A New Era in Acute Care

Gwenn Rausch
Jeanne L. Melvin

Occupational therapy in acute care is facing new challenges in the 1980s. The economic climate of our nation's health care system necessitates a closer scrutiny of all ancillary service utilization as a method of cost-containment (1, 2). Internally, our profession is directing its attention toward role definition in alternative delivery systems (3, 4). Both of these forces affect occupational therapy practice in acute care and challenge us to shape a well-defined, cost-effective service model. This special issue is intended to facilitate the definition of roles for the practice of occupational therapy in acute care settings.

The articles included in this issue represent a sampling of the many specialized clinical programs that have been developed in acute care. Articles on clinical practice in acute care are noticeably absent in the physical disabilities literature of occupational therapy. The treatment programs described by the authors illustrate the special skills and the consideration necessary for applying traditional occupational therapy in an acute setting with patients who frequently are medically unstable.

We have identified several topics of concern to acute care occupational therapy managers for discussion. They include (a) identifying priorities in patient treatment, (b) determining target patient groups, and (c) defining staff attributes and skills and marketing services to physicians. We hope these discussions provide impetus for program development within the constraints imposed by the Prospective Payment System (PPS).

Identifying Priorities in Patient Treatment

Selecting the treatment focus for the diverse and complex patient population of a general acute care hospital in which the average length of stay is 7 days and includes a period of complete bed rest is a major challenge.

Recently, at Northwestern Memorial Hospital we were faced with the Joint Commission on Accreditation of Hospitals (JCAH) requirement of establishing a patient priority system (5). The process of deciding which patients would receive treatment during times of unexpected staff absences or seasonal caseload peaks led to the identification of treatment priorities. In this facility three priorities stood out. The first was self-care training, especially feeding and personal grooming and hygiene care; the second was splinting and fabrication of special positioners; and the third was facilitation of alertness, cognitive function and movement.

The fabrication of orthotics and positioners attained a high priority because these devices often are an integral part of surgical intervention or were required to preserve joint integrity after injury; their
effective use shortens the course of rehabilitation or recovery.

The facilitation of alertness, cognitive function, and movement was given a high priority because these functions are early indicators of long-term recovery and rehabilitation potential. The facilitation of these functions requires a consistent approach, technical accuracy in applying facilitation techniques, and accurate observation of change. A delay or an interruption of this treatment could impede the recovery and rehabilitation.

Once verbalized, these priorities became the basis for a "working" philosophy of acute care. They express the belief that the ability to perform basic self-care is intimately connected with recovery from illness and essential for successful timely discharge.

The acceptance of this philosophy of occupational therapy intervention, which specifies that self-care function and posttrauma splinting take precedence over diagnostic testing, strengthening, and coordination, has also resulted in a more goal-directed and productive use of the therapist's time.

Once our philosophy and priorities were established, we determined that our protocols of care would include simultaneous evaluation and treatment implementation, in other words, treatment intervention would not be delayed because of an incomplete evaluation.

Determining Target Patient Groups

It is often the nature of occupational therapists and other health care professionals to attempt to "do everything for everybody." In a period of limited resources, this approach to patient care is neither rational nor effective. As a means of classifying the types of acute care patients referred to occupational therapy, the following categories were developed. They are proposed as one possible method of determining the allocation of occupational therapy staff and resources.

The first category is the single-episode or injury population, which includes patients admitted for total hip replacement or hand injury. These patients typically have a short hospitalization with a predictable course of treatment. Programs provided for these patients immediately focus on self-care training to facilitate discharge to the home or on positioning and splinting fabrication to prevent the loss of motion. Follow-up occupational therapy treatment in the home or outpatient clinic is planned immediately. This avoids the duplication of evaluation and splinting.

The second group includes patients in the acute phase of long-term rehabilitation such as those with head trauma, cerebral vascular accident, and spinal cord injury. The length of acute care hospitalization for these patients is more variable, and the patients often have life-threatening medical complications. The priorities for this population are to promote immediate involvement in self-care or to facilitate alertness, to prevent deformities or loss of motion, and to determine the rehabilitation potential and discharge rehabilitation needs. Whenever possible the acute care course of occupational therapy is closely coordinated with the rehabilitation team. As described in the article by Sargant and Brown in this issue, coordinating protocols for selecting splints and initiating self-care tasks should be developed with the rehabilitation team to avoid the duplication of effort and to reduce the period of rehabilitation.

The third group of acute care patients referred to occupational therapy encompasses the many chronically ill patients admitted for an acute exacerbation, surgical procedure, or concomitant disease. This includes individuals with diabetes, multiple sclerosis, cardiac conditions, arthritis, or cancer. This group of patients stays for an unpredictable length of time and may need a period of complete bed rest. The patient's recovery and discharge may be complicated by anxiety, depression, and physical debilitation. The intervention with this group may be periodic. Initial treatment might include splinting and environmental modifications as well as a documentation of current functional abilities. As the patient's condition stabilizes, a program of progressive activity may ensue. Often only a day or two of active treatment and assessment is allowed before the discharge placement must be determined. The
articles by Watson and Malamud, which appear in this issue, illustrate the treatment for patients in this category.

