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Kessler Institute for Rehabilitation 8th Annual Stroke Conference: Part 1 of 8 There's No Place Like Home

Recorded October 2019. Listen to it here.

[music]

URI ADLER: 00:04 The keys here are early involvement, setting goals, and being very realistic with the patients and their families as far as getting the patients home.

ANNOUNCER: 00:14 Welcome to the eighth annual stroke conference, Breaking Barriers: There's More to Getting Home than Walking. In this podcast, Dr. Uri Adler of Kessler Institute for Rehabilitation provided the welcome and his presentation, There's No Place Like Home. For more information about Dr. Adler, read his bio in the program notes. This conference was sponsored by Kessler Institute for Rehabilitation and was a one-day event that provided participants with an understanding of the multidisciplinary approach to rehabilitation that enables stroke survivors and their families and caregivers to rebuild their lives. Discussion will focus on communication, motivation, spatial neglect, sleep issues, bowel and bladder management, and community integration.

ADLER: 01:08 I'd like to welcome everybody. My name is Uri Adler. I'm the medical director at Kessler in Saddle Brook. I'm also the director of stroke services for all of Kessler. Kessler has four different hospitals in New Jersey. The theme of our conference today is There's More to Getting Home than Walking. And I think most of the lectures you'll see will somehow loosely fit into that theme. And we're trying to show everybody all the different things that have to be done-- or some of the different things that we can do to try to get our patients home. This block that we're having this morning-- I'm going to talk a little bit about discharge and terminations. Where do patients go from the acute care hospital, from a rehabilitation facility, and some of the barriers we have, and what we have to do to get them home in general. And following me, we'll have two lectures from-- well, three lectures from our experienced therapists: two of them by Gretchen March, one of them by Arielle Resnick. And at the end of my lecture, if I don't introduce them, just remind me and I'll tell you how this is a nice little block.

ADLER: 02:09 So what I'm going to do is I'm going to talk about how there's no place like home, just give a little bit of an overview for the whole day, and talk a little bit about some of the challenges that we find currently, some of the challenges that we've had historically, and what we are doing to try to get patients home from any level of care really. So by way of disclosure, I am the medical director here. I do work for an acute rehabilitation facility. I'm going to try to be as objective as I can when I talk about all different locations for getting therapy after a stroke. I really don't have anything financial else to disclose.

ADLER: 02:46 So goals of today's lecture, for me, we're going to talk about discharge locations for strokes. And this is regionally, throughout the country. This is different internationally, and nationally this is different a little bit. But I'm trying to focus a little bit in this area because that's what we care about mostly. But we will talk about even some international issues as well. We're going to talk a little bit about different discharge locations. So where do you go from your acute care hospital after you have your stroke? But also after you have your stroke, from the acute care hospital most

people will go to some sort of facility or go home. But if you don't go home immediately, where do you go from there? And what are some of the differences as far as the settings where you can get different rehab? And what are the things that go through for our decision-making process?

ADLER: 03:32

We're going to start out a little bit historically and talk about how things used to be, so in the good old days of rehabilitation. So maybe I started a little bit after. I've been working with Kessler for about 17 years. Before that, I did residency for five years. I have about 22 years-- and medical school before that-- mid 20 years of experience of stroke patients and where they were going. But we're going to talk about maybe a little bit further back than that and go through the years and see how things have changed. Things have changed a little bit over the last 20 years in stroke rehabilitation. So as you know, most people who have a stroke - this is still what's happening - people will go to an emergency room. Usually, they'll get admitted to the hospital for at least a short time. And then from there, we have to decide what to do. And of course, a lot of the decision about where that patient gets the rehabilitation depends on how severe the stroke was. And that's probably the overriding issue that hasn't changed so much. There have been some changes. I think the advent of TPA and our care in acute care hospitals has gotten a lot better. And people are getting better faster. And a lot more people are staying in the acute care hospital for a lot less time. And a lot more people are going home straight from the acute care hospital, which wasn't necessarily the case even 20 years ago. But how do we decide what to do? How long do they stay in each level of care?

