Improving Multidisciplinary Approach to Complex Discharge Patients: An Evidence Based Approach

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Abstract

Eskenazi Hospital’s rehabilitation therapists have identified a gap in how complex discharge patients care is approached. With increased caseloads and high role demands, the therapy team is not able to provide this population with the level of services they may benefit from during their stay. Moreover, a defined approach to discharge planning for this population is needed to identify barriers to discharge from admission. This capstone student worked collaboratively with identified stakeholders to complete an in-depth needs assessment and propose a multidisciplinary guideline for providing the best level of care for this population. A proposed method to facilitating patient routines during hospitalization was created through multiple rounds of feedback and implementation.

Keywords: Complex discharge, multidisciplinary approach, patient routine
Improving Multidisciplinary Approach to Complex Discharge Patients

Improving the quality of patient flow from admission to discharge is essential in maximizing hospital resources, preventing hospital acquired injuries or infections, and facilitating patient centered care (New et al., 2016). Hospital discharge requires a multidisciplinary approach, initiated at patient admission, to coordinate a safe transition plan from the hospital. Research indicates that early discharge planning has a significant effect on decreasing hospital length of stay and post-discharge readmission (Gabriel et al., 2017). Approximately 30% of hospitalized individuals experience non-medically related delayed discharges such as insurance related barriers or inadequate communication between healthcare providers on post-discharge recommendations (Gabriel et al., 2017). Patients with complex sociocultural needs often experience increased length of stays at the hospital as they require a unique approach to discharge planning. With increased duration of stay, patients are put at a risk for numerous adverse effects such as pressure ulcers, falls, and decreased mobility. This poses a unique challenge in improving quality of care for individuals who are experiencing increased length of stays due to delayed discharges.

Occupational therapists (OTs) have a unique role in this process as they not only focus on maximizing safety and independence with activities of daily living (ADL) at their next level of care, but also during their inpatient stay. Research has indicated that hospitalized patients continue to perform their basic ADL, but at a disrupted frequency, duration, and timing (Zisberg & Gur-Yaish, 2017). For patients with delayed discharges, this poses a continuous challenge in promoting their routines outside of their regular environment. Patients staying in bed for large portions of their hospitalization, combined with potentially unnecessary urinary catheters and monitoring equipment, puts them at a greater risk for sarcopenia, decreased mobility, and
infections (Surkan & Gibson, 2018). While occupational therapy has a specialized role in addressing these problems, OTs in the acute setting face barriers to providing these holistic services due to time constraints, discharge pressure, and large caseloads (Eckford, 2019). With these added burdens, OTs often prioritize patients who they are able to facilitate quick and timely discharges for. Consequently, these patients do not always receive the consistency of therapy to make the functional gains they need to maximize safety and independence upon discharge. Occupational therapists also have a unique role in this process as they help address the occupational justice concerns that delayed discharges produce. Occupational justice refers to the right of each person to be able to meet their basic needs and have equal opportunities and chances to engage in what is meaningful to them (Wilcock & Townsend, 2009). Individuals with complex sociocultural factors face barriers in the health care system that prevent them from equal access and opportunity, such as insurance coverage and low socioeconomic status. Occupational therapists address this through incorporating a client-centered lens in patient care and discharge planning.

**Site Description**

Eskenazi Hospital is located in downtown Indianapolis and 90% of its patient population resides within Marion County (Eskenazi Health, 2019). As a safety net hospital, Eskenazi’s mission is to advocate, care, teach, and serve. This means that Eskenazi takes all patients regardless of their ability to pay. Approximately 12% of individuals under 65 are without health insurance in Marion County (U.S Census Bureau, 2019). This uninsured population experiences gaps in health care coverage and associated occupational justice concerns. In addition, those who fall within certain gender and race demographics experience increased disparities in outcomes. Marion county’s population is 64% white, 28.9% African American and 51.8% female (U.S.
Census Bureau, 2019). Hispanic or Latino individuals account for 10.9% of Marion county’s population, with 13% of residents speaking another language than English (U.S. Census Bureau, 2019). Approximately 86.1% of Marion county residents are high school graduates, with 30.9% attaining a bachelor’s degree or higher (U.S. Census Bureau, 2019). The median household income is $48,316 with approximately 15.2% of individuals living in poverty (U.S. Census Bureau, 2019). Understanding the socioeconomic factors of Eskenazi’s population is essential to explaining how disparities in health care experience contribute to barriers in the health care continuum.

Eskenazi’s rehabilitation therapists use the term “rehab in house” to describe those patients who have complex discharges due to a variety of sociocultural and financial factors. Often times these patients only option for discharge is to receive enough rehabilitation services until they are at an appropriate level for discharge. An appropriate level of discharge is often when the patient is able to safely complete their basic ADL and mobility with modifications, or when their family has been trained to provide them with the assistance they require. It is important to note that there are two general classifications of patients when therapists refer to rehab in house patients. The first one are those without insurance and without social supports. This population is presented with a unique challenge as they do not have funding for placement outside the hospital and are unable to independently care for themselves. Without social supports to bridge this gap, these patients remain in the hospital for increased time frames until a solution is formed. The second classification are those patients without insurance but have social supports. For these patients, they have an avenue to discharge if their social supports are able to provide the required assistance upon patient discharge. The goal for these patients is to provide family training services while maximizing patient independence before discharge. Both these
categories include those patients who are pending insurance but do not have current coverage. This process takes varying amounts of time, so patients will receive rehabilitation services until their discharge to the next level of care.

**Needs Assessment**

In the initial need’s assessment process, an interview with the site was conducted, a gap analysis was performed, and literature was reviewed. The interview with the site provided to be the most essential step in identifying the needs of the site, the resources they have, the gap in practice and their long-term goals. The capstone student met with two occupational therapists and discussed needs and alignment to the doctoral capstone experience. Patients who require long-term rehabilitation was identified as a population in need at Eskenazi. These individuals experience delayed discharges due to complex socioeconomic and cultural factors. These factors include lack of insurance, social support, and citizenship status. As such, they must receive rehabilitation services during their stay to maximize independence in preparation for discharge. The lack of insurance for post-acute care or undocumented status of individuals was identified as two patient characteristics that contribute to delayed discharges. The capstone student inquired what barriers the healthcare and rehabilitation team perceive in providing care for this population. They explained that with higher priority acute care caseloads, it is difficult for the rehabilitation team to provide the consistency of therapy these patients would benefit from. Moreover, the rehabilitation department only has two rehab technicians, and the nursing department has two mobility technicians to aid in patient mobilization. Upon analysis of the interview, two major themes arose. First, long-term acute care patients are receiving lower amounts of rehabilitation than other patients. The second theme is that the organization is
struggling to support the needs of this population. A doctoral capstone project should consider these two themes when proposing a solution.

**Gap Analysis**

Eskenazi hospital is experiencing a multidimensional problem as it relates to timely patient discharge, patient outcomes during increased length of stays, and optimizing the rehabilitation team’s role with these individuals. The rehabilitation therapists have identified a gap in the flow of services and care rehab in house patients receive. A shift in perspective is needed from viewing these patients as acute care patients to viewing them as acute or subacute rehabilitation patients. The approach that currently exists is not meeting the needs of this population. A delineated multidisciplinary approach is needed to identify opportunities to improve the flow of rehab in house patients’ care and discharge planning.

**Problem Statement and Purpose**

Current practices at Eskenazi can be improved to incorporate each discipline more effectively to establish a systemic response to the care of rehab in house patients. The purpose of this capstone was to apply evidence-based practice and decision making from an occupational therapy lens to suggest a modified approach to rehab in house patients to meet their needs more efficiently. Suggestions for providing more consistent services for rehab in house patients were provided to the rehabilitation team. Furthermore, this capstone defined therapist specific roles in the discharge planning process and how these flow within the overall multidisciplinary process of discharge planning. To address therapists’ questions on the current multidisciplinary process for discharge planning for rehab in house patients, the capstone student also interviewed stakeholders and created a tool to outline this process. Overall, this project aimed to optimize the rehabilitation services provided to rehab in house patients while beginning to shift the
perspective of the multidisciplinary team through collaborative dialogue. Despite the unfortunate reality of lack of funding, these patients should be provided the same level of priority as those with funding. While they are unable to qualify for the services post-hospitalization they would benefit from, addressing their inpatient stay is one avenue to advocate for this population.

**Literature Review**

Appropriate hospital stays are defined as inpatient stays in which patients are receiving ongoing and medically necessary treatment that cannot be received through outpatient services (Niemeijer et al., 2010). Delayed discharges, also referred to as barrier days or excessively prolonged hospitalizations, occur when a patient is medically cleared for discharge but unable to leave due to extenuating factors (Rogers et al., 2014). In the United States, approximately 2% of hospitalizations are classified as prolonged, or over 21 days (Meo et al., 2020b). These 2% of hospitalizations account for almost 15% of total hospital bed days, a large percentage occurring when patients are medically cleared for discharge (Meo et al., 2020b). In the state of Indiana, the average cost per inpatient day at a non-profit hospital is $2,633 (Kaiser Family Foundation, 2020). For patients with excessively prolonged hospitalizations, the cost was three times higher, $54,646 vs $18,444 (Hwabejire et al., 2013). In 2012 alone, uninsured hospital stays accounted for $18.1 billion of hospital costs (Lopez-Gonzalez et al., 2016). This not only consumes resources that could be used for other patients, but also increases hospital expenditures (Meo et al., 2020a).

