



# Acute Rehabilitation Unit



## 2020 Disclosure Statement (Based on 2019 Data)

### Overview/Scope of Services

The Mildred Rauth RehabCare Center is a 30 bed acute inpatient rehabilitation unit located in Rolla MO. We are a partnership between Phelps Health and RehabCare (under the umbrella of Kindred Hospital Rehabilitation Services) established in 1995. Our comprehensive, CARF-accredited intensive inpatient rehabilitation program provides services for individuals age 18 or older who have sustained functional loss due to an illness or injury. This includes but is not limited to: Amputation, Brain Injury, Neurological Diseases, Orthopedic Conditions, Spinal Cord Injury, Trauma, Weakness due to Medical Illnesses, Stroke, Pulmonary/Cardiac Conditions. The Rehabilitation Program is accredited through CARF (Commission on Accreditation for Rehabilitation Facilities) for **General Medical Rehabilitation**.

### Mission

The mission of the Mildred Rauth RehabCare Center is to provide a comprehensive rehabilitation program of the highest quality, which will improve the functional independence of our patients. This mission is accomplished by helping people help themselves through professional services and personalized care. Our Medical Director is a Board Certified Physical Medicine & Rehabilitation Doctor (Physiatrist).

### Services Provided

The rehabilitation unit is directed by a Physiatrist (a physician that specializes in Physical Medicine and Rehabilitation). The unit has 24 hour physician coverage and rehabilitation nursing services. Patients may also have a medical doctor assigned to their team, or other specialists (cardiology, neurology, pain management, nephrology, oncology/hematology, wound/ostomy, surgery, orthopedics, etc.) as needed. Diagnostic tests may be done here at the hospital. Laboratory tests may be done on the Rehabilitation Unit. The results for medical imaging, x-ray or laboratory tests may be back immediately or may take longer, depending upon how the test was ordered or what was involved. Some tests require several days until results are available. In most instances, the results for diagnostic imaging (x-ray/CT scan) or laboratory tests are available on the same day. The doctor will make the determination on how quickly the results are needed to direct your care.

Pharmacy services are provided through the hospital. All medications are available based on how and when the doctor orders them to be given. If required, kidney dialysis is completed on-site, so there is no need to leave the hospital to receive dialysis. Therapy teams may also include rehabilitation nurses, a physical therapist, an occupational therapist and a social worker/case manager. Speech and language pathologists,

respiratory therapists, neuropsychologists (via referral), prosthetists, orthotists, and dieticians may be consulted as appropriate.

## Referral Sources

Our Patients are referred to the inpatient rehabilitation unit from a variety of sources, both inside Phelps Health and outside. These include primary care physicians, specialists, hospital case managers, transitional care/skilled nursing units, long-term acute care hospitals, home health agencies, and patient/family self-referrals. All patients must meet admission criteria and be accepted by a rehab physician prior to admission.

## Admission and Continued Stay Criteria

- Patient must be 18 years of age or older
- Patients must be medically stable, yet continue to have medical management needs
- Patient must be able to tolerate an intensive rehabilitation therapy program consisting of three hours of therapy per day at least five days per week or at least 15 hours within a seven consecutive day period, beginning with the day of admission
- Nursing care must be required 24 hours a day
- Patient must require 2 or more therapies (PT, OT, ST), as well as a coordinated interdisciplinary approach to their rehabilitation
- Patient must have experienced a functional decline, have potential for improvement, be cooperative and motivated to participate
- Patient must require supervision and management by a rehabilitation physician to address medical and functional needs
- Patient must have a pay source or arrangement with the hospital's financial services prior to admission

## Discharge and Transition Criteria

Our team works with you, the patient, and your family to ensure the most appropriate placement following discharge from the acute rehabilitation unit. When the patient's medical condition allows, the patient and family will be notified a few days prior to discharge by the case manager. Discharge from the program shall be considered when one or more of the following criteria are met:

- A patient has reached his/her rehabilitation potential and no longer warrants this level of intensity of therapy services
- A patient has plateaued in the rehabilitation process and a lack of progress is noted by any discipline for a period of one week
- A patient is medically unstable requiring more intensive medical intervention
- A patient is behaviorally unable to cooperate with the demands of the program or is jeopardizing his/her own safety or that of other patients and staff
- A patient refuses to participate in the program, despite being medically stable, and progress is not evident
- NOTE: if you are unable to complete the intensity of service, our case manager will assist in finding timely placement in a less intensive setting to continue services as needed

## Questions/Comments or Additional Information

Any questions or concerns regarding care provided during the stay may be directed to the Director of Post Acute Services (Nurse Leader), Jody Deluca at 573-458-7868 or Program Director, Charity Norton at 573-458-7883. General questions regarding acute rehabilitation services offered at Phelps Health may be obtained on our website at [www.phelpshealth.org](http://www.phelpshealth.org) or by calling 573 458 7885.

## Services Provided Directly (or by Referral) May Include

- Rehabilitation Medicine
- Medical Consults (as necessary)
- Rehabilitation Nursing
- Physical Therapy
- Occupational Therapy
- Durable Medical Equipment (DME)
- Speech Language Pathology
- Social Work/Case Management
- Activities
- Psychology
- Substance abuse
- Orthotics & Prosthetics
- Visual Assessment
- Driver Rehabilitation
- Respiratory Services
- Dietary Services
- Renal Dialysis
- Wound Care
- Chaplaincy
- Home Evaluation

## Primary Support Person

Patients may choose a family member, friend or other person as their Primary Support Person. This individual would be available to ask questions on the patient's behalf. They may also be present during admission and physician visits and act as a contact person to update family members of the patient's condition. In fact, this is preferred in order to coordinate communications. Support person(s) or caregivers may be requested to participate in training or meetings in preparation for discharge.

## Visitors

Family members or those involved in providing care for patients after discharge are welcome on the Rehabilitation Unit. To ensure the patient is benefiting the most from their therapy, friends are encouraged to visit after 4:30 pm., Mon through Fri, and weekends after 2:00 pm. Those wanting to check on a patient may also call. The Mildred Rauth RehabCare Center offers overnight lodging for out of town relatives/caregivers of patients living more than 20 miles outside of Rolla on the unit with prior approval from the Nursing Supervisor and if space is available. Overnight visitors may not detract from the care or rest of patients on the unit.

NOTE: Video and Photography are not allowed per hospital policy, unless consent is obtained and it has been determined to be a necessary part of the patient's treatment plan. Visitors/family members in the gym are limited to space availability and should not distract from or interfere with therapy for any patient.

## Therapy Schedule

Therapy programs will include individualized frequency and intervention by PT, OT, and SLP (physical, occupational, and speech therapy) as needed. Most patients will receive a minimum of three hours of therapy, five days per week of these combined services. **It is important that patients participate fully in their treatment plan as indicated by acute rehabilitation regulatory and insurance requirements and to receive the maximum benefits from their time here.** Therapy may be provided on Saturdays, Sundays, and holidays based on patient individual needs. In addition, each rehabilitation patient will have his or her own daily therapy schedule, typically from as early as 7:00 a.m. to approximately 4:00 p.m. We will attempt to accommodate personal preferences with scheduling whenever possible and rest breaks are built in as needed. Any concerns should be directed to your case manager or any member of the rehabilitation team.

## Clothing/Laundry

Patients are encouraged to wear comfortable street clothes during their stay. This includes usual items worn including pants, shirts, underclothing, socks and shoes with rubber soles. Personal grooming items, pictures or hobby items are also encouraged. Please label all belongings. Laundry is responsibility of the patient and/or family. A washer and dryer are available on the unit; infection control practices must be followed.

## Patient and Family Education

We encourage patients, families and caregivers to participate in educational sessions. The case manager, therapists and/or nursing staff may help determine the best time and way to participate. The patient will be given education on their medical issues as well as their treatment plan. There are a variety of educational opportunities available such as pamphlets, resource books, videos and demonstrations. A computer station is also available for researching medical condition. Patients may have family training scheduled during their Rehab stay, if needed or requested by their family. The team will work closely with patients and families from admission to discharge to ensure a smooth transition. The goal is a safe discharge back to the community.