ADLER: 04:56

So before I start going through this, I'm going to give you a couple of cases for us just to think about during the lecture. Think about how would we treat this case, what are our impressions of these cases initially, and see what things happen. So the first one I want to talk to you about is a Mrs. M. So I knew Mrs. M before she ever came to Kessler. I was called by one of our nurses. We have liaison nurses in all of our hospitals. One of our nurses called and wanted to present the case to me and says, "She's a 68-year-old female who's had multiple strokes in the past. Just most recently had another stroke. Not only is she having a lot of strokes, she has a lot of medical issues. And at this point, in the hospital, she's currently dependent with her activities of daily living and with her transfers. And we don't really think that she's going to be somebody who's going to be walking any time in the near future or ever. In fact, because of her current stroke, she already had some problems. She had spasticity. She had contractures. So this is not somebody who we were going to get up walking and hope to do that when they left here. So we were thinking not everybody that we take has to walk by the time they leave Kessler. Maybe we could do some other things with her. Maybe we can work on her speech; we could work on her understanding; we could work on arousal, we could work on feeding.

ADLER: 06:14

So I was told that actually she has pretty bad aphasia, too. And if you wanted to do a lot of therapy with her to try to improve it, she's not somebody who's really going to be able to sit in therapy for hours on end and attend to the therapist. She's very fatigued. Has decreased arousal, hard to stay awake. And I'm thinking to myself, "Why would we take this patient in an acute rehabilitation hospital?" So as you know, everybody here gets three to three and a half hours of therapy, at least, a day. Now

it's not like patients have to be able to run marathons. We can have patients and do therapy in a chair. We can do therapy in a bed even. But we do want some sort of level of participation. And we actually are required to give some sort of level of participation to their therapy. And not only that. The patient wasn't even in an acute care hospital. The patient was in a SNF, or a skilled nursing facility or a nursing home, already. So again I'm thinking it sounds like she's probably in her appropriate level of care. So why are they calling us to admit her to Kessler? So then the liaison nurse told me that actually this person is the mother of a local physician, a prominent physician, in a big hospital here who wanted us to take the patient to Kessler. So again I'm just going to leave this hanging. We'll talk about it a little bit later. Is this somebody who we should have taken to Kessler, if we took her at all? Meaning this is her background and we're just getting a call from a doctor saying, "This is somebody I'd like to be admitted to your rehabilitation hospital." I'm going to give you-- okay. That was the call that we got, so.

ADLER: 07:49

The next patient we have is at the other end of the spectrum. So this was a 30-year-old man. And I was called by the nurse again. He had a stroke. He had some cardiac infection, got an infectious stroke because of it. It was a right frontal parietal stroke. At home, he had a wife and a new infant. And how was he doing? He needs to be on IV antibiotics for a while because of the infection in the brain and in his heart. In the acute care hospital, I'm told that he's agitated. He's agitated, but as far as the level of functioning, he's actually doing very well. He's already ambulating. In fact, part of his agitation is that he's walking around the hospital. His balance is pretty good. His cognition is very good. And his dexterity also is pretty good. He's obviously not perfect. He does have some deficits from the stroke. And again he's very high level motorically and would we admit this patient? So at the other end of the spectrum we're thinking is this person even too high of a level to come to Kessler? Meaning should he just go home? It turns out his agitation really wasn't what we would call a medical agitation. It was more that he wanted to go home already. So again he's very high level motorically. He wanted to go home. And we're trying to figure out why are they calling Kessler to have this person admitted. So again keep these two cases in mind, and we'll talk about them a little bit later. If I forget any of them, just remind me.

ADLER: 09:10

So we're going to talk about post-acute care rehabilitation through the year. Post-acute just refers to any level of rehabilitation that you're getting or care that you're getting after your stay in an acute care hospital. And that term is used for a lot of different reasons. I'm going to leave it at that. So before we start, we'll give you some definitions. I hope everybody here-- first of all I guess our audience is made up of-- let me guess based on yesterday. We have some case managers here. Nobody? Any therapists? Some therapists. Nurses? And who else? Physicians. No. Okay, good. Any other--

AUDIENCE: 09:55

Students.