**Barriers to Discharge**

Barriers to safe and timely discharges can be described in terms of sociocultural, financial, placement, and legal factors. The unique intersectionality of these factors for each individual creates endless dispositions to discharge. Consequently, a broad overview of these
complex factors will be provided. Funding is a driving factor in delayed discharges. Eskenazi, operating as a safety net hospital (SNH), serves a large population of uninsured individuals. In 2017, the number of uninsured individuals in the United States reached 27.4 million (Garfield et al., 2019). Many uninsured individuals do not have the funding for placement at the recommended discharge location (skilled nursing facility, extended care facility, etc.) and do not qualify for home health services (MacKenzie et al., 2012). While the hospital is eventually able to enroll a portion of these individuals in Medicare/Medicaid, this process can be timely as it can be difficult to get the needed information and documentation from patients. Moreover, those individuals who are undocumented are ineligible for Medicare/Medicaid, creating a significant barrier to patient discharge. Lack of social support for this population is a considerable barrier as discharging home is the only option some individuals have (Osborne et al., 2018). Without assistance at home to maximize independence and safety, alternate placement options must be explored. This is especially difficult in times where patients require a guardian for medical decision making and do not have available social supports for determining next steps in patient care (MacKenzie et al., 2012). This starts a long legal process of identifying a state appointed guardian for medical decision making.

**Effects of Prolonged Hospitalization**

Prolonged inpatient stays increase patient risk for hospital associated harms, including but not limited to pressure ulcers, medication errors, hospital acquired infections and loss of functional mobility (Meo et al., 2020a). Patients with increased length of stays also face disruptions in sleep hygiene, social isolation, occupational deprivation and limited physical activity (Meo et al., 2020a). Older adults face increased risk for falls, delirium, and muscle atrophy, taking just 10 days of bed rest to negatively impact muscle strength, mobility and
aerobic capacity (Osborne et al., 2018). These 10 days of bed rest equals almost 10 years of functional decline. In terms of rehabilitation, research has indicated that early rehabilitation is essential for improving functional outcomes (Rogers et al., 2014). Gittler & Davis (2018) reported that in a cohort study of 360 subjects, those who received more than three hours of therapy a day made significantly higher functional gains than those who received less than three hours a day. During hospitalization, consistency of therapy services is much less than three hours a day. Delayed discharge to subacute or acute rehabilitation facilities due to patient specific barriers may delay a patient’s rehabilitation, thus delaying recovery and potentially worsening the patient’s prospective for recovery (Rogers et al., 2014).

**Federally Qualified Health Center Status**

In early 2013, Eskenazi was designated a Federally Qualified Health Center (FQHC). This is a type of safety net accreditation in which the mission is to increase the availability and accessibility of essential services to traditionally underserved populations (Sefton et al., 2011). The services provided at these institutions are primary and preventive health care services. Examples of these services are as follows: diagnostic, laboratory services, dental care, and health education. These populations tend to be lower income communities in which the geographic area is identified as having inequitable access to health care (Sefton et al., 2011). Eskenazi serves the constituents of the greater Indianapolis area, many which are homeless, low income, migrant workers, immigrants, and uninsured or other marginalized groups.

In striving to provide comprehensive care to the underserved population, there are admittedly gaps in care that arise within safety net hospitals. As FQHC’s attempt to bridge the gap in health care that is created by economic, physical and social barriers, they must also navigate the allocation of resources to meet the needs of those they serve. Research into safety
net hospitals has indicated lower quality and patient satisfaction with care (Nguyen et al., 2016). Moreover, in a study conducted by Timbie et al. (2019), a survey of FQHC’s showed that between 40-60% of health centers experienced different types of staff shortages and turnover of clinical and non-clinical staff. This can also lead to FQHC’s providing costly services in care due to the inefficient level of staffing (Akinleye et al., 2019). In turn, quality of patient care is adversely affected and leads to increased length of stay in the hospital (Akinleye et al., 2019). As FQHC’s are funded through grants from the government, these institutions must be sensitive to financial constraints when distributing its resources (Moore et al., 2016). Safety net hospitals find themselves providing more and more uncompensated care to patients who are uninsured (Berenson & Shih, 2012). As such, a more innovative approach to health care in safety net facilities is indicated.

As a SNH, Eskenazi takes on a significant role in providing comprehensive healthcare services to the medically and socially vulnerable population in Marion County, they are often viewed as providers of last resort (Sutton et al., 2016). Understanding the typical characteristics of the population served by SNHs helps outline the compounding effects of socioeconomic status on health care. Serving a large portion of the areas uninsured or Medicaid covered individuals comes with unique challenges in patients access and use of health care. Patients insured by Medicaid are lower-income patients who are more likely than uninsured or privately insured individuals to have chronic health conditions or disability (Lopez-Gonzalez et al., 2016). Moreover, uninsured individuals are less likely to be cognizant of any chronic conditions they may have and less likely to control said conditions through medical care compared to those enrolled in Medicaid (Lopez-Gonzalez et al., 2016). People of color are more likely to be uninsured at a disproportionate rate when compared to white individuals, accounting for over
half of the nonelderly uninsured population (Garfield et al., 2019). More specifically, Hispanics (18.9%) and Blacks (11.1%) have higher nonelderly uninsured rates when compared to Whites (7.3%) (Garfield et al., 2019). Language, immigration barriers, state of residence, income, and work eligibility account for some of these differences in insurance coverage by race and ethnicity.

In 2014, SNHs provided services for 43.1% of mental health associated inpatient stays, 36.3% of injury associated stays and 36.9% of maternal and neonatal stays, accounting for nearly 10 million discharges in 40 states (Sutton et al., 2016). Approximately 3.1% of safety net inpatient stays in 2014 were related to mental health diagnoses such as mood disorders and schizophrenia (Sutton et al., 2016). Conditions such as diabetes and skin infections were more likely to account for inpatient stays at SNHs (Sutton et al., 2016). The top six diagnoses for Medicaid specific hospitalizations were for pneumonia, asthma, diabetes mellitus, epilepsy, acute bronchitis and chronic obstructive pulmonary disease (Lopez-Gonzalez et al., 2016). Uninsured specific diagnoses that commonly account for hospitalization include: infectious diseases, respiratory diseases, alcohol related disorders, pancreatic disorder and biliary tract disease (Lopez-Gonzalez et al., 2016). Uninsured hospitalizations were more likely to be of males who live in low-income communities when compared with privately insured hospitalizations (Lopez-Gonzalez et al., 2016). Those with Medicaid as their primary payer on had on average a longer hospitalization, were more likely to be younger (25.3 vs 36.6) and live in the central metropolitan area compared to privately insured individuals (Lopez-Gonzalez et al., 2016). The similarity of diagnoses of the uninsured population seeking medical care at SNHs can be explained in terms of access to care. Uninsured individuals are less likely to utilize preventative health care services due to lack of access (Garfield et al., 2019). Forgoing these services facilitates preventable
conditions or chronic diseases from going undetected. In turn, this puts uninsured individuals at an increased risk of being diagnosed with diseases at later stages, increasing the mortality rate for this population (Garfield et al., 2019).

**Discharge Planning**

The literature on discharge planning outlines best practices for an effective discharge process. Not only do patients with delayed discharges experience lower satisfaction with their health care, but staff members also face significant burnout (Patel et al., 2019). To coordinate safe discharges, successful interprofessional collaboration is required. More than half of preventable adverse events that occur post-discharge can be linked back to poor communication between the multidisciplinary team during discharge planning (Patel et al., 2019). In a study by Patel et al. (2019), the implementation of multidisciplinary, team-based rounds improved communication, shortened length of stay and improved continuity of care. This team included case management (CM), the charge nurse, pharmacy, and a patient liaison. They utilized a standard script focusing on identifying patients who were able to discharge early the next day, identifying patients who are high risk based on readmission risk scores, and identifying barriers to discharge. Another intervention was incorporated in which an afternoon huddle was initiated to discuss patients who were likely to discharge the next day (Patel et al., 2019). In this huddle, CM would ask members of the care team to finalize patient needs for discharge such as durable medical equipment. Lastly, physician continuity was increased by changing the rotation length for residents from 14 to 28 days. Together, these interventions improved multidisciplinary communication and implemented a standard approach for all team members to follow (Patel et al., 2019).
In another study by New et al. (2016) a “Leaving Hospital Information Sheet” was developed to improve discharge communication between the multidisciplinary team and patients and their families. The goal of this document was to improve patient expectations of discharge recommendations, potential changes to recommendations, and barriers that might occur in this process. In a posttest randomized controlled study by Gabriel et al. 2017 a discharge goals checklist was used during interprofessional rounds, with a focus on addressing previously identified non-medical barriers to discharge. The intervention included the use of a daily discharge goals checklist during interprofessional rounds which was initiated within 24 hours of admission. Discharge goals were communicated with the care team and kept at the patient’s bedside with tasks for resolution written on the patient’s whiteboard (Gabriel et al., 2017). Registered nurses completed the checklist and referred to it during discussions on discharge planning with the care team. The time difference between medical discharge and actual discharge was shorter for the checklist group, though there was not a statistical significance. Researchers did indicate that this intervention may be more effective for populations experiencing larger delays in discharge due to non-medical concerns (Gabriel et al., 2017).