The fourth type of patient includes those admitted for invasive diagnostic testing or the regulation of medications. The diagnoses included in this group are new acute back injury, poorly controlled diabetes, and Parkinson's disease. The course of hospitalization for these patients typically is brief and relatively predictable, and it may include activity restrictions. The inpatient occupational therapy intervention for this patient group will, in most cases, be limited in duration and frequency. Instruction and training in work simplification, body mechanics, joint protection, or activity pacing are needed to prevent deterioration. Splints and strengthening activities may often be accomplished during outpatient follow-up visits. Exceptions to this are individuals who are not independent or reliable in the self-care tasks required for discharge. The article by Caruso and Chan, which appears in this month's issue, is an example of this course of intervention.

These categories of acute care patients referred to occupational therapy are not intended to be all-inclusive or restrictive. However, they may serve as guidelines when service cutbacks or seasonal case-load fluctuations require the use of a patient priority system. They may also facilitate viewing occupational therapy intervention as a continuum of which acute care occupational therapy is only the beginning.

**Staff Attributes and Skills in Acute Care**

Selecting staff for acute care can present a serious challenge, particularly in areas where the supply of therapists is inadequate. Because treatment is often conducted at the patient’s bedside and not infrequently in intensive care units, the opportunities for direct staff supervision are limited. Additionally, very little, if any, time is available for developing "patient rapport." These factors often preclude hiring inexperienced staff.

At Northwestern Memorial Hospital, the ideal therapists for acute care positions are individuals with a demonstrated area of clinical expertise and willingness and enthusiasm for treating the different kinds of patients found in acute care. Therapists with fieldwork experience at a hospital, who have had the advantage of working under the supervision of an expert clinician, may perform well on occupational therapy programs with established protocols.

A target skill for the acute care therapist is the ability to integrate evaluation, treatment, and patient instruction into each therapy session. This is affirmed by Baum’s proposal that a primary function in acute care occupational therapy is triage (6). The therapist must immediately assess which treatments are needed, document self-care potential for discharge planning, and recommend the appro-

---

**AOTA Resources for Acute Care Management**

The following resources have been or will be published by the American Occupational Therapy Association, 1383 Piccard Drive, PO Box 1725, Rockville, MD 20850-4375. To make a purchase or to get some information on any of the listed items, contact AOTA’s Products Division or the other divisions mentioned.

5. The Commission on Practice is developing documentation standards, and the AOTA Practice Division plans to develop a monograph for documentation guidelines related to specific service delivery areas.
6. The Quality Assurance Division has a series of efficacy data briefs available that describe research studies showing the relationship between occupational therapy and the beneficial outcome of care.
7. Marketing and public relations materials are available through the Public Affairs Division.
8. A videotape providing an orientation to PPS is available from the Products Division.
appropriate setting for continued rehabilitative care.

Not to be overlooked is the skill and precision that the therapist needs to have to work with the medically unstable patient. An in-depth knowledge of medical and surgical procedures is needed to confidently initiate self-care training, splinting, or sensory stimulation with these patients. At Northwestern Memorial we have identified occupational therapy experts in orthopedics, neurosurgery, and spinal cord injury to provide technical assistance for patients with complex needs. In addition, JCAH guidelines imply that therapists are required to be proficient in basic cardiopulmonary resuscitation (7).

Marketing Services to Physicians

The Prospective Payment System has placed increased responsibility on physicians to exercise care when selecting the ancillary services provided for their patients (8). The conservative use of diagnostic tests, pharmaceuticals, and therapeutic services is prompted under a system of diagnostic-related, fixed reimbursement. However, when services or treatments are demonstrated to facilitate the recovery of the self-care abilities that the patient needs to leave the acute care environment, these services or treatments become highly desirable.

Certain factors contribute to successfully negotiating a place for occupational therapy in the treatment regimen of diagnostic groups with fixed reimbursements. First, the proposed treatment should have a readily observable outcome. Second, the frequency, intensity, and cost of treatment should be consistent and predictable. Third, the therapist involved should be intimately aware of the physician’s protocol and guidelines for progressing the treatment. (Ideally, the physician will contribute to the development of a therapy protocol for his or her patients and adequately advise the therapist of precautions to be taken.)

The clear, concise, and timely documentation of a patient’s level of function or dysfunction can be valuable to a physician responsible for determining the most appropriate discharge plan for his or her patient. The occupational therapist’s documented assessment of a patient’s rehabilitation potential, psychological coping, and performance in basic life skills (feeding, dressing, and grooming) is an important resource to many physicians concerned about the total care of their patients.

Summary

Acute care continues to be the primary place of employment for occupational therapists. It is a challenging environment that requires the skills of our most experienced practitioners. Because the acute care hospital is likely to remain an entry point for rehabilitative care, this area of practice warrants continued attention in our professional literature. We hope this issue will stimulate therapists to write more articles, conduct more research, and develop more programs in acute care occupational therapy.

REFERENCES


RELATED READINGS