ADLER: 09:55

Students. Okay. Okay, good. Okay. So I think most of us know what a stroke is even if we can't give you the exact definition. But we know it's an acute onset of a vascular event that affects your brain that causes neurologic deficit. And it actually, as I think

most of us know, is the most common neurologic problem that causes hospitalization in the United States. An ACH is what we refer to in the slides, acute care hospital. So those are places like Hackensack, like Holy Name, like Valley, where patients will go when they have acute medical issues and have to be hospitalized. These are our traditional, what we call, hospitals. An IRF, or an in-patient rehabilitation facility, is a place like Kessler. An IRF, or an acute rehabilitation facility some people call them, is classified as an acute care hospital. But it's a little bit of a specialized hospital. We're not like Hackensack Hospital where you go when you're having a heart attack. You come here for therapy. But we're treated by the government, as far as compensation, and we're classified as an acute care hospital. We're not classified as a nursing home.

ADLER: 10:59

A SNF, or a skilled nursing facility - or in some of the literature, they refer to them as a subacute SNF; and a lot of people refer to them as subacutes colloquially - are nursing homes where patients go when they have nursing care and they need some medical attention and they can't be at home. And a lot of the nursing homes started giving therapy as well. And they would call themselves subacute or skilled nursing facilities. Home care is when, obviously, you go home and you get some sort of care at home, whether it's therapy, whether it's nursing, whether it's both. Outpatient means you'll go home. And you won't need anybody helping you in the house, but you will still continue to get therapy or other nursing care - it's my daughter's carpool - outside the home. And there are other places. There's hospice-type setups. There are assisted livings. But those are much less common.

ADLER: 11:57

Okay. So now not everybody who has a stroke looks the same, as we talked about a little bit before. So it's very difficult for us to say, "If you have a stroke, you have to do this." So what we try to do-- and strokes are pretty unique in that nobody has the same exact stroke. And the type of stroke you have and the deficit you have really depends on how much of the brain was damaged and how much of the brain was damaged before. So it's really tough to put all your strokes into one category and try to figure out what's the best place for them. And it's really even very difficult for similar types of strokes because everybody has a stroke that's a slightly different size. Everybody has other medical problems that are the backdrop for what their level is as far as their motoric level, their cognitive level. But what we try to do, as best as we can, is try to put them into four separate categories. And a lot of this is the eyeball test. You look at a patient. You say, "Is this person-- did they have a mile stroke? Did they have a moderate stroke, severe, or very severe?" And in each of those, we look at their mobility, their activities of daily living. And obviously, there is crossover. Some people could be a mild stroke with some severe issues in some categories. But in general, when you look at a stroke, in their mobility, ADLs, transfers, balance, speech, cognition, do they fit into being a mild, moderate, severe, or very severe? And I guess traditionally-- and we could even be accused of, many years ago, maybe even trying to pick the patients who really could benefit from a lot of therapy, can really participate, and maybe they tended to be a little bit more the milder, or the moderate, or maybe the mild type of severe strokes when we would admit them here maybe 30, 40 years ago.

ADLER: 13:36

And the patients who were very severe strokes who we thought really didn't have a lot of rehabilitation potential or couldn't participate in a full rehab program, we would

very often say, "Maybe coming to a place like Kessler is not the best place for you to go," maybe like Mrs. M, our first patient, "and maybe you should go to a nursing home first. Most people who have a stroke do get a little bit better. And if you're able to tolerate therapy, you can come to us. Or maybe you can go home from there."