## Customer Service

Our primary goals are patient safety, comfort and satisfaction. Our focus is to prepare patients for ongoing recovery and a return to their highest level of function. Please let us know of any concerns as soon as possible. Patients/families may direct any concerns to the Director of Post-Acute Services (Nurse Leader), Jody Deluca at 573-458-7868 or Program Director, Amy Robnett at 573-458-7877. We take patient feedback seriously and work to continually improve. Patients will receive a survey at discharge from the Rehabilitation Program. Patient comments are very important to us and we appreciate the time taken to fill out and return the survey. Patients may also receive a call from customer relations shortly after discharge.

## Financial Considerations:

### (A financial counselor is available through the hospital to answer questions)

Medicare Part A: Pays for cost of inpatient rehabilitation provided that you meet criteria at admission and during stay, which includes full participation in intense therapy services. Out-of-pocket expenses may include: deductible applicable to inpatient hospital stays and daily co-insurance for inpatient stays. Supplementary secondary insurance (when applicable) typically covers co-insurance or portion that Medicare does not pay. For specific coverage information, visit Medicare's website at [www.CMS.hhs.gov](http://www.CMS.hhs.gov) or ask to speak to Case Manager. Your rehab stay falls under the hospital level benefit, and is always subject to review by Medicare. Private insurance, Medicaid and Managed Care (including Managed Medicare) benefits will be verified prior to admission and prior authorization for admission will be obtained. This is not a guarantee of payment. We make every effort to obtain accurate information, but encourage you to please contact your provider representative to personally verify your coverage. If there are coverage limitations, a representative will discuss these with the patient, as well as alternative resources to help meet the patient's needs. A representative will communicate with the patient's insurance company to obtain continued authorization throughout their stay. Based upon the information we have at this time, payment for acute inpatient rehabilitation will be made by:

\_\_\_\_\_ Medicare, approximate days available \_\_\_\_\_

\_\_\_\_\_ Medicaid, \_\_\_ days approved

\_\_\_\_\_ Commercial Insurance \_\_\_\_\_ days approved with \_\_\_\_\_% coverage

\_\_\_\_\_ Workers Compensation \_\_\_\_\_ days approved

\_\_\_\_\_ Other (specify) \_\_\_\_\_

## General Information:

- **Discharge against medical advice (AMA):** Competent patients, legal guardians, or active durable power of attorney for health care have the right to leave the hospital against medical advice. In that event, the hospital's AMA policy will be in effect. The physician will inform the patient of the potential risks. It will be explained to the patient that they may then be responsible for the full cost of their stay on the rehabilitation unit. The patient, guardian, or durable power of attorney for healthcare will then sign a release of liability for leaving AMA.
- **Security of Personal Possessions:** Patients are encouraged to leave valuables at home. In the event that such items are brought with the patient, he/she is encouraged to notify nursing so that security can be notified to place items in the hospital safe.
- **Patient Rights:** The persons served, families, friends, caregivers, and community has the right to respectful, considerate care from all rehabilitation team members at all times and under all circumstances. All individuals served will have the freedom from abuse, financial exploitation, retaliation, humiliation, and neglect. We do not discriminate based on race, ethnicity, national origin (including language), spiritual beliefs, gender, age, current mental or physical disability, sexual orientation, or socioeconomic status. A copy of Patient Rights will be provided. Interpreter services via a language line or web-based service are available if needed.
- **Advance Directives:** Information on advanced directives can be obtained from case manager/social worker. Any patient with an advance directive in place is requested to provide a copy upon admission.

## Quality Indicators

In September 2014, Congress passed Improving Medicare Post-Acute Care Transformation Act which requires the submission of standardized data from post-acute settings with the intent of providing better care, healthy people and communities and affordable care. In doing so it developed a uniform clinical assessment instrument from five quality measure domains. Through the use of the standardized tool it enable interoperability and access to longitudinal information for post-acute providers to facilitate coordination of care, improved outcomes and overall quality comparison.