The Mayo Clinic has utilized a multidisciplinary framework to standardize the discharge planning process. The first step was aligning discharge planning support through two different positions: discharge planning nurse specialists and social work (SW) (Holland & Hemann, 2011). These two positions were merged into one department to aid in role clarification and take a team-based approach. A decision support tool was embedded into the nurse admissions assessment through the electronic medical record (EMR) to aid in early identification of patients who might need further discharge planning evaluation. The decision support tool consisted of four patient characteristics: age, self-reported functional mobility limitation, prior level of
function, and overall disability on the Modified Rankin Disability scale (Holland & Hemann, 2011). A score of 10 or more initiates a referral to the discharge planning team. In conjunction with this tool, multidisciplinary discharge planning rounds were instituted. An additional assessment was introduced for use with high-risk patients, or those at risk for adverse consequences if their continuing care needs are not evaluated. This assessment evaluated a patient’s cognitive, behavioral, emotional status, functional status with ADL, finances, environmental factors and health status. The patient and caregivers are interviewed, giving the caregiver the opportunity to discuss whether they are able to support the patient upon discharge or if they will need assistance from community service providers (Holland & Hemann, 2011). The results from the assessment allowed the discharge planning nurse to discuss with the hospital staff and community providers the patients continuing care needs such as home health agencies, nursing homes and outpatient services. This information is shared to the patient’s dismissal summary so members of the health care team can readily access it. The team continued to work with the patient until their needs were met for discharge.

**Guiding Model/Theory**

**Framework for Occupational Justice**

In examining the problem that Eskenazi is facing, the occupational justice framework provides the most applicable model. The goal of this capstone was to propose a solution to improving the flow of discharge planning for rehab in house patients while optimizing the rehabilitation services they receive during their extended stay. Currently, the problem this population is facing is a concern of occupational justice. The framework of occupational justice “offers a critical occupational perspective of justice or injustice grounded in inter-related, structural influences on everyday occupational possibilities” (Townsend, 2012, p. 10). In other
words, living in an occupationally just world would allow an individual to flourish and be able to participate in meaningful activities that are beneficial to themselves and their communities. This relies on the inter-relationships of contextual and structural factors of society to support occupational outcomes and rights (Townsend, 2012). Structural factors include underlying occupational determinants such as cultural values, national policies, and economy. They also include occupational instruments such as income supports, health and community support, employment, education, transportation, and housing (Townsend, 2012). Structural factors in conjunction with contextual factors such as age, gender, sexual orientation, ability/disability, religion, ethnicity, create conditions of occupational injustice. Examples of occupational injustice are occupational imbalance, marginalization, deprivation and alienation (Townsend, 2012).

The population of complex discharge patients that Eskenazi serves possess characteristics such as low income supports, unstable housing, low education levels, and low employment rates. Their contextual factors such as disability, nationality, ethnicity, homeless status and income status lead to conditions in which these individuals will face occupational injustice. With lower income, homelessness, lack of employment for insurance, these individuals face disparities in access to healthcare services. This leads to occupational deprivation, alienation, marginalization, and imbalance. Without access to proper health care services, such as receiving the recommended amount of rehabilitation during hospitalization, these individuals risk worsening of their health conditions. Moreover, they are also alienated from participating in occupations that are meaningful to them such as work, being with their family, and being independent because they remain in the hospital for longer length of stays. Upon discharge home or to their
next level of care, patients are at a disadvantage as they did not receive the optimal level of therapy to make the functional gains, they need to be successful and independent.

**Capstone Project Plan and Process**

Upon beginning at Eskenazi, it became clear a complete and thorough needs assessment was warranted to understand the system processes that have led to this capstone's need. The Eskenazi Rehabilitation therapists have been at the forefront of trying to determine the best approach to providing care to long length of stay patients. Consequently, a significant portion of the capstone’s process included on site interviews with rehabilitation team members and hands on experience with this population. Multiple stakeholder discussions were conducted throughout this capstone to tailor a sustainable plan. The evaluation plan of this project consisted of a presentation to the rehabilitation department and a brief survey following. This survey measures perceived benefit and use of this capstone project. Project goals and objectives aim to address the identified need using evidence-based practices.

**Project Goals and Objectives**

Project Goal 1: The student will develop a sustainable multidisciplinary protocol to care for rehab in house patients to address current gaps in care within 8 weeks.

Objective 1: The student will conduct a needs assessment to determine the specific needs for these patients, the resources available and develop a method to assess patient outcomes.

Objective 2: The student will speak with stakeholders (patients, nurses, rehab, mobility techs, hospital administration etc.) to determine current projects, departmental goals, perceived barriers and opportunities for improvement.
Objective 3: The student will utilize knowledge from the needs assessment and interview of stakeholders conducted on the site and explore the literature to determine best practices for an interprofessional protocol to care.

Project Goal 2: The student will propose evidence-based rehabilitation protocols to provide supplemental services to this population of patients within 6 weeks.

Objective 1: The student will examine the literature to determine best rehabilitation protocols utilizing interprofessional members to facilitate desired patient outcomes.

Objective 2: The student will propose a plan outlining recommended interventions and resources needed.

Project Goal 3: The student will develop a method to assess program effectiveness of the project.

Objective 1: The student will research different outcome measures to measure patient improvement from the beginning of capstone.

Objective 2: The student will define the areas they are focusing on for patient outcomes such as rehabilitation therapists perceived benefit of rehabilitation protocol.

On-site Needs Assessment

Stakeholders

In order to propose a solution with a strong multidisciplinary focus, stakeholders were identified from each department working with rehab in house patients. A current complex discharge committee working with rehab in house patients was identified, consisting of CM, SW, nurse manager, legal, and administrative physician. Additional members of health care teams were identified consisting of occupational therapists, physical therapists (PT), speech therapists, rehabilitation technicians and mobility technicians. SW and CM, paired with the rehabilitation therapists, have a unique role in discharge planning for this population, making this an opportune
relationship to base recommendations on. Most importantly, working with patients who are experiencing complex discharges has provided patient specific views to barriers and opportunities. Engaging stakeholders collaboratively is an essential component to improving patient outcomes and project sustainability.

**Objectives and Methodology**

In person or phone interviews were conducted with each stakeholder once on site. Each participant was provided with a brief introduction to the capstone project focusing on rehab in house patients. Interview notes were transcribed following each meeting. A strength, weaknesses, opportunities, and threat (SWOT) analysis was completed based on data collected. Interview objectives are as follows:

1. Determining the role, scope and participants of the current complex discharge committee.
2. Understanding daily schedule and responsibilities for each stakeholder.
3. Understand each stakeholder’s role in working with rehab in house patients, barriers to patient care they have encountered, and suggestions for improvement.
4. Determining rehabilitation specific barriers and goals for providing rehabilitation services to this population.
5. Understanding the current multidisciplinary flow for discharge planning.
6. Understand patient specific barriers to discharge.

**Interview Results**

Interview results have been organized by stakeholder type with common themes identified. With this capstone project having a strong rehabilitation focus, the results will provide a more detailed report of therapy interviews. The following results reflect each stakeholder’s perception of the barriers to discharge and care for rehab in house patients.
Rehabilitation Team Members

Population of Rehab in House Patients.

The term rehab in house refers to those patients who are experiencing increased length of stays due to social or financial related factors. As a result, they are unable to discharge, meaning they will stay on therapy’s caseload until they are discharged from the hospital or discharged from therapy. Sociocultural factors that contribute to the complexity of cases from a therapy lens are those patients who are undocumented, non-English speakers who require heavier assist for mobility and self-care. These patients require more assistance from all disciplines and are at a higher risk for pressure ulcers and decreased mobility. These rehab in house patients are typically those with acute injuries who would benefit from acute or subacute rehabilitation but are unable to get to that next level of care. Another population of rehab in house patients are those with chronic diagnoses who are most likely going to plateau with therapy in terms of functional gains.

Patient Payor Source as a Barrier to Discharge.