ADLER: 14:02

So that's how we used to look at things. And we still look at things based on these categories. But maybe how we treat them is starting to change. So we're going to talk a little bit about what happens initially. So patients are admitted to the hospital. Where do they go from the hospital? And then, wherever they went from the hospital, so a place like Kessler or a place like a nursing home, where do they go from there? And what are the barriers for them to get home? And how do we make these decisions? We're going to look at what the literature says. There are a lot of patients for us to look at with strokes. Very popular all of a sudden. So as most of you know, there's almost a million strokes a year. So there's about 900,000 strokes a year in the United States. There's about five to six million stroke survivors. So we would think that there's a lot of great literature about what to do with these patients. And the truth is, based on what I was saying before - because it's hard to categorize these patients - the literature is not so great. But we'll try to go through some of the better literature.

ADLER: 15:04

So what did things look like in the 1990s? So here's an article from JAMA, a very reputable journal, where they compared IRFs, or places like Kessler, inpatient rehabilitation facilities, versus SNFs. And they saw that at six months, people who went to a place like Kessler versus people who went to a nursing home-- and in those days, they might not have gotten so much therapy in the nursing home, I'll admit. The people who went to Kessler did better as far as their ADL, their activities of daily living and recovery. They did better as far as regaining their functional loss to their prestroke levels. So what that means is a lot of people with strokes are elderly and have a lot of medical problems, maybe even had a stroke prior. So we don't, obviously, expect people to have a stroke and then go to therapy and get better than they ever were. But before their stroke, what level were they at? Where were they after the stroke? And how much of that percentage can we get back? So people who went to an acute rehabilitation facility tended to do a little bit better and get closer to their pre-morbid state than people who went to a skilled nursing facility. And there was a higher level of discharge to community when you go to an acute rehabilitation facility. So if you came to a place like Kessler, you were more likely, at a year, to be home than to be somewhere else.

ADLER: 16:14

The problem with studies like this is, first of all, there's a lot of nebulous terms here, like what does ADL recovery mean? What do they mean regaining functional loss? Is it that you reached 80% and they reached 78%? So it's really tough to tease out. There's also a little bit of a selection bias because, like I said, people who came to Kessler probably started out at a higher level. And if you're at a higher level after a stroke, your chances of recovery, for a lot of different reasons which we can't talk about in this lecture, are a little bit better. So the better you are when you start, the better you'll be when you end up. So we will admit that, even though it looks like Kessler's a better place to go, we're not exactly 100% sure. We're going to try to tease this out over time. They also looked at the subacute SNFs versus a regular, traditional nursing

home with no therapy. So if you got therapy in a-- you went to a nursing home, if you got therapy versus you went to a nursing home with no therapy. And very interestingly, they found there was no difference in functional recovery between that, which is a little discouraging for me because I like to prescribe therapy a lot. However, people who went and got the therapy did have a better discharge to the community rate. I can't tell you exactly why.

ADLER: 17:22

The interesting piece that I wanted to talk about here-- again we don't know what's going to happen, but as of October 1st, a lot of this is going to change I think because the way places like Kessler got paid is very similar to the way an acute care hospital gets paid. So you have a medical diagnosis, you get admitted to the hospital, the hospital gets a certain amount, let's say $5,000, to take care of you. And they get that $5,000 whether you're there for an overnight and you go home or if you're there for 20 days. I'm sure a lot of you know this. The way skilled nursing facilities were paid is they got paid on a daily rate, and they got paid based on how much-- they got paid more for giving therapy. And the more therapy they gave, the more they got paid. So that's why a lot of the nursing homes-- one of the reasons why a lot of nursing homes started to give a lot of therapy. They got paid more. As of four days ago, the rules have changed. And now Medicare is paying nursing homes based on the level of nursing care, not based on the level of therapy. So we had a few people who worked in nursing homes here yesterday. And we asked them. And they said so far, in the last four days, they haven't changed how much therapy they're giving to their patients. But this is an interesting phenomenon. And we have no idea what's going to happen. Hopefully, people will do what's best for patients, and they will continue to give the therapy the patients need. But unfortunately, in medicine a lot of times things go the way the checkbook goes. So it'll be interesting over the next year to five years to see what happens.