The tool reviews areas of Self-care/Mobility which is then able to pinpoint a more directed level of functioning in everyday activities as related to the specific category for example, eating, toileting, dressing, putting on/taking off footwear. The mobility category would focus on ability to get in/out of bed, up/down from sit to stand, transferring from chair to bed, on/off toilet, transferring in/out of vehicle, as well as, observe ability to ambulate. The indicators review patients' prior level of functioning, monitor for improvement throughout patient stay and then reassess at discharge to determine functional gains made throughout. The assessment is based on a 6 point rating scale ranging from independent level of functioning to dependent level of functioning.

In 2019, 361 patients were discharged, with an average QI gain of 24.2 points during their rehabilitation stay. The regional average for QI gain for all Rehabilitation Programs in 2019 was 32.2. On average, patients came in needing a moderate amount of help (50% help from a caregiver), and on discharge required supervision only (no hands on help from a caregiver).

## Discharge Destination

75.1% of our patients were discharged to the community (home) in 2019.

6.65% of our patients were discharged back to an acute care hospital in 2019.

17.5% of our patients were discharged to a skilled nursing facility (SNF) in 2019.

3.4% of our patients were discharged to another destination in 2019.

## Patient Satisfaction

100% of our patients in 2019 would recommend our program to others. Our survey response rate is approximately 35%.

## Demographics 2019

In 2019, 37% of our patients were 75 years of age or older, and another 27% were 65-74.

49% were female, 51% male,

59% had traditional Medicare primary as their insurance, 15% had Medicaid, 3.3% commercial and 2.5% HMO, and only 4.7% had managed Medicare plans.


97% admitted directly from an acute hospital, 1% from home, 1% from a skilled nursing facility, and 1% from a long term acute care hospital.

## Quality Outcomes for Major Areas 2019

Diagnosis	Number of Patients	% of total discharges	Avg Length of Stay	Discharge to Community	Avg FIM gain	% age 65+	% Male/Female	% Satisfaction "Would You Recommend"
Stroke	83	23%	12.7	71%	26.1	59%	46/54	100
Hip Fracture	54	15%	11.3	76%	25.7	87%	36/64	100
Brain Injury	18	5%	9.9	79%	25.1	68%	79/21	100
Neurological Diseases	24	7%	11.2	79%	22.9	48%	52/48	100
Other Orthopedics	20	6%	9.5	50%	23.2	58%	34/66	100
General Medical	47	13%	10.3	81%	31	77%	56/44	100
Cardiac	24	7%	9.8	67%	25.2	86%	55/45	100
Pulmonary	22	6%	8.8	91%	22.2	70%	63/37	100
Spinal Cord Injury	7	2%	9.2	90%	19.9	55%	56/44	100
Amputation	29	8%	9.6	67%	21.0	45%	70/30	100
Trauma	12	4%	8.5	85%	30.0	57%	57/43	100
<b>All Rehab Patients/Averages</b>	340	100%	18.5	76%	25.7	66%	43/57	100

## Our Commitment to You

In accordance with our Program Mission and the Philosophy of Phelps Health, our team members will: be an advocate for our patients; show respect for the dignity and rights of the individual whether patient, family member, visitor, co-worker, client or any other person;; provide the highest level quality, clinical, and customer related services; demonstrate fairness and honesty in all interactions;; adhere to professional codes



and practice guidelines; provide an accurate portrayal of services and outcomes of the program,; and be ethical in all activities. We will treat patients as if they were our own family member. We will abide by our organization's core values of compassion, integrity, innovation, and philanthropy.

## **Program Exclusions**

We do not admit children or adolescents under the age of 18, patients that are dependent on a ventilator, patients with a Rancho Los Amigos score below Level 3, patients on TPN, with severe burns or patients with active TB requiring respiratory isolation. Patients requiring CPAP or BiPAP must be on home settings or on auto-titrate to qualify for admission. On a case-by-case basis, patients with spinal cord injuries Level C5 or higher (complete and incomplete), patients with a Rancho Los Amigos Level 3 and above may be admitted. If for any reason our services are unable to meet the needs of a patient referred, recommendations for alternate services will be provided.