An identified barrier leading to increased length of stays is related to patient payor source. Patients are grouped into three informal types based off of their payor source, which in turn affects their post-discharge placement options and recommendations. These three categories are: 1) uninsured patients who are not eligible for Medicare/Medicaid 2) uninsured patients who are eligible for Medicare/Medicaid 3) insured patients. For patients under the first condition, therapy will most likely have to work towards discharging them home with social support. For patients under the second condition, SW can begin the process of signing them for Medicare/Medicaid, but during this waiting period, patients might progress too far in therapy and thus become “too good,” surpassing eligibility for acute rehabilitation.
An identified area for improvement for rehabilitation staff arises during documentation of discharge recommendations. Upon hearing that a patient does not have the funding for acute, subacute rehabilitation, etc., therapy team members can be more proactive in documenting that the patient will not be able to reach the recommended next level of care. This can look something like: patient would benefit from acute rehab, however, will discharge home with intermittent assistance once A, B, C, D are met. The problem arises when this is not documented in rehabilitation notes. Miscommunication arises when other members of the health care team open a patient’s chart and see physical and occupational therapy recommending acute, subacute etc., when the patient does not have funding for such and will have to discharge home, if possible. Without clearly documenting that the patient has no other likely disposition than to discharge home, it does not appear to other health care members that therapy is working towards preparing that patient for home. Rehabilitation therapists have an opportunity to streamline communication on patient disposition for home by including the goals that must be met to get the patient home safely. An identified opportunity for improvement could include incorporating primary and secondary discharge recommendations for these complex patients.

Involving Patients Families and Social Supports Earlier on in Admissions

Involving patient families and social supports earlier in the admission process to frame discharge and rehabilitation expectations was another identified theme. As soon as a patient is identified as having to discharge home with family/social support due to payor status, SW and therapy should work together to facilitate family training as soon as possible. There are two main reasons for this. The first being to prepare families for home modifications and equipment needs. This gives families ample time to get everything ready for the patient instead of waiting closer to discharge and potentially delaying patient discharge further. The second reason is to frame
family expectations for the patient's expected functional baseline at discharge and how much assistance the patient will require. The importance of having family understand the patient’s functional baseline and assistance needs is so family can decide if they are able to provide this level of care. In the past, family has become involved later in the process and upon realizing how much assistance the patient needs, they become overwhelmed, and some families decide they cannot provide this level of care. That leaves SW and CM struggling to find another discharge option for the patient. Another problem arises with COVID and family members not being able to visit as often. This leads to gaps in families understanding of the reality of this patient's situation. Communicating with family early on also allows the care team to discuss transportation needs the patient and family might have for discharge and follow up appointments.

Another opportunity to frame family expectations is in regard to those patients who do not have insurance, but SW has started the process of enrolling them. With these patients, there is a waiting period until they are covered. It is important to let families know that therapy is currently recommending acute rehabilitation for this patient, but if they progress to a certain point with therapy, they will be “too good” for acute rehabilitation and have to discharge home. Therefore, families should be prepared that if the patient meets certain milestones with therapy, nursing, respiratory therapy, etc., they will be discharging home to family. Without framing family expectations for this, it comes across as therapy changing recommendations.

**Organizing Discharge Planning from Admissions with a Multidisciplinary Focus**

The most common theme from discussions with rehabilitation team members has been coordinating discharge planning more effectively from patient admissions. A common question that arises is with the complex discharge committee and exactly at what point they become involved in a patient's case. An opportunity for improvement arises with this committee by
identifying a system to make the escalation process more efficient. Establishing a more fluid procedure with designated roles can aid in a more efficient discharge process. An area of improvement that therapy has identified in this process is that it is often placed on therapy as why a patient is still in the hospital. This leads to a perceived responsibility from the rehabilitation therapists of being the ones who raise concern about these more complex cases. In turn, this contributes to the delay of discharge planning.

One avenue that has been routinely mentioned throughout interviews is the use of an “algorithm” or decision-making tree that identifies rehab in house patients from admissions and begins a fluid process for the multidisciplinary team to follow. The goal of this is to have an organized and timely response. With each team member aware of their roles and responsibilities with this population, discharge planning can become more efficient. A multidisciplinary discharge checklist was also mentioned as a possible solution. With a checklist, each department has a clear understanding of the steps they must take to facilitate timely discharge. This would include areas pertinent to independence upon discharge such as nutrition, bowel and bladder, respiratory needs, and self-care. A potential algorithm would also include initiating family involvement earlier in the process. A potential barrier noted in such algorithms or decision-making tree is that each patient's case is so different with an endless combination of sociocultural factors. Any algorithm or decision-making tree would have to be sensitive to this wide variability.

A central theme in the multidisciplinary focus of this project is the need for more effective multidisciplinary communication. A concern that has been voiced is that all professions need to be held accountable for aiding patients in discharge planning and their mobilization at the hospital. A more effective means of communication between care teams is needed to assist in
this process. Therapy is often becoming a gatekeeper for this patient's discharge needs when it should be a more collaborative approach.

**Rehabilitation Therapists Improvements with Rehab in House Patients**

Opportunities and barriers specific to the therapy team were discussed in length. Rehab in house patients are not always seen consistently due to therapists having higher priority caseloads. In reality, these patients would benefit from being treated like they are in acute inpatient rehabilitation. An opportunity arises to coordinate between occupational therapy and physical therapy to see patients twice a day, so they are receiving more consistent therapy. This would involve communicating with nursing more effectively as well. Due to being in the acute hospital setting, a barrier arises as patient availability throughout the day is inconsistent as lab work, imaging, consults, and procedures can occur at any time. A disconnect arises when therapists are recommending acute rehabilitation, but not seeing the patient every day. This poses a question on how therapists can facilitate their rehabilitation during days where they are unable to provide services to these patients. This is of concern especially for patients who hit their functional baseline to ensure they do not become deconditioned. A potential solution would have to include members of the multidisciplinary team such as mobility techs, nursing, and rehabilitation techs.

Keeping a most consistently updated list on EPIC, Eskenazi’s electronic medical record, of rehab in house patients is another identified area for improvement. This allows other therapists to see who is on the list and potentially pick up patients on their caseload if they are having a lighter census.

**Establishing Routines with Multidisciplinary Team to Facilitate Mobility and Routines**

The opportunity to involve disciplines such as nursing, rehab techs and mobility techs is another common theme. As therapy is oftentimes only able to see a patient once a day,
incorporating these disciplines more effectively can help promote routines in the hospital setting and increase mobility. In the past, mobility techs have been specifically trained by therapy for certain transfers in order facilitate patient mobility. This is an avenue that can be explored more, especially when therapy cannot mobilize a patient on a certain day. Another opportunity arises with discussing a schedule nursing can follow with the patient to increase mobility and healthy routines throughout their stay. Starting this conversation early is important, especially in instances where therapy eventually discharges a patient. One example was discussed in which a patient was discharged from therapy as he reached his functional baseline. At this point, nursing took ownership of this patient and mobilized the patient more consistently. This is a good example of nursing taking more ownership of patient mobility. Routines for patients can look like suggestions for getting up to the bedside chair for meals, completing self-care tasks throughout the day, completing leisure tasks in their room, and in and out catheterization at certain times. Routines would be tailored to a patient’s needs.

**Social Work**

In a discussion with SW regarding rehab in house patients, the following themes arose. To begin, the main commonality between rehab in house patients is their funding/payor source. While it is possible to sign eligible patients up for Medicare/Medicaid, this process can be elongated by difficulty getting documentation needed from patients and their families. Another theme echoes those identified in discussions with therapy. This involves SW communicating with therapy and other providers earlier on in the admissions when it is clear that the patient does not have the payor source they need for acute or subacute rehabilitation.

A central theme in discussions with SW is that discharge planning requires unique solutions for complex situations. Unique avenues that have been taken to facilitate discharge
planning include flying patients back to their home country where they have social support, paying for a patient’s room at a nursing facility, and paying for the necessary durable medical equipment needed to facilitate independence.

Another theme identified is one similar to that of therapy’s themes. The multidisciplinary team can do a better job of framing family/social supports perception of the rehabilitation patients receive in the hospital and what that looks like. A lot of times, families are under the impression a patient is going to meet all their therapy goals and be independent upon discharge. This is almost never the case. Establishing earlier on in the admissions a more efficient process of SW and therapy coordinating discharge planning was an identified opportunity for improvement.

**Nurse Manager and Mobility Technicians**

A theme that emerged in conversation with nurse management is the barrier of time in working with rehab in house patients. Nurses have a large list of responsibilities to complete throughout the day. When it comes to new hires, the documentation burden is very heavy, and they are often focused on completing their tasks. As such, they may not have the time built into their day to make sure they are mobilizing each patient and facilitating routines as their schedule can be unpredictable. Moreover, for new hires, it can be difficult when they are not accustomed to working with patients with different diagnoses.

