OCCUPATIONAL THERAPY NEEDS IN THE EMERGENCY DEPARTMENT

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HOW IS OT CONSULTED IN THE ED?

- **I. Screening (RN, case manager, MDs)**
  - Screen patient for possible OT needs (e.g. ADLs, caregiver training)
  - MD places consult and indicates specific requests
- **II. Evaluation/ Intervention**
  - Assess for functional impairments/ deficits, depending on diagnosis and comorbidities
  - Provide patient/ caregiver/ family training and education as indicated
- **III. Considerations**
  - Limited or lack of appropriate resources
  - Insurance, finances
- **IV. Discharge Planning**
  - Provide recommendations to patient/family & medical team (discharge location, rehab & equipment needs)
  - **Advocate** for your patient's needs

Goals

- Provide staff with education and resources to screen for OT appropriately
- Collaborate with medical team to optimize patient's function, independence, & safety
- Provide appropriate OT services for individuals in need

COLLABORATING WITH THE INTERDISCIPLINARY TEAM

- **Case manager:** coordinating safe discharge disposition, recommending adaptive equipment and durable medical equipment
- **Social work:** anticipating & identifying social barriers/needs (e.g. caregiver resources)
- **Nursing:** ensuring appropriate care and carryover in regards to ADLs & functional mobility
- **Medical doctors:** clarifying activity restrictions (e.g. weight bearing, ROM, spinal precautions), consulting for other services (e.g. orthotics/prosthetics, PM&R)
- **Physical & speech therapy:** co-treating & recommending services when indicated
- **Family/caregiver:** education, appropriate resources & training when indicated

WHY DOES IT MATTER?

- Hospital readmissions account for billions of dollars in annual Medicare spending
- Increased risk of hospital-acquired infections and complications
- 19.4% of patients discharged from acute care hospitals readmitted within 30 days, 51.6% within 1 year
- Personal burden on patients and families
- Examining predictors of readmission is crucial to avoid penalize for returning patients
- Early identification of patients with conditions or circumstances that place them at high risk for readmission, combined with risk-reduction strategies, can create a positive impact

(Roberts & Robinson, 2014)

CURRENT EVIDENCE SUPPORTING OT IN ACUTE CARE

OT is the only category in which additional spending had a significant association with lower readmission rates for three health conditions studied: heart failure, pneumonia, and acute myocardial infarction

Six areas of focus

- Caregiver training & education
- Assess cognition, safety, and ability to manipulate items (e.g. medication containers)
- Assess ADLs & need for AE/DME
- Work with PT to increase rehab intensity & improve patient's overall strength
- Home safety suggestions or modifications
- Safe discharge location

(Rogers, Bai, Lavin, & Anderson, 2016)

CURRENT LEGISLATURE: SB 1152

- Effective July 1 2019, aims to reduce "patient dumping" practices in CA hospitals
- Hospitals have more responsibility to ensure safe discharges for homeless patients
  - Homeless patients previously discharged back onto streets or shelters where they couldn't access appropriate care or resources
- New requirements under SB 1152
  - Discharge planning process includes appropriate referrals & resources (e.g. Appropriate shelter, mental health resources)
  - Ensure certain conditions are met: offering a meal, appropriate vaccinations and infectious disease screenings, weather-appropriate clothing, transportation to discharge destination, and providing necessary medication if the hospital has a retail pharmacy

(Jung, 2018)

Social Work Template – Homeless Patient Discharge

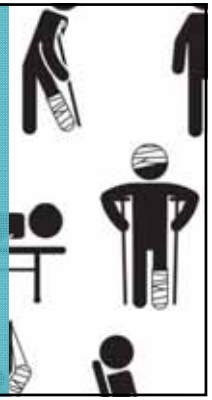
J. Taylor, personal communication, Feb 2020

CASE STUDY 1

- 26 year old R handed male, no significant PMHX
- Pushed into a wall (both elbows and wrists extended) during competitive basketball game
- X-rays showed minimally displaced L olecranon fracture & minimally displaced R distal radius fracture
- L elbow placed in hard cast (positioned in ~30˚elbow flexion), R wrist in resting hand splint
- NWB through L elbow & R hand x6 weeks
- No AROM L elbow & R wrist x4 weeks; no AROM restrictions fingers R hand, elbow, or shoulder
- Ambulates without issue but difficulty with all ADLs

CASE STUDY 2

- 65M PMHX DM2 (poorly controlled), diabetic neuropathy, low vision (legally blind in R eye), TBI 30 yrs ago with very mild cognitive deficits.
- Patient found down in bathroom by caregiver.
- ER course: L hip ORIF due to fracture s/p fall.
- NWB LLE x 8 weeks.
- PLOF: MOD INDEP; used SPC for longer distances. MOD I for extra time with ADLs. Private caregiver 3x/week x 3-4 hrs for IADLs. Lives alone, SSH, no steps.
- OT/PT co-eval: Supine<>EOB = Mod A to support trunk & LLE. Patient hopped 45 ft using FWW, with PT providing moderate to minimal tactile & verbal cues.
- Max to mod A with LB dressing, toileting.
- PT rec: home health PT & OT + 24/7 caregiver assist.
- OT rec: acute rehab.



CASE STUDY 3

- 96F admitted to ER from ALF 2/2 ground level fall.
- Intractable, severe back pain, & inability to ambulate or perform bed mobility/ ADLs x3 days.
- CT of T-spine showed new T8 compression fracture & 40% loss of vertebral height (compared to previous T-spine CT from 2018).
- PLOF: MOD I for household distances using 4WW, INDEP with ADLS; has caregiver to assist with all IADLs. No other AE/DME. No family.
- OT evaluation: Min A to Setup A with UB/LB dressing, Min A for supine<>EOB & log rolling, CGA to ambulate ~80 ft with 4WW.
- Consulted with orthopedic MD re: appropriateness of brace/ TLSO. Ultimately ruled out due to patient's severe kyphosis & decreased skin integrity.

CASE STUDY 4

- 55M s/p MVA, no significant PMHX, found to have pain & difficulty with cervical ROM
- ED course: C-collar placed due to C6 fracture (no surgery indicated), patient able to ambulate and discharged home within 10 hours of MVA
- Upon 24 hours d/c home, patient began to have intractable back pain & inability to mobilize despite taking prescribed pain meds, so he ended up staying in bed
- Returned to ED via gurney transport
- Full spine x-rays performed, indicated T7-8 fractures
- OT & PT consulted 3 days later while patient remained in ED
- Consulted with orthopedic MD for TLSO
- Consulted with PM&R for acute rehab

REFERENCES

Jung, H. (2018). Hospital patient discharge process: Homeless patients (SB 1152). Retrieved February 21, 2020, from Hospital Patient Discharge Process: Homeless Patients (SB 1152)

Roberts, P. S., & Robinson, M. R. (2014). Health policy perspectives—Occupational therapy's role in preventing acute readmissions. *American Journal of Occupational Therapy*, 68, 254–259. http://dx.doi.org/10.5014/ajot.2014.683001

Rogers, A. T., Bai, G., Lavin, R. A., & Anderson, G. F. (2016, September 2). Higher hospital spending on occupational therapy is associated with lower readmission rates. *Medical Care Research and Review, 1–19*. https://doi.org/10.1177/1077558716666981