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American Academy of
Physical Medicine and Rehabilitation

Physicians Adding Quality to Life®

American Academy of Physical Medicine and Rehabilitation Position Statement:

Physiatrists Role in Skilled Nursing Facilities

Physiatrists have the knowledge and expertise to serve an important patient care and leadership role in all post-acute care (PAC) settings, including Skilled Nursing Facilities (SNFs). Physiatrists are optimally suited by way of the unique combination of medical and functional knowledge and expertise to achieve the highest functional outcome for patients at the least financial cost to our society.

Post-Acute Care Settings

Post-acute care is defined by CMS as care after an acute hospitalization that includes treatment in an Inpatient Rehabilitation Facility (IRF), Skilled Nursing Facility (SNF), Long-term Care Hospital (LTCH) and Home Health Agency (HHA). The selection of the appropriate PAC setting for an individual patient largely depends on the diagnosis, functional status, expected gains in function and ability to participate in therapy, but there are several important non-clinical factors to consider. Some of these factors include geographic availability of various types of PAC settings, patient preference for a PAC setting close to home, home accessibility and level of caregiver assistance available at the time of discharge. The availability of funding is another important factor that influences the selection of PAC location.

Inpatient Rehabilitation Facilities (IRFs)

Inpatient Rehabilitation Facilities (IRFs) serve patients with complex rehabilitation needs and are highly regulated regarding patients admitted, physician involvement and the requirement for intensive therapy services, (generally considered to be 3 hours of therapy per day, 5 days per week, although there are other ways to define intensive therapy services). In 2014, there were about 1,180 IRFs in the United States and Medicare fee for service covered about 339,000 beneficiaries in 376,000 IRF stays.[1] There are increasing restrictions on IRF admissions and pressure to reduce the overall length of stay in IRFs to provide an efficient treatment program while maximizing functional outcomes.

Skilled Nursing Facilities (SNFs)

When patients have rehabilitation needs that do not require the intensity of interdisciplinary services provided in an IRF setting, they may benefit from a rehabilitation program to optimize recovery and functional outcomes in a SNF setting. Skilled Nursing Facilities are an increasingly important setting for provision of rehabilitative care in the United States health system, with more patients receiving rehabilitation treatment in SNFs than in hospitals and acute inpatient rehabilitation units. In 2014, about 15,000 skilled nursing facilities provided skilled care to 1.7 million patients and 2.4 million Medicare fee for service covered stays.[2] Skilled Nursing Facilities vary considerably in their ability to provide a rehabilitation treatment program. Rehabilitation in a SNF setting is often described as subacute rehabilitation, but subacute rehabilitation does not have a consistent definition and is not defined in Medicare or other regulations. Medicare does define criteria for designation as a skilled nursing facility. "Skilled nursing facilities (SNFs) provide short-term skilled nursing care and rehabilitation services such as physical and occupational therapy and speech-language pathology services."[3] Medicare will cover up to 100 days of SNF care after a hospital stay of at least 3 days. Medicare has detailed regulations regarding funding of a patient stay in a SNF. Medicare will cover SNF level care if all of the following are met:

- The patient requires skilled nursing services or skilled rehabilitation services, i.e., services that must be performed by or under the supervision of professional or technical personnel; are ordered by a physician and the services are rendered for a condition for which the patient received inpatient hospital services;
- The patient requires these skilled services on a daily basis and;
- The daily skilled services can be provided only on an inpatient basis in a SNF.

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- The services delivered are reasonable and necessary for the treatment of a patient's illness or injury, i.e., are consistent with the nature and severity of the individual's illness or injury, the individual's particular medical needs, and accepted standards of medical practice. The services must also be reasonable in terms of duration and quantity.[4]

Medicare goes on to define skilled services as when "the inherent complexity of a service prescribed for a patient is such that it can be performed safely and/or effectively only by or under the general supervision of skilled nursing or skilled rehabilitation personnel."[5] In addition it is expected that the medical record documents patient goals, the treatment plan, team coordination, the patient's progress toward achieving those goals and the ongoing need for skilled services.[6] Medicare does not specify the intensity of therapy services provided in a SNF and the attending physician is required to see the patient only every 30 days.

Physiatrists Role in SNFs

Physiatrists are medical specialists in Physical Medicine and Rehabilitation (PM&R) who have expertise in rehabilitation management and work to assure the highest quality of rehabilitative care in the most cost-effective manner so patients will achieve the highest level of functional ability and quality of life.