ADLER: 18:47

Okay. I'm going to try to go through a little bit more. Here's another study. I'm going to skip this one. And we'll go into the 2000s. So that was the 1990s. In the 2000s-- again some of this data was based on the 1990s data, but probably the studies from the 1990s were based on the 1980s data, so. They looked at IRF versus SNF. And again they saw that the IRFs, the places like Kessler, had a little bit better outcome as far as their FIM and their discharge to community levels. Again that's what we saw before. However, we started to see a little bit of difference when we did a little bit tighter research. And we said that you are better off going to a place like Kessler than going to a nursing home. However, there are certain subpopulations of stroke that you're not better off necessarily. Anybody can guess which populations? I'm not going to call on anybody. People who had very minimal motor impairment. So you have a stroke, and it really doesn't affect you that much. So maybe your hand is a little weak, or your foot's a little bit weak. But you're basically okay. You're 95, 85 percent of what you were before. So those people - and it makes sense - probably don't have to come to a place like Kessler. They could have gone home, or they could have gone to a nursing home maybe - I would have rather have gone home - and worked on what their deficits were with outpatient therapy. People with very severe motor impairment or had very severe strokes also didn't do better at Kessler. The reason for that is probably that they needed so much therapy. People stay at Kessler, let's say, 18 to 20

days. These people will need months of therapy. And honestly, some of them may not get that much better quantitatively, maybe a little bit better qualitatively. But since they would need months and months of therapy, they didn't necessarily do better than if they would have gone to a nursing home. And people with severe cognitive impairment also didn't do better in a place like Kessler. Now we are set up to work with people with cognitive impairments here probably better than a lot of other places. But again if you're somebody who wasn't processing what the therapist was telling you, wasn't able to participate in therapy so much, you're probably not going to do that much better in a place like Kessler as opposed to a nursing home.

ADLER: 20:50

So this study started to look at the prospective payment, the way the hospitals are paid that I was talking to you about. And we started to see in the 2000s that there started to be less overlap in patient characteristics between a place like Kessler. There was like a self-selection where certain types of patients would go to a place like Kessler. Certain types of patients would go to a nursing home. Certain types of patients would go home. So it was a little tougher to do the studies. However, we did find that - and this may be reminiscent of the last study we talked about - people who went to a skilled nursing facility initially or people who came to a place like Kessler and then when to a skilled nursing facility had similar outcomes. And we can explain this in a couple of ways. Maybe if you had a very severe stroke and you came to a place like Kessler and, even after two weeks or three weeks here, you couldn't go home, it was probably because your stroke was so severe that you couldn't go home. And you would have to go to a nursing home. So again these are the very severe levels of strokes. And maybe they could have gone to the SNFs to begin with. Or the amount of therapy they got here didn't really change so much. People who came to a place like Kessler and then went home and had outpatient therapy did better than people who went to a place like Kessler and then went home from Kessler but needed home care. So that also makes sense. If you're going to need home care, it means you probably have some medical issues going on, or you're at a lower level, you couldn't function in your house so much, you needed somebody there to help you as opposed to if you were able to go to outpatient therapy.

ADLER: 22:17

And this is an interesting study that I wanted to talk about as well. This is the first study that I found that talked-- I'm sure it's not the first study-- but that didn't really look so much at outcome, at your level of outcome, but it looked at what they call a cost-effectiveness ratio. So they started saying if a patient who has a stroke-- obviously you want to go to a rehabilitation setup that's going to get you as good as possible. So you want to get to your highest level of function. And you don't care so much what it costs, especially if the insurance company or Medicare is paying for the rehabilitation bill. However, the government, or the payers, or your insurance companies don't necessarily say to everybody, "We want to pay as much as possible for everybody just so they can get as good as possible." We want to look at a ratio. Where do you get your best bang for your buck? And this does make sense especially if you want to be fiscally responsible. And we're being forced to be a little bit more fiscally responsible, whether we like it or not because there's only that many dollars to go around for everybody. So the question is really where's the best place to go where you can get the most improvement for the least amount of money.