The nursing department has two mobility technicians who assist in mobilizing patients. These mobility technicians are assigned to different floors to help mobilize patients with a bedside mobility assessment tool (BMAT) level of 1 or 2. These patients are those who are at a higher risk for pressure ulcers, have poor skin integrity and are at risk for deconditioning. A perceived barrier is that nursing may benefit from more targeted training with complex transfers
to assist in mobilization. The mobility technicians have been trained for specific transfers by therapy members to assist in mobilizing patients when therapy is not available. The mobility technicians have a heavy caseload and are restricted by time barriers. With rehab in house patients, they have established routines with certain patients on their own, but this is something that takes time away from seeing other patients.

Case Management

A discussion with a case manager on the complex discharge committee echoed themes presented thus far. Common barriers to discharge include those patients without insurance and no social support. Eskenazi does have a Health Advantage plan which is a program for Marion county residents that can be used for medications and pays for portions of inpatient stays. It does not cover rehabilitation or durable medical equipment. The CM department bears the cost of any durable medical equipment that a patient without funding is discharged home with.

In terms of the complex discharge committee, they meet once a month to discuss complex cases. Cases are sent to them by CM and SW when they realize they have no feasible options for a patient’s discharge planning. There is no established means of escalation at this time. The monthly meetings consist of the medical director, CM director, a legal department representative, and representative for hospitalists, nurse leadership, and SW. The cases discussed in the committee center around legal, financial and ethics discussing options for the patient. In this case, this mostly concerns those patients who do not have funding and do not have social supports. They communicate with the rehabilitation therapists to ensure they have all the information prior to meetings. CM is open to opportunities for improving the discharge process.
SWOT Analysis

The SWOT analysis conducted considers this site’s characteristics against best practices for multidisciplinary discharge planning and rehabilitation best practices (Table 1). A considerable strength of Eskenazi is the presence of a complex discharge committee. Multidisciplinary teams are able to communicate via secure chat on EPIC in regard to patient concerns. The case manager on the committee is also open to suggestions for improving the committee’s flow. Weaknesses arise in that the committee is meeting only once a month and it is unclear what steps are taken outside of this time. The lack of escalation for rehab in house cases also leads to increased time spent in the hospital. This provides an opportunity for incorporating a tool to identify these patients earlier in admissions to decrease length of stay. Identified as a common theme in the interview process, improved interprofessional communication is needed as a basis for this project. Therapy also has an opportunity to implement changes in making rehab in house patients a higher priority. A considerable threat to this project is the time constraints and role demands of nursing and therapy. A successful project should aim to incorporate a suggestion that works into the existing framework of Eskenazi’s workflow.

Capstone Project Implementation

Methods

Development of a Multidisciplinary Flow Diagram

During conversations with the rehabilitation therapists, an identified gap in the multidisciplinary discharge planning process was understanding the extent of each discipline’s roles. In an effort to make this process more fluid and clearer for members of the multidisciplinary team, the capstone student met with SW and the case manager on the complex
discharge committee. The capstone student also spent time observing and providing care to rehab in house patients to understand rehabilitation therapist’s role in the discharge process.

Social work described their initial intake assessment of patients upon admission. In this intake they ask patients questions about their home, mobility, work, and prior level of function with ADL. From patient admission, it is evident within 24-48 hours if a patient will have insurance or not. If this patient does not have insurance, they will become a rehab in house patient. These patients are grouped into two main categories, both without funding, but one group has identified social supports. An area of improvement that has been identified is alerting members of the care team earlier on that this patient will not have funding for rehabilitation placement post-acute care. A care coordination tiering assessment tool (Berry et al., 2013) was suggested by the capstone student as a method to standardize the process of identifying these patients sooner and having a clear escalation process. The social worker indicated that getting buy in from the whole SW department may be difficult, therefore this feedback was taken in changing the flow diagram to fit within the existing framework, including the tiering assessment as a suggested tool. It was also discussed that SW typically secure chats the care team on EPIC in regard to any barriers to discharge the patient may have. Therefore, to escalate this process from admission, the capstone student recommended to immediately refer all patients with no insurance and no social supports to the complex discharge committee.

Though literature supports weekly discharge planning meetings for complex cases, the case manager on the complex discharge committee indicated that the progress made in patient cases is not enough to meet more than once a month. A secure chat check-in to communicate concerns or updates following the meeting is an identified area to improve communication between the care team. Moreover, the case manager indicated support for the use of a discharge
goals checklist to communicate patient goals for discharge during multidisciplinary communication.

Through multiple rounds of feedback from rehabilitation therapists and SW, a final multidisciplinary flow diagram was developed (Figure 1). This diagram contains a flow of events, most which are already occurring, to help the care team visualize the steps necessary in the discharge process. The goal of this diagram is to bring each member of the care team’s attention to their role in the process to promote an efficient and timely response. The diagram was created with five objectives in mind, each which is color coded. Goal 1, in blue, is to identify, track and escalate complex discharge cases (Meo et al., 2020). As the use of the tiering assessment is optional, this step involved SW reaching out in a timely manner to the care team to escalate those cases in which a patient has no funding and no social supports. The second goal, in yellow, focuses on early and comprehensive discharge planning services. This includes SW interviewing the pt or family/caregivers to determine family goals, level of available support, home set up etc. to share with the care team. This information allows therapists to determine the best discharge disposition for the patient. This goal also includes the immediate referral to the complex discharge committee for those patients with no funding and no social supports. In terms of rehabilitation therapists specifically, this includes documenting primary and secondary discharge recommendations for this population as well as needed durable medical equipment (DME) and home modifications.

Tying into the previous goal, the third goal centers on timely communication between hospital staff, patients and their families (Berry et al., 2013). With a strong focus on multidisciplinary communication, this involves therapists communicating discharge recommendations, DME needs and home modifications to the care team. SW and therapists are
then able to coordinate family training for the patient’s social supports to frame their expectations for rehabilitation and anticipated support upon discharge. Following family training, therapists will communicate any updates or additional barriers to the care team through secure chat. The social worker is also tied to this goal by messaging the care team about patient barriers after their initial assessment. Lastly, a weekly secure chat check-in between CM, SW, the physician and therapists will be executed on secure chat on EPIC or in person in efforts to keep the care team updated, as well as having the physician be at the center of the care team. The use of a discharge goals checklist (Figure 2).

The fourth goal relates to adapting patients’ inpatient norms and routines during their long stay. In order to facilitate this process, a routine checklist (Figure 4) was created. In conjunction with this, rehabilitation therapists write this information on the patient’s white board as to be easily seen by the care team. Therapists are able to train rehabilitation technicians or mobility technicians for specific patient’s transfers to assist in mobilizing them during the day. Therapists are also able to train rehabilitation technicians to complete range of motion (ROM) for specific patients. This is especially important for those patients who are eventually discharged from rehabilitation therapist’s caseload but remain at the hospital.

The last goal aims to maximize rehabilitation services to these patients who are here long term. This involves coordinating between the rehabilitation therapies to see the patient more consistently during the week, especially for patients whose discharge recommendations are acute or subacute rehabilitation. Recommendations to do so are OT seeing a patient Monday, Wednesday and Friday and PT seeing a patient Tuesday and Thursday, if the patient does not require co-treatment. The following week, these disciplines can switch days. Another recommendation is coordinating between OT and PT for one discipline to see the patient in the
morning and one to see the patient in the afternoon, so the patient is receiving twice daily services. This is dependent on availability in rehabilitation therapists schedule and not conflicting with patients’ labs or procedures. This goal also ties into the previous goal in training rehabilitation technicians to mobilize the patient or complete ROM exercise.

**Development of a Discharge Goals Checklist**

To aid in multidisciplinary rounding and check-ins, a discharge goals checklist was created (Ainsworth et al., 2013). The final checklist (Figure 2) includes an area to distinguish patient room number and primary care team. The patient goals section allows the user to free write goals that the patient must meet in order to reach discharge as well as patient stated goals. The multidisciplinary objectives section begins with a section to indicate any pertinent lines, foley, telemetry etc. that the patient might have. The purpose of including this is for the care team to be consistently aware of them and evaluating if each of these things are necessary, as to not have patients on lines that are not needed. Another section is included to indicate all disciplines consults have been placed to, so all members are aware of who is a part of the care team. Spaces for diet orders and precautions is also included. A space for recommended DME, AE and home modifications is included. The goal of including this on the checklist is to help facilitate the process of ordering this equipment early on. A section is included to state whether family training is required and if/when it has been scheduled for. Another space for community services being engaged, discharge location and anticipated level of assistance needed is included. Including community services being engaged allows for rehabilitation therapists to understand the level of assistance that will be provided upon discharge. The incorporation of the free write goals section at the end gives the care team the ability to write down and track goals each patient
must meet in relation to each discipline. This is also an area to write down any goals for family training if applicable.