Physiatrists have a well-established role in the leadership and medical management of IRF programs in medical centers and freestanding rehabilitation facilities. The role of the rehabilitation physician in the IRF is regulated by the Center for Medicaid and Medicare Services (CMS). CMS requires a rehabilitation physician, defined as a physician with specialized training and experience in rehabilitation services, serve as the supervising physician in the IRF setting. CMS regulations state, "A primary distinction between the IRF environment and other rehabilitation settings is the high level of physician supervision that accompanies the provision of intensive rehabilitation therapy services."[7]

Physiatrists have historically had variable levels of involvement in SNFs, but physiatrists can serve an important role in this setting to help assure the highest quality outcomes and the most efficient use of resources. Physiatrists, by virtue of their training, experience and knowledge of rehabilitation, impairment and function have the unique qualifications and expertise to be the leader of the SNF rehabilitation team. In the ideal situation, a physiatrist in a SNF setting will serve in a consulting or co-treating physician role and visit the patient two to three times a week depending on the needs of the patient. Physiatrists can also serve as the SNF medical director and/or be the attending physician in some situations. Patients receiving a SNF rehabilitation level of care may not need the same frequency of physician visits as patients receiving an IRF level of care,[8] but their rehabilitation requires more frequent physician oversight than that mandated for primary attending physicians in SNF settings. Close communication with the primary attending physician is essential for high quality patient care. The physiatrist will not just track the medical status of the patient but will track and document the patient's functional status demonstrating progress toward goals and identifying barriers to reaching functional goals. Physiatrists will also provide medical services such as treatment of spasticity or pain that is limiting functional gains and will make recommendations for further medical evaluation and treatment. When clinically appropriate, they will additionally identify and prescribe adaptive or assistive devices for safety and to further facilitate function.

To expand the role of physiatrists in SNF settings it will be necessary to educate SNF staff on all aspects of the rehabilitation model of care with which they may not be familiar. This includes education on the need for coordinated, physician led rehabilitation treatment that includes weekly team meetings to discuss the patient's functional status, barriers to discharge, expected length of stay and other factors. A focus on setting functional goals and utilizing an evidence-based model for rehabilitation treatment while including patient and family engagement and factoring in patient and family goals and expectations is also important. As the leader of the SNF rehabilitation team, the physiatrist will set functional goals for the patient and closely monitor the progress toward those goals and barriers to achieving the goals. The physiatrist will also set the discharge goals and will work to manage the patient stay and facilitate the transition to the next setting in a timely manner.

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The physiatrist must also work with the SNF administration, nursing and therapy leadership to monitor the quality of rehabilitative care in the SNF, performance improvement and work with funding agencies to determine the appropriate level of care.

Conclusion

There is increasing pressure in the healthcare system to provide high quality, efficient rehabilitation care to patients across PAC settings including SNFs. In the future, more patients will be receiving their rehabilitation care in a SNF setting. Physiatrists have unique expertise and should take an active role in this setting. Physiatrists will focus on the coordination of the rehabilitation team, set functional goals, manage medical and other complications related to the rehabilitation diagnosis, minimize hospital readmissions, and work to transition the patient to home as quickly and safely as possible. The physiatric management of patients in the SNF setting will lead to greater functional gains by the patient, earlier discharge and cost savings for the healthcare system. ■

REFERENCES

1 MedPAC Report to the Government, March 2016, Medicare Payment Policy, Chapter 9, page 237 (available online at **http://www.medpac.gov/documents/reports/march-2016-report-to-the-congress-medicare-payment-policy.pdf?sfvrsn=2**).

2 MedPAC Report to the Government, March 2016, Medicare Payment Policy, Executive Summary, page xvi (available online at **http://www.medpac.gov/documents/reports/march-2016-report-to-the-congress-medicare-payment-policy.pdf?sfvrsn=2**).

3 MedPAC Report to the Government, March, 2016, Medicare Payment Policy, Chapter 7, page 179, (available online at **http://www.medpac.gov/documents/reports/march-2016-report-to-the-congress-medicare-payment-policy.pdf?sfvrsn=2**).

4 Medicare Internet Only Manual 100-02, Medicare Benefit Policy Manual, Chapter 8, Section 30 (available online at **https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c08.pdf**).

5 Medicare Internet Only Manual 100-02, Medicare Benefit Policy Manual, Chapter 8, Section 30.2.2 (available online at **https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c08.pdf**).

6 Medicare Internet Only Manual 100-02, Medicare Benefit Policy Manual, Chapter 8, Section 30.2.2 (available online at **https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c08.pdf**).

7 Medicare Internet Only Manual 100-02, Medicare Benefit Policy Manual, Chapter 1, Section 110.2.4, (available online at **https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c01.pdf**.

8 Rehabilitation physicians in IRFs are required to see their patients at least 3 times per week, but often see the patient daily. Physicians seeing patients in a SNF are only mandated to see the patient at least once per month.