CAREGIVER THREE HOURS FIVE DAYS A WEEK. TWO CHILDREN AND THEIR FAMILIES LIVE NEARBY BUT ARE UNABLE TO ASSIST DUE TO THEIR WORK AND/OR SCHOOL SCHEDULES. THIS IS A PATIENT WITH MAYBE NOT NO SUPPORT BUT -- I WOULDN'T SAY POOR SUPPORT BUT INCONSISTENT SUPPORT. THE BIGGEST ISSUE WITH THIS IS OBVIOUSLY THIS PATIENT MAY NEED MORE THAN JUST THREE HOURS A DAY AND FIVE DAYS A WEEK OF A CAREGIVER.

THEIR LEVEL OF FUNCTION IS PROBABLY SUPERVISED AND, AGAIN, ANOTHER POST-SUPERVISION TYPE PERSON. AND, YOU KNOW, SOME OF THE THINGS THAT YOU CAN HELP THE FAMILY COME UP WITH, ONE, FIRST OF ALL, CAN WE GET MORE IN-HOME SUPPORTIVE CARE SERVICES FOR THE PATIENT, MORE THAN JUST THE THREE HOURS A DAY, BECAUSE THE OTHER HOURS OF THE DAY THE PATIENT IS LEFT ALONE. THIS CAREGIVER IS PROBABLY DOING SOME KIND OF MEAL PREP AND ALSO ADLS LIKE SHOWERING FOR THE PATIENT. SO, CAN WE INCREASE THOSE SERVICES? CAN THE FAMILY GATHER THEMSELVES TOGETHER AND HAVE A CONVERSATION ON WHAT THEY CAN REALLY PROVIDE FOR THIS PATIENT? THERE'S NO ONE OVERNIGHT. CAN THEY STAY OVERNIGHT? THE IHSS CAREGIVER IS NOT USUALLY A PERSON THAT CAN STAY OVERNIGHT WITH THE PATIENT. CAN THE FAMILY PUT TOGETHER RESOURCES TO STAY OVERNIGHT WITH THE PATIENT? IF NOT, CAN THEY AFFORD TO FIND SOMEONE TO PROVIDE THAT OTHER NIGHTLY SUPPORT? AND THEN IF ALL OF THOSE ARE POSSIBLE, GREAT. IF NOT, WHAT ARE OTHER THINGS TO THINK ABOUT, SAY IHSS

CAN INCREASE TO EIGHT HOURS DURING THE DAY, THAN THE OTHER PARTS ARE MAYBE THE FAMILY CAN SET UP CAMERAS IN THE HOUSE, MAYBE PURCHASE A BED ALARM THROUGH AMAZON AND, YOU KNOW, THAT COULD SIGNAL -- USING SOME TECH TO HELP TO MANAGE THE PATIENT AT NIGHT. CAN THE PATIENT GO HOME TO THE FAMILY TO LIVE EVEN IF THEY ARE NOT AROUND DURING THE DAY, CAN THEY FIND A PROVIDER? THERE HAVE BEEN FEW IHSS CAREGIVERS WHO CAN STAY OVERNIGHT, BUT THERE'S A LONG PROCESS THROUGH OUR COMMUNITY RESOURCES IN ORDER TO HAVE THAT SPECIAL SERVICE DONE. IT'S NOT IMPOSSIBLE BUT IT IS VERY DIFFICULT TO GET. ALSO ADULT DAY HEALTH MIGHT HELP DURING THE DAY LETTING THE IHSS CAREGIVER COME IN THE EVENING UNTIL THE FAMILY MEMBER CAN TAKE OVER. THESE ARE ALL QUESTIONS TO MAKE IT A SAFER DISCHARGE.

ALL RIGHT. I DIDN'T TALK ABOUT SNF REHAB FOR THIS PATIENT ONLY BECAUSE THE PATIENT HAD A SINGLE FALL AND DIDN'T HAVE ANY INJURIES. THEY ARE ESSENTIALLY AT THEIR BASELINE AFTER THE EVALUATION. SO NOW THE ROLE OF THE PT IS JUST LOOKING AT FIGURING OUT RESOURCES TO HELP THIS PATIENT STAY EITHER IN THEIR HOME OR MAKING RECOMMENDATIONS ABOUT WHAT THEY REALLY NEED. MAYBE THE FAMILY CAN ALSO START TO THINK ABOUT AN ASSISTED LIVING FACILITY OR A BOARDING CARE, BUT THAT WOULD DEPEND ON THEIR FINANCE AND WHAT THE FAMILY AND PATIENT WERE WILLING TO DO. ALL RIGHT. SO, SORRY ABOUT GOING THROUGH THE LAST TWO CASE STUDIES PRETTY QUICKLY. WE HAVE DONE -- LOOKS LIKE WE HAVE THREE MINUTES LEFT. DOES ANYBODY HAVE ANY OTHER QUESTIONS? ASK AWAY. I WILL TRY TO ANSWER THEM ALL.
>> HI, EVERYONE. THIS IS CALISTA, YOUR MODERATOR. IF YOU HAVE ANY QUESTIONS OR CLARIFICATION AND YOU WOULD LIKE TO ASK DR. WONG, GO AHEAD AND PLACE THOSE IN THE Q&A. THERE'S A QUESTION ON QUESTION 7. YOU WANT ME TO READ IT TO YOU.