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ADLER: 23:22

So again this is a little bit tougher. But interestingly, so again a place like Kessler does cost more per day, much more per day, than a nursing home, maybe 4 times more per day than a nursing home. Maybe 10 times more per day. So if you improve by 10 or 20 rehabilitation units, and a place like Kessler costs 10 times as much as a nursing home, so that ratio is, let's say, 20:10, so 2. If you would go to a nursing home or you would go home, you would look at that cost-effectiveness ratio, and would you get a ratio of 2? So at the end result, a patient might actually end up a lot better off having gone to a place like Kessler or gone to a nursing home or going straight home. But where do they get the best bang for their buck? So interestingly they found that nursing homes, which are much cheaper than Kessler, have the worst cost-effectiveness ratio. I can't tell you exactly why. But that's what it was. They did find, obviously, we all knew that IRFs were the most expensive, but they did have the best recovery.

ADLER: 24:31

Okay. How about the 2000s? So we wanted to know-- we still don't have any great answers. Is somebody going to tell us, where, at the end of the day, is the best place to go if you have a stroke? So AMRPA, the American Medical Rehabilitation Providers Association, decided to commission a company to look at this. And they looked at it over two years. And they looked at multiple diagnoses, not just stroke. And they did find-- and we try to be objective about this. They did find that there are some diagnoses where, actually, it doesn't pay, necessarily, to go to a place like Kessler. So we used to get, 15 years ago, a lot of total knee replacements, a lot of total hip replacements. And the study showed that they probably didn't do any better if they would come here versus if they went to a nursing home or if they went home. But these are the findings that they found for stroke. People who had a stroke who went in a acute rehabilitation would have a shorter length of stay post-acute care. So they would stay here an average of 16 and a half days-- sorry, 16 and a half days less than they would stay at a nursing home. Some of this is probably related to how nursing homes got paid. And this is changing also because of the way they're being paid. However, they found these patients were able to spend more time at home with their families, over three months more time at home. Their life expectancy was also over three months longer than people who went to nursing homes. The mortality rates decreased. The ER visits decreased. And the readmission rates to the hospitals decreased. So these numbers might not look so impressive. Again it's three months' less stay in the hospitals, but it is significant. And I think that if you look at other disease-- I heard somebody once say this. If this was a cancer medication or a chemotherapy drug, everybody, for whatever disease they had, would be taking this if I could promise you three months more of life.

ADLER: 26:27

So again how do we decide where to go, Neils Bohr, famous physicist and chemist, who won the Nobel Prize in both, I believe, tells us that prediction is difficult. Here I'll just put up for you-- I think it's in your handout as well. Different countries looked at what do we need to do, what's the most important factor to see if a person's going to go home or not. So I'll just do a couple of these. In Canada, there were a couple of studies from Canada. If the person lived home alone prior, probably they had a good setup to begin with, they would more likely go home. And also depending on their FIM level, their functional independence measure. And another interesting one is

from Australia where they found that if a person's able to do a 10-meter walk, so that's walking about 30, 33 feet, they're able to sit and stand and turn around, those people are much more likely to go home. And that actually makes sense because most of us can confine ourselves to a place in our house where we can get to our bedroom, our bathroom, our kitchen, whatever, within 30 feet. And if I could get up from where I am, walk to that place, sit down by myself, turn around maybe so I can open the refrigerator or something, I'm more likely to go home.

ADLER: 27:36 So we are a little short on time, so I'm not going to go through all of them. This isn't working now. I was going to have you all vote on which practitioner has the most power to decide where patients go. And I'm sure a lot of you thought that it's people like Dr. Adler.

