Self-study evaluation for ‘Discharge Planning in Acute Care Physical Therapy’:

1. Which of the following is not an effect of the Affordable Care Act?

A. Implementation of the Hospital Readmissions Reductions Program
B. Mandatory use of outcome measures in the hospital environment
C. Expanded healthcare coverage under Medicaid
D. Decreased payments to Medicare Advantage Plans

2. What factors should be considered when determining a discharge recommendation?

A. Patient’s ability to participate
B. Insurance coverage and financial resources
C. Functional level and prior level of function
D. All of the above

3. What is not covered under Medicare Part A?

A. Outpatient therapy services
B. Inpatient hospital services
C. Skilled nursing facility services
D. Hospice Care

4. Which outcome measure is appropriate for use in the acute care environment, can help to predict discharge destination, and has four subscales including mental status, bed mobility, transfers, and mobility?

A. FIM
B. Physical Function ICU Test
C. Barthel Index
D. Acute Care Index of Function

5. James is a 68 y/o M admitted to the hospital following MVA. Pt is NWB on LUE and LLE and has spinal precautions, requiring Aspen collar. Pt requires max assist of 1 to transfer supine to/from sit and sit to/from stand. Pt requires max assist of 1 to transfer to w/c. Pt requires constant verbal cues for NWB status and spinal precautions. Pt does not tolerate 15 min PT sessions well. Pt lives alone with no family in the area. Pt has Medicare part A and B. What is your recommendation for discharge?

A. Inpatient rehabilitation
B. Home with home health
C. Skilled nursing facility (SNF)
D. Long term acute care (LTAC)

Answers:

1. B
2. D
3. A
4. D
5. C – patient would not be appropriate for inpatient rehabilitation at this level due to his apparent inability to tolerate the necessary 3 hours of therapy. Pt’s insurance coverage allows skilled nursing facility coverage. Patient would be appropriate to receive therapy at SNF in hopes of discharge either to inpatient rehabilitation or home following stay at SNF.