REHABILITATION/POST-HOSPITAL CARE OF THE GERIATRIC FRACTURE PATIENT

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WHAT IS COVERED

• Recovery rates post-fracture
• Goals and variables
• Rehabilitation across settings
• Subacute (SNF) rehabilitation
• Home care and falls assessment
• Transitions across settings
MORTALITY AFTER GERIATRIC HIP FRACTURE

• 7% at 1 month
• 13% at 3 months
• 24% at 12 months
• 50% at 6 months for patients with end-stage dementia
• Fracture is marker of frailty
• Mortality increases with:
  ➢ Uncontrolled systemic disease
  ➢ Multiple comorbidities
  ➢ Dementia

FUNCTIONAL RECOVERY AFTER GERIATRIC HIP FRACTURE

• Pre-fracture ability and post-fracture complications drive recoverability

• At 6 months:
  ➢ 60% recover pre-fracture walking ability
  ➢ 50% recover pre-fracture performance of ADLs
  ➢ 25% recover pre-fracture performance of IADLs

• At 12 months:
  ➢ 54% able to walk unaided
  ➢ 40% able to perform all ADLs independently
  ➢ 25% require long-term SNF placement

REHABILITATION GOALS

• Regain function
• Pain control
• Maintain ROM and strength of unaffected limbs
• Restore ROM and strength of affected limb
• Clarify long-term needs and develop care plans
• Communicate prognosis
• Prevention of:
  ➢ Pressure sores
  ➢ Constipation
  ➢ DVT
  ➢ Pneumonia
  ➢ Depression
VARIABLES AFFECTING REHABILITATION

- Pre-fracture chronic disease control
  - COPD, CAD, HTN, DM, arthritis, CHF, anemia, incontinence, vision, hearing, malignancy, nutrition
- Cognitive status
- Mood
- Delirium
- Pre-fracture ambulatory status
- Weight-bearing status
- Type of fracture and repair
REHABILITATION ACROSS SETTINGS

• Continual process from hospital to SNF to home/LTC
• Acute vs. subacute rehab: no differences in outcomes for geriatric fracture patients
• >5 PT sessions per week likely beneficial
• A systematic home-based program may be effective
• No significant data supporting or refuting ongoing home rehab s/p traditional rehab program

ACUTE, IMMEDIATE POST-OP REHAB

- Pain control
- Stand, transfer
- Walker use instruction
- Early unrestricted weight-bearing accelerates hospital d/c without increasing risks of operative complications
- Full weight-bearing vs. non-weight-bearing exercises: similar outcomes in strength, balance, and function

SUBACUTE (SNF) REHAB

• Up to 100 days covered by Medicare if 3-day hospital stay

• Regional and facility variations

• Interdisciplinary care usual and mandated
  
  PT     Social work
  OT     Recreational therapy
  Medical    Nutrition
  Nursing    Clergy
SUBACUTE (SNF) REHAB PARTNERSHIP CONSIDERATIONS

- Full time, on-site medical staff
- Dedicated transitional care/rehab unit
- Ability to manage parenteral meds, multidrug-resistant organisms, medical comorbidities
- Shared electronic data systems
- Financial/institutional relationships
- Weekend therapy and admission ability
- Location
HOME CARE

• Requires order from physician
• Generally short and episodic care only
• Frequency of visits limited
• Post-rehab ongoing home therapy not proven effective to improve function or decrease repeat falls
  ➢ However, may be of benefit for other reasons
FALLS ASSESSMENT

• In-home assessment and intervention not yet proven effective
  ➢ PROFET
  ➢ FACT — ongoing in New Zealand
    • Health assessment
    • Home hazard identification
    • Bone health assessment and treatment
    • Structured exercise program

• PQRI 2008 — Screening for Future Falls Risk
ELEMENTS OF FALLS ASSESSMENT

• Predisposing risk factors/ diseases

• Balance and gait assessment
  ➢ Single best means of identifying pts at risk:
    • Get Up and Go
    • Performance Oriented Assessment of Mobility

• Review of previous fall situations
FALL PREVENTION

• Environmental modifications
  ➢ Lighting, rugs, toys, pets, bed/chair height, bars/rails

• Endurance, resistance, flexibility and balance training effective (FICSIT)

• Medication management
  ➢ Orthostasis, psychoactives, anticholinergics

• Vision exam and cataract removal

• Talking and walking
TRANSITIONS IN CARE

“...random events connected to highly variable actions with only a remote possibility of meeting implied expectations.”

Roger Resar, MD
Senior Fellow, Institute for Healthcare Improvement
POOR TRANSITIONS

• Duplication of tests and services
• Medication errors
• Increased costs
• Increased readmissions
• Patient/family dissatisfaction
• Friction among clinicians

Coleman. JAGS 2003;51:549-555.
COMPONENTS OF A SUCCESSFUL TRANSITION

- Communication clinician : clinician
- Communication clinician : patient/caregiver
- Medication reconciliation
- Patient self-care knowledge \(\rightarrow\) “What do you need to make the next move?”
- Clearly defined follow-up expectations
- Mindset of continuous management

Coleman. JAGS 2003;51:549-555.
DISCHARGE SUMMARY ELEMENTS FOR GERIATRIC FRACTURE PATIENTS

• Baseline and current functional status
• Medication reconciliation
• Requirements for durable medical equipment
• Advance directives
• Statement of prognosis
• Disposition: From → To in short term → To in long term
• Complete and accurate summary of complications
• Listing of involved clinicians and contact info
THANK YOU FOR YOUR TIME!

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