AUDIENCE: 27:52 [inaudible]

ADLER: 27:54 Okay. I'll hedge it. It's actually case managers. But case manager, patients, and therapists all are way up there as far as where patients are going-- deciding where patients are going. And this is some of the discussion we had yesterday is it's very important while you're in an acute care hospital for everybody to decide where's your best place to go. Documentation is very crucial we heard yesterday. I didn't know this because I don't see it from that end, but apparently insurance companies, Medicare, look through charts and looking for specific phrases. And I had this with my own grandmother. If a therapist writes, "This person is a nursing home candidate," it's very hard to overturn that. So I would just ask everybody to keep an open mind as to where you are discharging your patients. But after we see the really powerful people, we see then comes the internal medicine. You would think that the people like the physiatrists have power, but we're really-- see, we're way, way down there as far as the influence that we have. Although now a lot of acute care hospitals do have physiatrists implanted in the hospitals, and we're hoping that those can help with some decision-making process as well.

ADLER: 29:03 So now let's go back to how we were thinking 20, 25 years ago. So we, a lot of times, would have patients who maybe weren't ready to go home or they could really use a little bit more therapy. And if we can get them more therapy, what's wrong with that? So there were a lot of people that we would say, "Let's take them from Kessler. They're probably doing well enough that if we want to, they can get them home. But you do get more therapy in a nursing home than you would if you went home, so why don't we just send them there? It's probably the best thing for the patient." A lot of people thought they were entitled to it. Medicare pays for X amount of time in an acute rehabilitation facility. They pay for X amount of time in a SNF. We still hear this a lot, that families need more time to prepare things. And no matter how good their family member is doing, they're going to a nursing home from Kessler. It was also probably a little bit easy for us. Instead of me having to write out 10 prescriptions when somebody leaves, if I send them to a nursing home, I don't have to write out any prescriptions. We don't have to order any equipment because they're going to a nursing home and they'll take care of that. So for a lot of reasons, we didn't object too much for a patient that's going to a nursing home.

Kessler Institute for Rehabilitation 8th Annual Stroke Conference: Part 1 of 8 There's No Place Like Home

ADLER: 30:11	But let's go back now to the cases I told you before. So Mrs. M. Remember this is a person who nobody here would say should come to Kessler, right? She was way too impaired. She didn't have any goals. So that's what I was thinking also. So I agree with you. But I said, "You know something, there's a reason why they're calling us." So I spoke to the physician - actually, I think I spoke to the physician's wife - and they said that, "We know that this person is never going to walk again. She's going to be up only a couple of hours a day. We know that she doesn't have that much time left. Why do we want her to come to Kessler? She's in a nursing home, and we don't feel she's getting the things that we need her to get. What do we want from you? She very much enjoys spending time with her family and participating in some meals. Right now, she's NPO. She's not able to eat anything. We want her to come to Kessler because we know you can assess her feeding. We can assess the safety of swallowing, give some recommendations so she can eat a little bit. Even if she's not getting all her nutrition, she can participate in some meals. She can eat with the grandkids. She can go out for ice cream. We also want you to give us your expertise as far as how to position this patient. We're going to hire-- we have the means to hire somebody to be with her for 24 hours a day. But we want you to train that person how to position her in bed, what is the right equipment, which type of bed is the best bed. Can you design a wheelchair for us? And the most efficient way to do that is to admit her to Kessler." And we said, "You know something, we'll take her. We'll limit how much time she's here. And we'll try to hit those goals." So we were able to get her home. And she was able to eat-- not eat everything, but she was able to meet the goals of spending more time with the family, and having a safe discharge home, and being able to spend time safely at home, and probably not having to get admitted back to the hospital because there were problems.
ADLER: 31:49	Our other patient - I don't have a slide - who was the very high-level stroke, who was very agitated and wanted to go home. So we did a little digging there as well. And we found out that what the problem was was that the wife was just a little bit overwhelmed. She had the infant at home. And they were throwing him out of the acute care hospital, and she needed a couple of things. She needed to get things in order because she wasn't home much in the house. She needed to get things straightened out with the infant. And she wanted to learn how to handle the - she was going to be helping out with the IV administration - how to handle the intravenous and just learn a lot of instruction on how to take care of him medically. And that's what we did as well. Again, it was a very short stay. Taught her how to utilize the IV. He had good care here. And she was able to set up the home. And he also was able to get home.
ADLER: 32:44	So we are much more open-minded now as far as which patients we're taking, whether they're low-level patients, whether they're the high-level patients. In our brain injury program, we have what we call disorders of consciousness patients who are almost unconscious. So we take all levels of patients here. And we think that we can make a significant difference as long as we set the goals properly for the type of patient that we are going to get. The other thing that we notice is that even those patients who we thought weren't ready to go home-- so they were at a certain level of function, we sent them to a skilled nursing facility. They stayed three months there.