**Development of Rehabilitation Support Tool**

In an effort to map out rehabilitation therapist’s unique role with rehab in house patients, a rehabilitation support tool was created with consideration to patient type (Figure 3). The support tool groups patients into those who have no funding, no social supports, and nowhere to go and those with no funding, have social supports or somewhere to go. The goal of this support tool is to group together rehabilitation therapy’s role in the process all in one place to assist decision making. The decision support tool contains five different domains of rehabilitation therapists experience with this population. This includes: care team communication, frequency of rehabilitation services, patient routines, discharge planning, and discharge path. Unique to those patients with no funding and no supports, care team communication includes the immediate referral through SW and CM to the complex discharge committee. The use of the discharge goals checklist to guide multidisciplinary discussion, communication of therapy goals on the white board, and weekly secure chat check-ins between CM, MD, SW and therapy is common between both groups for this domain.

The domain of frequency contains the same recommendations for each population. This includes coordination between rehabilitation therapy to see patients more consistently by either OT and PT seeing a patient separately in morning and afternoon if they do not require co-treatment or to alternate Monday, Wednesday, Friday and Tuesday, Thursday. Another avenue mentioned above is to train rehabilitation and mobility technicians on specific transfers to assist in mobilizing patients when rehabilitation therapists are unable to see the patient on a certain day. OTs and PTs can also train rehabilitation technicians on ROM to perform on patients.
To facilitate routines for both groups of patients, therapists can work together with the patient, family and nurse to create a routine for the patient during their stay. When communicating with the nurse, it is important that therapists do so in terms of the Bedside Mobility Assessment Tool (BMAT). This is an assessment that nursing uses with their patients to determine mobility and assistance levels. Each level on the BMAT corresponds to an assistance score used by therapy. Level I, level II, level II and level IV of the BMAT correspond to dependent, moderate assistance, min assistance and independent respectively. With use of the white board, therapists can write the patients routine, home exercise program, care team information etc. This allows anyone who enters the room to be aware of the routine the patient is following. The use of a routine schedule posted on the patient’s door is another method to promote routines for the patient.

**Development of Routine Checklist**

The routine checklist was created (Figure 4) with the goal of normalizing inpatient routines for the patient and maximizing independence. It also serves as a tool for the multidisciplinary team, especially nursing, to have as a central resource on the patient’s functional mobility and ADL assistance. In the process of developing the routine checklist, an informal discussion with six nurses was conducted to receive feedback on what helps them facilitate routines for rehab in house patients. A discussion to barriers and the specific use of the checklist on the patient door also took place. Upon the most common barriers discussed was time. Most nurses have four patients on their case load and are unable to follow through with consistently mobilizing a patient as they have other responsibilities. For this reason, the checklist was created to have general guidelines for mobility and a routine for ADL. Most nurses voiced that this checklist would be helpful in the patient’s room, so they do not have to search through
the patient’s therapy notes to find how the patient completes transfers and mobility. To be respectful of the care teams schedule, the routine checklist does not incorporate specific time frame recommendations to complete the routines. Rehabilitation therapists are able to go through the checklist and fill out this information specific to the patient. They are also able to check which items on the checklist apply to each patient.

The checklist consists of six domains: feeding, activity, toileting, medication, grooming, and therapy goals. The feeding section includes suggestions for eating meals in a chair, self-feeding with or without assistance and adaptive equipment, eating meals at specific times, diet orders, and precautions. The activity section includes ROM or home exercise programs, how the patient transfers to a chair, suggestions for out of bed activity, and ambulation status. The toileting section includes where the patient should toilet and contains a free response section for rehabilitation therapists to write any other information related to toileting assistance. Feedback from nursing suggested to remove the medication portion of the schedule, but after discussions with rehabilitation therapists, the medication section was kept for those patients who have scheduled medications. The grooming section contains a free response for oral care and bathing/grooming. Lastly, the therapy goals section contains a free write section to write the most important therapy goals for the patient.

**Patient Implementation and Rehabilitation Staff Education**

The capstone student worked directly with rehab in house patients on case load to develop an individualized routine using the routine checklist. The capstone student collaborated with the OT and PT working with the patient to ensure the routine fit their needs. The recommended routines for these patients were written on the white board inside the patient’s room while the routine checklist was placed outside their door. The patient was educated on the
purpose and benefit of the routine. Furthermore, each patient’s nurse was educated on the purpose of the routine checklist. Through trial with each of these patients, the routine checklist was changed based on further feedback from therapists and nursing.

During the process of working with rehab in house patients, one particular patient required a customized routine schedule. Due to the complexity of his hospital course, the patient required daily intensive therapy as well as wound care and dressing changes. The patient was often limited in his session due to poor pain tolerance. The multidisciplinary team came together for a patient conference in which they discussed creating a daily schedule for the patient around his pain medication. A schedule was created through collaboration with a burn unit team, palliative care team member, and nurse management (Figure 5). The formation of a time specific schedule is not anticipated to be a common practice but was necessary in this patient’s case.

In the last week of the capstone experience, an OT reached out to the capstone student about adapting the routine sheet for spinal cord injury patients. The OT had attended a meeting with the critical care committee in which they identified a gap in multidisciplinary communication for spinal cord injury patient’s functional status and assist levels. The routine checklist was adapted for this patient population (Figure 6). The main changes were consolidating the toileting section to a free write portion and including a space at the bottom for the patient’s identification label. A section for communication was added to the routine checklist as spinal cord injury patients often have impacted speech. A note was written on the bottom right to request this document follow the patient throughout their hospitalization. Although was not directly related to the capstone purpose, some rehab in house patients are those with spinal cord injuries. This was a good opportunity for the capstone student to broaden the scope of this projects purpose and increasing awareness to individuals outside of the identified stakeholders.
An in-service was provided to the rehabilitation therapy staff to discuss the capstone student’s proposed protocol to working with rehab in house patients. The capstone student discussed how the majority of steps for the multidisciplinary team are already happening, and this project helped to map out the steps of each team member. Moreover, the capstone student explained the proposed rehabilitation support tool as a guide to working with rehab in house patients. The capstone student elaborated on the purpose of each of these steps in relation to organizing rehabilitation therapists’ approach to these patients and helping to facilitate discharge steps more efficiently. The capstone student also spent time discussing how OT and PT can specifically coordinate to see a patient twice a day, or each discipline alternating seeing a patient once a day to provide more services. Again, many of these steps are already being followed, but it was presented to the rehabilitation department in an organized way with clear direction. Lastly, the capstone student explained the purpose and use of the routine and discharge goals checklist and how to implement these into their routine. An in-depth discussion was provided on the rationale for the creation process for each of these tools and how the rehabilitation staff can implement them into practice. The capstone student explained that the project is meant to fit within the existing framework of the rehabilitation department’s approach to patient care and is not meant to add additional work into their routine. Time constraints and large caseloads will always be a barrier to following this proposed process, therefore it was reiterated that this is a suggestion to follow as therapists are able. The two main points for actionable change in how rehab in house patient’s cases are approached are as follows: 1) the use of a routine checklist outside the patient’s door and 2) initiating secure chat check-ins with SW, CM and the physician.

The final discharge goals checklist, multidisciplinary support tool, and routine checklist were also provided to SW and the case manager on the complex discharge committee. The case
manager stated that she would share these materials with her team, indicating a particular interest in the discharge goals checklist. These materials were also sent out to all the case managers and social workers. An explanation of the intended use and purpose of these materials were provided to the nurse manager to share with nursing staff.

**Project Evaluation**

The project evaluation process took place in the form of a survey sent out to the rehabilitation therapists following the in-service. The survey was reviewed by the capstone student’s site mentor and professor advisor for measurement errors. Five questions utilized a Likert scale to gauge therapist’s perceived use of project materials (Appendix). A free response section was also included for additional feedback. Out of the N= 16 participants, twelve indicated they are very likely to use the routine checklist, and four indicated they would be likely to use the routine checklist. Nine indicated they would be very likely to write routines on patient white boards where seven indicated they would be likely. Twelve participants strongly agreed that the discharge goals checklist would be helpful in multidisciplinary discussion, and four agreed the discharge goals checklist would be helpful. Six participants strongly agreed the rehab flow chart will help guide their approach, nine agreed, and one was neutral. Lastly, eight participants strongly agreed that they understood the purpose of each step in the rehab flow chart, where eight participants agreed.

Project evaluation also took place in the form of informal discussions with stakeholders following project implementation. Following the in-service, multiple therapists had a discussion on the capstone project, with questions and areas for improvement as time progresses. The capstone student took note of these questions and suggestions and compiled them into a final thoughts document on the project. This was shared with the capstone mentor. Feedback from the
nurse manager and case manager was also beneficial in the evaluation process. The case manager indicated that this project is something she is also likely to be invested in moving forward.