>> YES, DR. WONG. IT STATES ACCORDING TO THE OFFICE OF DISEASE PREVENTION, HOW IS SOCIAL DETERMINANTS OF HEALTH DEFINED?

>> I BELIEVE SLIDE FOUR WILL HAVE YOUR ANSWER FOR YOU. IF THAT HELPS. I'M HOPING THAT HELPS. I WILL GO AHEAD AND READ THE ANSWERS HERE. A IS CONDITIONS AND AVAILABLE ASSISTANCE PROVIDED BY THE FAMILY DURING THE AGING PROCESS THAT AFFECT WIDE RANGE OF FUNCTION AND QUALITY OF LIFE. B IS CONDITIONS IN THE ENVIRONMENTS IN WHICH PEOPLE LIVE, WALK,PLAY, WORSHIP. C, IS CONDITIONS OF COGNITIVE ABILITIES TO MAKE INFORMED DECISIONS REGARDING HEALTH, FUNCTIONING AND QUALITY OF LIFE AND FINALLY D IS CONDITIONS AND MEDICAL AND FINANCIAL STABILITY THAT PROVIDE FOR IMPROVED HEALTH, FUNCTIONING AND QUALITY OF LIFE. I DON'T SEE ANY OTHER SPECIFIC QUESTIONS, OH, IS IT FERNANDA, YOU ARE ASKING IF IHHS IS AVAILABLE IN ALL STATES? I DON'T KNOW THE ANSWER TO THAT. I DO KNOW IN MY STATE THAT IT IS AVAILABLE THROUGH THE MEDICAID, MEDI-CAL PROGRAM. MEDICARE DOES NOT HAVE THIS PAID. IT DOES NOT PAY FOR IHHS CAREGIVER BUT I THINK MEDI-CAL WILL PAY FOR IT IN OUR STATE.

>> IS THERE A SLIDE THAT REFERS TO MEDICAL RESPITE? LET ME GO THROUGH AND TAKE A LOOK QUICKLY HERE. I BELIEVE THE DISCHARGE DESTINATION -- I LISTED RESPITE THERE, BUT I DIDN'T PUT MAYBE THE ANSWER YOU WERE LOOKING FOR. I DIDN'T WRITE THAT DOWN IN THE SLIDE. AGAIN, JUST MEDICAL RESPITE IS THE MEDICAL BEDS IN A SHELTER. AND PATIENTS WOULD NEED TO BE INDEPENDENT IN THEIR ADLS AND MOBILITY IN ORDER TO STAY AT A RESPITE BED. ALL RIGHT. I DON'T SEE ANY OTHER QUESTIONS. WE HAVE SOME GREAT COMMENTS COMING IN FROM EVERYONE ABOUT WHAT A WONDERFUL CLASS THIS WAS. THANK YOU, EVERYONE. AND THANK YOU ESPECIALLY TO DR. WONG FOR SHARING YOUR EXPERTISE WITH US TODAY.

>> YOU'RE WELCOME. I HOPE IT WAS CLEAR ENOUGH FOR YOU GUYS TO KIND OF BE ABLE TO START ADDRESSING SOME OF THESE SOCIAL COMPLEXITIES. AGAIN, IT'S A GUIDELINE. DON'T USE IT AS A COOKBOOK BUT I HOPE IT IS GIVING YOU SOME KIND OF GUIDELINE INTO ADDRESSING THESE VERY, VERY DIFFICULT SITUATIONS. AGAIN, IF -- CALISTA, I DON'T KNOW IF I HAVE ANY CONTACT INFORMATION ON THE WEBSITE. IF ANYONE HAS ANY QUESTIONS, E-MAIL ME. I'M MORE THAN HAPPY TO ANSWER MORE QUESTIONS OFF LINE.

>> WONDERFUL. IF YOU WANT TO -- YES, WE DON'T HAVE YOUR E-MAIL ADDRESS. IF YOU WANT TO PROVIDE THAT, WE CAN.

>> OKAY. SHOULD I PUT THAT --

>> CAN YOU HELP ME OUT WITH THAT? IF ANYONE HAS MORE QUESTIONS AND WANT TO ME MAIL ME. THAT IS MY PERSONAL E-MAIL. I WILL TRY TO ANSWER THE BEST I CAN.

>> WE WILL OFFICIALLY CLOSE OUT TODAY'S COURSE. HAVE A GREAT DAY, EVERYONE AND I HOPE TO SEE YOU BACK IN THE CLASSROOM TOMORROW AS WE RESUME OUR ACUTE CARE VIRTUAL CONFERENCE.

>> THANK YOU, EVERYONE. THANK YOU. WE WILL HAVE TO WAIT 15 MINUTES FOR THE ATTENDANCE REPORTS TO CLEAR BEFORE YOU CAN TAKE THE EXAM. LOG IN TO PHYSICALTHERAPY.COM AND ACCESS YOUR PERSONAL ACCOUNT, FIND TODAY'S COURSE AND I BELIEVE IT IS THE FAR RIGHT SIDE OF THE TITLE OF TODAY'S COURSE AND HIT "TAKE EXAM." HAVE A GREAT DAY, EVERYONE. AND THANK YOU, AGAIN, DR. WONG.
>> OH, THANK YOU.