And what happened to them? They eventually went home because after three months the skilled nursing facility says that Medicare's no longer paying, you now have to pay the fee." And the family, all of a sudden, when they looked at a bill of $400 a day, they were able, magically, to take their family members home even though their functional level wasn't much different. So what we're doing now-- and again we're being held much more responsible for taking care of the patients. So 10 years ago, this is maybe what we used to-- we were happy sending our patients from Kessler to a nursing home to get more therapy. And now we're trying to get our patients home.

ADLER: 33:56

I'll skip through this. This is another very impaired patient. We'll skip through that. So what are we doing? Because I'm a little bit over and I want to get Gretchen her time, although she's telling me that I don't have to get her her time. So what are we doing now? So we used to have patients admitted here. And we would treat them like very paternalistic type of attitude where we would take care of everything. We'll take care of all the nursing. We'll see you in three weeks. A few days before discharge, we'll show you a couple of things, how you can handle your family member at home. We'll show you how to put on the equipment. And we'll show you the couple nursing things and how to feed people who need a peg. And what we're doing now is on day one, or day two, or day three, we are involving the family. We're telling them that our goal is, "Your loved one is here. And our goal is to get him home or her home." We can get people home at any level of function. Obviously, the home has to be set up for it. But we want to start thinking about that on day one, that, "If there's no significant improvement, you have to make certain modifications to your house. These are the things you're going to have to do medically. You're going to have to check the blood sugar. You're going to have to give insulin. You're going to have to feed people through a peg. This is some of the equipment that you may need." And we used to say we have very little room in our therapy gyms. We don't want families in the therapy gyms for a lot of different reasons. Now we're having our families meet with our therapist very early on. We show them this is the level that they're at. And we feel, actually, that when we show the families, it doesn't scare them off. They start seeing that, "Oh, this is a person who needs help transferring. This is how we do it. And this is something that this therapist could do. So if this therapist could do it, I could do it as well." And if they see it every day, they get a little bit used to it. And they say this is the new level for the patient. And they get a lot more used to it and much more willing to take the patients home as opposed to the shock that they found three weeks later that the person can't get out of bed by themselves.

ADLER: 35:50

So again the keys here are early involvement, setting goals, and being very realistic with the patients and their families as far as getting the patients home. And we actually are having a significant amount of success in our discharge to home rate.

ADLER: 36:06

I think this is the last slide. Yeah. So as you know there is no place like home. So I wanted to take a couple of minutes to introduce-- I won't take any questions now because we're going to have the panel discussion afterwards. But I think the segment that we're going to have now-- we're going to have two lectures by Gretchen. Gretchen's going to talk to us about proper goal setting. So again what we were referencing a little bit here -- in two ways. First of all, how do we phrase our goals for

our patients? Do we do it from a patient-centered perspective? Do we do it from a therapist-centered perspective? From an objective or a subjective perspective? She's also going to talk to us about-- we were talking here about where do we think patients should go. So we think a patient who had a stroke, now they're ready to go to acute rehabilitation facility. We have to also take the patient into account. And as you know therapy's going to be only successful if patients are ready for it and are willing to accept the therapy. The other lecture we're going to have is by Dr. Arielle Resnick, one of our therapists here, who's going to talk to us about not only does a patient have to be mentally ready, but we want to have them physically ready to do it as well. So their proper conditioning not only when they're here but also for their life ongoing. How do we get our patients in shape to be able to function after their stroke? So I thank you for your attention, and I hope you enjoy the rest of the morning.

[music]

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