**Capstone Discussion and Impact including Sustainability Plan**

The population of patients who are classified as rehab in house is not unique to Eskenazi but requires a site-specific solution. This population is facing a disparity in health care coverage that in turn affects their health care outcomes. As occupational therapists at Eskenazi work to bridge this gap in the acute care setting, special note must be taken to considering these patients' roles and routines outside of the hospital and incorporating a sense of normalcy through routine at the hospital level. This project was able to organize the concerns rehabilitation therapists have voiced in regard to how the multidisciplinary team approaches rehab in house patients. Initiating conversations with the stakeholders has helped initiate implementing change for these individuals. While addressing these patients’ length of stay is ultimately outside the scope of this project, the capstone student has been able to recommend evidence-based suggestions for improving multidisciplinary communication in hopes of streamlining the discharge planning process.

The capstone student addressed project goals by creating a multidisciplinary flow diagram through a thorough needs assessment process with stakeholders. Collaborating with the stakeholders allowed the capstone student to understand the current approach to rehab in house patients. The second goal of this project was met by proposing a rehabilitation protocol to help organize therapist’s response to these patients. Feedback from the primary stakeholder of this project, therapists, has been the most informative evaluation method for this project. In addressing these goals, the capstone student referred to the literature for best practices. When conceptualizing the routine checklist and rehabilitation support tool, literature discussing effects
of immobility was at the forefront of this process. Ideally, patients would be able to receive 1-3 hours of rehabilitation at least 5 days a week at acute or subacute rehabilitation (Glitter & Davis, 2018). As patients are unable to receive this consistency of therapy, the capstone student shifted the perspective to increasing the frequency of services. This shift in perspective was also guided by increased risks patients face due to immobility, such as muscle weakness and pressure sores (Osborne et al., 2019). With providing a recommendation to increasing weekly frequency of patient rehabilitation services, these patients will be mobilized at an increased rate. The routine checklist also aims at improving multidisciplinary communication. Often times, as Eskenazi rehabilitation therapists have noted, lack in team communication can lead to delays in the discharge process.

Overall, this project aimed to promote a more efficient process of caring for the rehab in house population. Incremental changes in how therapists work with these patients will hopefully lead to a long-term change. Barriers to project follow through include rehab therapists increased caseloads. During periods of time when therapists have large caseloads, they are unable to see rehab in house patients consistently. Another limitation is that CM and SW would benefit from a more formal introduction to this project. Even though the capstone student has communicated with individuals in this department, department head orientation to this project would be beneficial to ensure carry over through other disciplines. Moreover, nursing has many responsibilities throughout the day and when it comes to mobilizing patients, especially those with more complex diagnoses such as spinal cord injury, they may not have the time to follow through.
Impact and Sustainability

With this project defined process for working with rehab in house patients, therapists will be able to advocate for these individuals through actionable steps. Regular check-ins on secure chat with SW, CM, and MD promotes open lines of communication while keeping the physician at the center of the care team. The routine checklist allows all members of the care team to understand the patient’s goals and how their routine can lead to the discharge goal. It also serves as an effective communication tool with nursing. Most importantly, this routine will help give patients more autonomy to their daily routine while promoting mobility. These small changes will help push a shift in how the care team conceptualizes their approach to these patients. While a truly effective shift in mindset and hospital culture would require an institutional wide change, this project has provided a beginning for the site to start these conversations.

Following the in-service, the questions received weighed heavily on project sustainability. It was explained that initially, this project will have to be initiated by the rehabilitation therapists. They will have to be the ones that ensure this project follows through. The goal is that by following through with the main two actionable steps, this will create a shift in perspective for the whole care team. In establishing project sustainability, special attention was paid to incorporating suggestions that fit into the existing processes. The capstone students OT mentor, a PT and PTA have committed to carrying this project forward. These three individuals have been major stakeholders of this project, providing invaluable feedback and direction. Their goal is to follow through with the proposed project and to help keep therapists accountable. They will also be able to make any changes to fit their needs better. The capstone student sent an email to the case manager on the complex discharge committee informing her of the three identified individuals who will be carrying this project forward. The case manager will
be able to reach out to these therapists with any further questions about rehab in house patients. A capstone student from the Indiana University Occupational Therapy Department will be completing her capstone at Eskenazi starting January 2022. Part of her project will be continuing to follow through with project sustainability and evaluation. This allows for additional insurance for project sustainability and improvement to meet the sites needs as implementation progresses.

One of the biggest impacts was on the capstone student’s understanding and firsthand experience with advocating for a vulnerable population. This project was created by OT, PT and speech therapists identifying a gap in patient care and advocating for improving patient care and experience. Occupational therapy has a very unique role in this process as OTs are able to evaluate and work with these patients consistently to observe their functional status. Often times, the patients rehabilitation therapists are the most consistent members of their care team as nursing and physician teams change frequently. Consequently, OTs are able to identify and report gaps in patient care and how that affects their functional outcomes. Engaging stakeholders across multiple stakeholder’s is a challenging process to navigate through but creating something collaboratively is the best way to facilitate positive patient outcomes.

Conclusion

This project is an important step in initiating change for a vulnerable population. At the core, this project is about advocacy and addressing occupational injustice. Rehabilitation therapists at Eskenazi have taken the first step in identifying and voicing concern for how rehab in house patients hospital course is carried out. Through collaboration with multiple stakeholders, the capstone student was able to propose steps to promote positive change. Therapists must be the initial frontrunners of this project to promote sustainability. With an
identified team of three therapists to move forward with this project at Eskenazi, the goal is to start a shift in culture for how rehab in house patients are approached.
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### Table 1

**SWOT Analysis**

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<tr>
<th><strong>Strengths:</strong></th>
<th><strong>Weakness:</strong></th>
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<tbody>
<tr>
<td>● Monthly complex discharge committee</td>
<td>● Committee meeting only once a month</td>
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<tr>
<td>● Multidisciplinary teams</td>
<td>● Lack of escalation process for complex cases</td>
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<tr>
<td>● CM open to suggestions for improving committee flow</td>
<td>● Lack of clear role delineation in discharge process</td>
</tr>
<tr>
<td>● Rehabilitation therapists’ investment</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Opportunities:</strong></th>
<th><strong>Threats:</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>● Improved communication between professions</td>
<td>● Time demands and role demand of therapy and nursing</td>
</tr>
<tr>
<td>● Improving therapy consistency with rehab in house patients</td>
<td>● Multidisciplinary buy in for sustainability</td>
</tr>
<tr>
<td>● Decision making guidelines to assist in multidisciplinary decision making</td>
<td>● Rotating of care team members</td>
</tr>
<tr>
<td>● Screen to identify patients at risk for complex discharges</td>
<td></td>
</tr>
<tr>
<td>● Discharge planning beginning at admissions</td>
<td></td>
</tr>
</tbody>
</table>
Figure 1

**Multidisciplinary Flow Diagram**

- **Pt Admission**
  - SW: Initial Assessment of pt with own assessment tool or triaging assessment
  - SW: Messaging care team about pt barriers to d/c
  - SW: Interviews family/caregiver to determine family goals, level of available support, pt PLOF
  - Coordination b/w therapy, RN and SW to bring in family/social supports to frame expectations for rehab in house and anticipated support upon d/c, continuing care needs
  - Documenting primary & secondary d/c recs
  - Therapy: initial evaluation of pt
  - d/c recommendations, DM/ADT needs, home modification needs
  - Process of ordering equipment and home modification initiated early
  - Therapy and RN work together to create routine for pt during their stay routine posted on white board, door
  - Report updates of supports or barriers to DC committee through secure chat
  - Monthly complex d/c committee meeting
  - CM, SW, MD therapy complete secure chat check-ins during week as needed and weekly secure chat check-in
  - Communication of d/c goals using d/c goals checklist during Multidisciplinary check ins & write identified areas for resolution on pt white board
  - Pt continues to rehab in house
  - Pt meets therapy goals
  - Pt to d/c home with family/supports once cleared from rehab or pt d/c to next level of care
  - RN/mobility tech/rehab tech aide carry over inpatient routines for pt until eventual d/c from hospital

- **Pt Discharge**
  - SW/C M continue to collaborate out of committee meetings to facilitate d/c
  - DC Committee comes to solution for no funding no social supports pt
  - Pt meets functional baseline with therapy d/c from rehab

- **Immediate referral to complex d/c committee**
- **Pt without funding/ Social Support/Place to d/c to**
- **Pt without funding, with social supports**
- **Coordination between therapy to see pts more consistently**
- **SW: Interviews family/caregiver to determine family goals, level of available support, pt PLOF**
- **Communication of d/c goals using d/c goals checklist during Multidisciplinary check ins & write identified areas for resolution on pt white board**
- **Pt continues to rehab in house**
- **Pt meets therapy goals**
- **Pt to d/c home with family/supports once cleared from rehab or pt d/c to next level of care**
- **RN/mobility tech/rehab tech aide carry over inpatient routines for pt until eventual d/c from hospital**

**Documentation of meetings/ updates to share with care team on EPIC**

**Monthly complex d/c committee meeting**

**Coordination between therapy to see pts more consistently**

**Immediate referral to complex d/c committee**
Figure 2

Discharge Goals Checklist

Discharge Goals Checklist

Room Number:  
Primary Care Team: 

