Assessing Needs for Appropriate Placement and Home Care for Older Patients

With the help of the nurses, physical therapists and social worker, you can determine the best placement for an elderly patient after an acute illness or a prolonged hospital stay.

It is important to determine what they were able to do prior to hospitalization, what living situation they were in, and what help they were receiving.

*Determine whether they are independent in their activities of daily living (ADLs):*
1. Transferring
2. Toileting
3. Bathing
4. Dressing
5. Feeding self

*Determine whether their condition would improve with physical and/or occupational therapy.*
- Specific examples include stroke, hip fracture, head injury, or generalized deconditioning from a pneumonia or prolonged bedrest.

If so, **do they have sufficient endurance to participate in at least 3 hours of therapy each day or would they only tolerate 1.5 hours or less?**

*Do they have any other skilled need?*
- Examples include IV medications, specialized wound care, tube feeding, respiratory care (ventilator or tracheotomy care)

Differentiate **skilled nursing needs** from **custodial care** which is to help with ADLs and help with activities that patients generally perform for themselves, such as catheter care, colostomy care, oxygen therapy. This care can be performed by less highly trained personnel.

Below I have summarized the different levels of care available and I have provided case examples for you to practice with.

Also attached is the patient transfer form that is filled out and signed by a physician any time this type of decision is made.

I hope this will help you understand the information gathering process and help you become more involved in talking with your patients and the interdisciplinary team about these issues.

**Acute Rehab** (Transitional Care Unit, GEM Unit, Rehabilitation Hospital)
- generally located within a hospital
- for patients who are more ill and need closer medical attention or complex care
- also for patients who are stronger and can tolerate intense rehab
- provides intensive therapy up to 3 hours a day
- physician visits daily
Skilled Nursing Facility (Subacute Rehab, Nursing Home Rehab)
- located in nursing homes
- must have a skilled need (as above)
- less intense therapy (~1.5hrs/d) that is provided over a longer period of time
- covered by medicare after at least 3-day hospital stay for 20-100 days
- physician visits weekly

Long Term Care Facility (aka Intermediate Care Facility)
- located in nursing homes
- more permanent residence for someone who needs help with ADLs and doesn’t have rehab potential or skilled need, i.e. severe dementia, chronic stroke
- provides medication administration, help with ADLs, incontinence care, social activities
- physician visits every 60 days.
- not covered by Medicare
- Medicaid, private pay, or long term care insurance covers this

Assisted Living Facility (ALF)
- may be separate facility or included in a continuing care facility
- residence for patients who are independent in ADLs, but have impairments in their instrumental activities of daily living (IADLs)
- provides medication administration, transportation, meals, cleaning services
- may keep own physician, no required visits
- generally private pay or private insurance, may be expensive

Home Health
- covered by medicare for short term skilled needs following hospitalization, usually only 1-3 times a week
- this situation is very dependent on the patient’s ability to care for themselves or having family or other caregivers in place
- one who is dependent in ADLs or moderate cognitive impairment generally requires 24 hour supervision
- one with dependence in IADLs can live independently as long as they have someone come by once a day to monitor meds and food intake
- home custodial care is usually private pay only
- respite services may be available for short term

Case Examples: What is the ideal option for each patient?

1. 45yo patient with spinal cord injury whose hospital course was complicated by a sacral decubitus wound and a highly resistant pneumonia who is still trying to establish a bowel/bladder regimen and plans to return home to care for his 7 year old daughter

2. 83yo woman who came in after fall and left hip fracture who tolerated hip repair and is now full weight bearing. She was living alone prior to hospitalization and independently driving and taking care of her home, needing help only with home repairs and yardwork. Currently she is using a walker and needs assistance with bathing and transfers.
3. 53yo man with diabetic foot ulcer which was surgically debrided and now needs IV antibiotics for two more weeks. He is independent with his ADLs but needs help with wound dressings. He has no family members or friends available to help.

4. 69yo man with history of stroke 7 years ago with significant left sided weakness in a wheelchair who was brought in by neighbors for issues of neglect. He is having difficulty caring for his home, not able to bathe himself, and has no family available since his wife died within the last year.

5. 91yo woman with progressively worsening macular degeneration who has been living alone but depending on her daughter to handle her finances and medications and drive her to the grocery store. She is in the hospital for digoxin toxicity. She is having more trouble identifying her pills and having difficulty cooking and cleaning because of her poor vision. They are both requesting an alternative living situation.

6. 78yo man with bilateral knee replacements for arthritis, living alone, travels frequently to South America. He is using a walker, tolerating rehab well, and pain is well controlled.

Placement Recommendations

1. Acute Rehab. Has multiple medical issues that require close observation, has complex rehab needs, and can tolerate intense rehab with goal of full modified independence.

2. Subacute rehab in a nursing facility. Standard rehab protocol, achievable goal of returning home to full independence. Will likely need home health physical therapy for a time after Medicare days are finished to complete the gradual return to independence and to evaluate home safety and/or need for adaptive equipment (shower grab bars, stair railings, etc).

3. Subacute rehab in a nursing facility. Could also have done home health IV therapy and wound care if he or his family could have handled some of the IV care or wound dressings.

4. Long term care in a nursing facility (intermediate care). Has dependence in ADLs, no social support network. He may benefit from therapy, but this would depend on PT/OT evaluation. He would still be able to get physical therapy in a long term care setting.

5. Assisted living. She is independent in her ADLs, but needs help with her medications and IADLs. Other alternatives would be living with her daughter or having a caregiver come to her house on a daily basis. This depends on patient preference and financial means.