**Comprehensive Discharge Planning and Hospital Readmission Rates**

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| Authors | Design | Methods | Findings | Applicability |
| Smith B et al, 2010 | Retrospective study | Calculated PT d/c recommendation versus actual d/c destination and reason for mismatch. Regression analysis performed to evaluate relationship between mismatch and hospital readmission.  | A patient was 2.9 times more likely to be readmitted when PT d/c recommendation was not implemented. The majority of mismatches occurred in patients who were discharged home. The most frequent reason for mismatch was patients who did not receive home therapy when recommended. 18% of the sample was readmitted to the hospital within 30 days.  | The results demonstrate how important the role is of a PT in the discharge process and that recommendation implementation can lead to more positive outcomes. |
| Naylor M et al, 2004 | RCT | Compared comprehensive discharge planning versus traditional planning via group differences in patient outcomes and charges for care; Only cardiac medical and surgical DRGs, patients admitted from home and patients without cognitive deficits were selected for this study.  | Patients in the medical DRG group had fewer readmissions with comprehensive discharge planning, fewer total days rehospitalized, lower readmission charges and lower charges for health care services after discharge. No difference was found between surgical DRGs and control group (traditional discharge planning). | Comprehensive discharge planning can lead to better patient outcomes with less or no increased cost.  |
| Lockery S et al, 1994 | Prospective cohort study | Patients interviewed during discharge planning and 30 days post discharge. Data analyzed to explore how hospital readmission rates are influenced by patient factors prior to hospitalization and the discharge planning process itself.  | 17% of 264 patients rehospitalized within 30 days of discharge. Factors associated included being white, female, average age of 75.3 years, lower/middle class socioeconomic status, single, and patients that lived alone prior to hospitalization.  | This information can be used to help identify individuals at a high risk for rehospitalizations. |
| Bull M et al, 2001 | Qualitative study | Interviews performed and data collected to identify components of effective discharge planning and factors that impede planning in a hospital in Southwest London.  | Four stages of proper hospital discharge for older patients: getting to know the patient, identifying initial discharge plans, preparing the patient for their return home, assessing the older adult’s transition back to the community following acute hospital stay. A multidisciplinary approach is vital. Communication is central to effective discharge planning in all stages.  | Open, honest communication between health care professionals and between health care professionals and the patient are imperative. PTs should have these skills as members of the multidisciplinary discharge planning team.  |

**Physical Therapist practice in acute care and the discharge planning process**

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| Authors | Design | Methods | Findings | Applicability  |
| Kasinskas C et al, 2009 | Survey | Survey administered to PTs in 28 various hospitals in Connecticut to examine the PT role in the d/c process | "The ability to transfer and ambulate", "the patient's cognitive status" and "having a person at home to assist" were top 3 considerations for d/c planning. Others included the patient's "home environment", "prior functional status", "medical/surgical diagnosis" and patient's "community resources".  | PTs in acute settings synthesize a multitude of information during the discharge planning process, which could contribute to more effective discharge recommendations.  |
| Jette D et al, 2003 | Qualitative study  | Grounded theory strategy used to interview PTs and OTs to generate a model that explains the relationship among constructs used in discharge recommendation decision making | A PT examines patients and collects info about their functioning and disability, wants and needs, ability to participate, and the context in which they live their lives. This with the PT’s experience forms an initial recommendation. The PT then considers health care system regulations and limitations placed on options for recommendations and shares opinions with other team members before deriving a final recommendation.  | This model can be used in the acute care setting, demonstrating the complexity of a PTs d/c decision-making process. The relationship between d/c destination and patient outcomes was not examined so it cannot be inferred that this model helps to improve accuracy of PT d/c recs. |
| Masley P et al, 2011 | Qualitative study | PTs were interviewed, constructs and themes developed using grounded theory method about acute care practice and clinical reasoning  | Four constructs suggest core of clinical reasoning; collection and analysis of clinical information, application of specialized physical therapy knowledge, communication to gain info, and communication to provide info. Three themes that suggest influences on clinical reasoning process; continual dynamic assessment, professional responsibility, and complex environment.  | Provides insight in to acute care practice and complexity of factors involved. |
| Gorman S et al, 2010 | Survey | PTs surveyed to address knowledge areas, professional behaviors, and patient/client management approaches that are specific to acute care. | PTs practicing in acute care have a unique skill set due to the medical instability and unpredictability of their patients and work environment including helping patients and caregivers navigate the complex medical system, having foresight to secondary complications, and advocating to ensure a patient’s maximal mobility and physical performance.  | PTs have to synthesize fluctuating medical statuses, concomitant comorbidities, health preferences and beliefs, and available resources (fiscal and human) in acute care environments.  |
| Jette D et al, 2009 | Observational study | PTs filled out check lists over 2 weeks of treating patients to identify what aspects of care they provided and to whom | Results suggest that PTs in acute care focus on functional activity. There was no clear pattern of examinations, goals, interventions, or combinations related to specific diagnoses.  | Variations across different diagnoses suggest that PTs focus on the individual and tailor the treatment and intervention as they see appropriate.  |
| Curtis K et al, 1993 | Survey | Survey questionnaire addressed frequency of PT eval and treatment practices, problems in delivering PT services, coordination of d/c planning, and perceptions of staffing trends in PT in light of changing health care environment.  | Since implementation of prospective payment system, patients have shorter lengths of stay at the hospital giving PTs less time to accomplish goals. Other factors that interfered with patients reaching goals included medical complications, organizational factors (staffing shortages, caseloads), healthcare system constraints (difficulty changing orders, limited time to work with patient). | Basic functional assessment, time management, caseload management, and patient education are key skills necessary for acute care PT practice and should be addressed by PT curriculum.  |
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**Physical therapy patient population demographics in North Carolina**