Main Goals: (what goals will help the patient progress to their next level of care)

Multidisciplinary Objectives:
The patient has an: Arterial Line  Foley  Telemetry  Other:  
Consults have been placed for: OT  PT  Speech  Other:  
Diet orders:  

Precautions:  

Recommended DME/AE and environmental modifications:  

Family training required? Yes  No  If yes, scheduled for  
Disciplines requiring family training  OT  PT  Speech  RN  RT  Other:  

Multidisciplinary Objectives Continued:
Community services being engaged? If so, list:  

Recommended discharge location:  

Anticipated level of assistance needed:  

<table>
<thead>
<tr>
<th>Date</th>
<th>Team</th>
<th>Goal</th>
<th>Completed</th>
<th>Date Completed</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>
**Figure 3**

Rehabilitation Support Tool

<table>
<thead>
<tr>
<th>Care Team</th>
<th>Pt with No Funding/No Social Supports/Nowhere to Go</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Immediate referral through SW to complex d/c committee</td>
<td></td>
</tr>
<tr>
<td>□ Use of d/c goals checklist if appropriate between care team to guide multidisciplinary discussions</td>
<td></td>
</tr>
<tr>
<td>□ Communicate therapy goals for the week on white board</td>
<td></td>
</tr>
<tr>
<td>□ CM, SW, MD and therapy complete daily/weekly secure chat check-ins</td>
<td></td>
</tr>
<tr>
<td>□ Coordination between therapy to see patients more consistently if appropriate</td>
<td></td>
</tr>
<tr>
<td>□ OT &amp; PT alternating seeing pt MWF and TuTh once no longer needing co-tx or BID if possible/appropriate</td>
<td></td>
</tr>
<tr>
<td>□ Training rehab techs for specific transfers/ROM to get these patients up or perform ROM exercises on Tu &amp; Th if therapy doesn’t get to them as needed</td>
<td></td>
</tr>
<tr>
<td>□ Identify a fellow therapist in your respective profession to collaborate with for days off to promote consistency in care team</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Therapy, pt, &amp; RN work together to create routine for pt during their stay—RN activity order?</td>
</tr>
<tr>
<td>□ Communicate with RN in terms of BMAT scores for recommending routines</td>
</tr>
<tr>
<td>□ Write pt routine, HEP, toileting, bathing med schedule, diet recs etc. on white board</td>
</tr>
<tr>
<td>□ Use of Routine schedule on pt door</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Routine</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ d/c recommendations, DME/AE needs, home modifications, PO diet or permanent form of nutrition</td>
</tr>
<tr>
<td>□ Report updates of barriers to care team through secure chat</td>
</tr>
<tr>
<td>□ Pt meets functional baseline with therapy—d/c’d from rehab</td>
</tr>
<tr>
<td>□ RN/mobility techs carry over inpatient routines for pt until eventual d/c from hospital—RD activity order?</td>
</tr>
<tr>
<td>□ Complex d/c committee comes to a solution—pt d/c’d</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>D/C path</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Use of d/c goals checklist if appropriate between care team to guide interdisciplinary discussions</td>
</tr>
<tr>
<td>□ Communicate therapy goals for the week on white board</td>
</tr>
<tr>
<td>□ CM, SW, MD and therapy complete daily/weekly secure chat check-ins</td>
</tr>
<tr>
<td>□ Coordination between therapy to see patients more consistently</td>
</tr>
<tr>
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</tr>
<tr>
<td>□ Identify a fellow therapist in your respective profession to collaborate with for days off to promote consistency in care team</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>D/C Planning</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Therapy, pt, family &amp; RN work together to create routine for pt during their stay—RN activity order?</td>
</tr>
<tr>
<td>□ Communicate with RN in terms of BMAT scores for recommending routines</td>
</tr>
<tr>
<td>□ Write pt routine, HEP, toileting, bathing med schedule, medicine schedule, diet recs etc. on white board</td>
</tr>
<tr>
<td>□ Use of Routine schedule on pt door</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>D/C path</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ d/c recommendations, DME/AE needs, home modifications, PO diet or permanent form of nutrition</td>
</tr>
<tr>
<td>□ Coordination between SW and therapy to bring social/family supports in ASAP frame expectations for rehab in house and anticipated support upon d/c, continuing care needs</td>
</tr>
<tr>
<td>□ Report updates of social supports/barriers to care team through secure chat</td>
</tr>
<tr>
<td>□ Pt meets functional baseline with therapy—d/c’d from rehab</td>
</tr>
<tr>
<td>□ RN/mobility techs carry over inpatient routines for pt until eventual d/c from hospital—RD activity order?</td>
</tr>
<tr>
<td>□ Pt has not met all therapy goals but pt is indicated for d/c soon</td>
</tr>
<tr>
<td>□ Pt/family training completed</td>
</tr>
<tr>
<td>□ Communication with multidisciplinary team via check ins on secure chat to discuss any items that need to be addressed as a team using d/c checklist</td>
</tr>
<tr>
<td>□ Pt meets therapy goals. Family/social support meet therapy goals</td>
</tr>
</tbody>
</table>
Figure 4

Routine Checklist

Rehab in House Patient’s Daily Routine

- Diet orders:
- Feeding Assistance:
- Meds Consumed:
- Feeding Precautions:
- Safety Modifications:

- Chair Transfer via ________________________ with ☐ Rehab, ☐ RN or ☐ Mobility Tech
- Pt to complete ROM Exercises/HEP ________________________ a day ☐ UE ☐ LE
- Ambulating __________ Times a Day ☐ with ________________________ Device
- Mobility Precautions:

- Up to Bedside Commode
- Up to Toilet

- Bathing/Grooming:
- Oral care:

-
Figure 5

*Patient Specific Timed Routine*

<table>
<thead>
<tr>
<th>Time</th>
<th>Daily Schedule</th>
</tr>
</thead>
<tbody>
<tr>
<td>7:45 AM- 8:00 AM</td>
<td>Eats breakfast sitting on edge of bed with assistance from care tech or RN</td>
</tr>
<tr>
<td>8:00-8:30 AM</td>
<td>Oral pain medication</td>
</tr>
<tr>
<td>9:00 AM</td>
<td>Therapy session</td>
</tr>
<tr>
<td>9:30 AM</td>
<td></td>
</tr>
<tr>
<td>10:25-10:45 AM</td>
<td>Up to bedside chair following therapy – no more than an hour. Pressure relief</td>
</tr>
<tr>
<td>11:00-11:30 AM</td>
<td>Eats lunch sitting up in bedside chair or EOB with assistance from care tech or RN</td>
</tr>
<tr>
<td>11:45 AM</td>
<td><strong>IV Pain medication</strong></td>
</tr>
<tr>
<td></td>
<td>Transferred back to bed with mobility tech, RN or rehab tech using combi sling</td>
</tr>
<tr>
<td>12:00 PM</td>
<td>To Burn Unit for wound care and dressing changes</td>
</tr>
<tr>
<td>2:00 PM</td>
<td></td>
</tr>
<tr>
<td>4:00 PM</td>
<td></td>
</tr>
<tr>
<td>5:00 PM</td>
<td>Up to bedside chair or seated EOB for dinner with mobility tech or RN with combi sling</td>
</tr>
<tr>
<td></td>
<td>Eats dinner in bedside chair with assistance from care tech or RN</td>
</tr>
<tr>
<td>6:00 PM</td>
<td></td>
</tr>
<tr>
<td>7:00 PM</td>
<td>Return to bed using combi sling with mobility tech or RN</td>
</tr>
<tr>
<td>7:30 PM</td>
<td></td>
</tr>
<tr>
<td>8:00 PM</td>
<td></td>
</tr>
</tbody>
</table>
### Spinal Cord Injury Patient Routine

#### Feeding & Communication
- Diet orders:
- Feeding Assistance:
- Meds Consumed:
- Feeding Precautions:
- Safety Modifications:
- Communication:

#### Activity
- Chair Transfer via \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ with □ Rehab, □ RN or □ Mobility Tech
- Pt to complete ROM Exercises/HEP \_\_\_\_\_\_\_\_\_\_\_\_ a day □ UE □ LE
- Ambulating \_\_\_\_\_\_ Times a Day □ with \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Device
- Mobility Precautions:

#### Toileting
- Toileting:

#### Grooming
- Bathing/Grooming:
- Oral care:

#### Therapy Goals
- 
- 
- 

---

*Please Make Sure This Document Follows the Patient*
Appendix

List of Survey Questions Asked:

1. How likely are you to use the routine checklist in/outside patient rooms?
2. How likely are you to write patient routines on their white board?
3. The discharge goals checklist will be useful in multidisciplinary rounding/discussion
4. The rehab flow chart will help guide my approach with rehab in house patients
5. I understand the purpose of each step in the rehab flow chart