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The Physiatrist's Role in Post-Acute Rehabilitation

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Integrated Rehab Consultants (IRC) is the nation's largest group of Physiatrists (Physical Medicine & Rehab Specialists) within the skilled setting. As the landscape of the post-acute industry is changing, IRC continues to grow by providing clinical-based solutions to the issues most affecting skilled nursing facilities; re-admissions, outcomes and patient satisfaction.

Physiatrists are physicians who specialize in physical medicine and rehabilitation. Physiatrists specialize in restoring optimal function to people with injuries to the muscles, bones, tissues, or nervous system, such as stroke and orthopedic patients. Physiatrists assess patients for functional deficits and work with the rehab team to both minimize disability and maximize independence. We set goals appropriate to the patient and family's needs and work to eliminate any barriers impeding transition to home or a more home-like environment.

In order to do so, we use long-standing and time-honored physiatry principles including medical knowledge of the pathology and pathophysiology of diseases and trauma that may lead to physical and cognitive impairments. Assessments of physical, cognitive and behavioral aspects of people with acquired and congenital disabilities focus on preservation and/or restoration of function. We use an evidence-based model that utilizes physical agents, activity, repetition, and neuromuscular re-education that can restore function; prescription of pharmacological agents, technology (such as prosthetics) and physical agents, to minimize pain and disability. We focus on maximizing independence by encouraging incremental improvement toward self-efficacy and have the ability to counsel patients and families at a time when they may be in crisis due to a loss of independence.

Traditionally, Physiatry has been linked to medical rehab units in hospitals and Inpatient Rehab Facilities (IRF). Over the past decade and more intensely over the past 5 years, there has been a steady decline of patients being approved for Inpatient Rehab stays by Medicare. Through payer regulatory changes and certain determinations, these patients who would have been approved for IRF's are now being discharged to Skilled Nursing Facilities (SNF).

Rehabilitation in the SNF environment is rapidly emerging as the predominant level of post-acute rehabilitation care in the United States. More patients will receive their rehabilitation in a SNF today than in an IRF- and the trend is likely to continue!

With this increase of patient care within skilled nursing facilities, SNF's more than ever have to up their "clinical game". The problem is, each facility varies greatly in their ability to provide a consistent, cost effective rehabilitation "product". The cause is multi-factorial.

The recent shift to managed Medicare and accountable care organizations (ACO's) is trying to change this inconsistent dynamic within SNF's. Facilities are held accountable to provide increased clinical care, while shortening the average patient's length of stay.

First, only a small minority of SNF's are currently geared up for these shorter dictated lengths of stay with a higher intensity of therapy to assure a good outcome in such a short time.

Second, medical direction of the rehabilitation case in a SNF is often lacking. SNF Medical Directors and attending physicians are often general internists or geriatricians and do not usually have the training or experience in leading a rehabilitation team like a physiatrist does. Unfortunately, the result is that leadership within the SNF rehabilitation team may be absent or deferred to either a therapist or non-physician therapy director.

Lastly, most SNF physicians see their patients on admission and monthly unless there is a problem. Parenthetically, while there is a Medicare requirement that patients in a SNF be seen at least monthly by their attending physician, this requirement seems to have somehow led to a widespread interpretation by doctors that the patient may only be seen once a month while in a SNF. Therefore, most are not available in the facility to attend team meetings or follow their patients closely during a short-term active rehabilitation. The role may be delegated to a mid-level provider (physician assistant or nurse practitioner) who is likely equally untrained in coordinating rehabilitation care.

Physiatrists tend to follow their patients closely through the rehabilitation forming a close relationship with them. Often this leads to the Physiatrist recognizing a change in the condition of the patient before the nursing staff or primary physician does. In some cases, the physiatrist may suggest to the primary changes (elimination of medication leading to an adverse side effect, for example). In other cases (e.g. early identification and treatment of a UTI) may lead to the patient being able to continue rehab uninterrupted. These examples demonstrate physiatrist interactions that often help reduce the likelihood of a hospital readmission, a goal of most organized systems of healthcare.

The changing landscape of healthcare and specifically skilled nursing facilities, requires a change in clinical care. SNF's cannot function without their Medical Directors and primary physicians handling patient's general medical issues. By adding a Physiatrist to actively manage SNF rehab patients, they are \ enhancing the level of care and restoring a patient's function to help ensure patients are able to discharge home as safely as possible. Regular and routine communication between a physiatrist and the primary physician (or mid-level provider) allows the SNF patient the highest level of clinical care. A Physician adds years to a patient's life. A Physiatrist adds life to a patient's years. Having the best of both worlds is ultimately the best solution.

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