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| Authors | Design | Methods | Results | Conclusions |
| Freburger J et al, 2012 | Cross-sectional, descriptive study | Hospital discharge data from 2006-2007 from 128 acute care hospitals in NC were examined to identify common patient characteristics for those patients receiving PT.  | Joint replacements and stroke were 2 most common diagnoses receiving PT acutely. Other diagnoses included CVA, back problem, pneumonia, CHF, hip fracture, leg fracture, device complications, septicemia, respiratory failure, acute MI, COPD, other fracture, and UTI. No demographic associations found between joint replacements and PT utilization. Being older, on Medicaid, and being uninsured associated with PT and stroke.  | Study demonstrates common patient populations encountered in acute care.  |

Outcome Measure Utilization in Acute Care

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| Authors | Design | Methods | Results | Conclusions |
| Jette D et al, 2009 | Observational  | Survey administered to PTs to determine the utilization of outcome measures and perceptions regarding barriers | PTs were less likely to utilize outcome measures in acute care settings compared with outpatient and home health care settings. Top reasons for not using outcomes included that they take too much time to complete, too much time to analyze/score, are difficult for patients to complete independently, that they aren’t completed at discharge so they don’t show progress, and that they do not contain relevant items or questions.  | Further education about outcome measures that can be utilized in acute care, especially short and efficient measures, is important for PT curriculum.  |
| Ekstrand E et al, 2008 | Prospective longitudinal cohort study | COVS scores recorded at admission, discharge, and 3 months post-stroke onset | The COVS can predict LOS, d/c destination and future home facility at 3 months after stroke.  | This instrument could be used for early prediction, to enable effective planning of the services of the acute stroke unit and efficient discharge. |
| Unsworth C, 2001 | Cross-sectional study | FIM and RICFAS scores obtained within 3 days prior to d/c. D/c destination was recorded for patients. Stepwise discriminant function analyses performed to identify items that helped to predict d/c destination.  | Orthopedic patients: patient performance on stairs, bed transfers and eating using the Adult FIM is an accurate way to predict discharge destination. For stroke patients, the inclusion of data from four non-FIM variables in addition to adult FIM including instrumental ADLs, premorbid housing, premorbid cognitive status and social situation, improved prediction rates slightly | This can serve as a qualitative tool to use during discharge planning when the adult FIM is involved. For stroke patients, this can also cue a PT in to what other variables need to be considered along with FIM scores.  |
| Hinkle J, 2008 | Prospective study | Demographic data, FIM, Alpha FIM, and Barthel Index (BI) scores collected for 551 older adult patients, as well as discharge destination and any delays in discharge.  | All three tools found to be valid and reliable. Score averages found for patients discharging home, to a community hospital or other rehab, home with care package, death, further care, or transfer to other hospitals for each measure. Scores were significantly different between discharge destinations. | These measures should be used to help in the discharge planning process for older adults to give practitioners and idea of the patient’s level of function.  |
| Lo A et al, 2011 | Prospective observational study  | Data analyzed for 891 patients referred for inpatient stroke rehabilitation through an internet-based referral system to determine correlations between AlphaFIM rating and rehabilitation outcomes. | AlphaFIM instrument found to be significant in predicting admission and discharge FIM ratings at rehabilitation, as well as length of stay. AlphaFIM score inversely related to FIM gain.  | AlphaFIM is a valuable tool to use in acute care to facilitate discharge planning. Patients with lower AlphaFIM scores should not be denied rehab admission as they have the potential to make significant functional gains.  |

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