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DISCHARGE OUTCOMES: AN EVALUATION

OF A FUNCTIONAL INDEX

OF PHYSICAL ASSISTANCE

by

Jan R. Snell

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A Publishable Paper in Lieu of a Thesis in

Partial Fulfillment of the Requirements for the

Degree Doctor of Physical Therapy

———

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ABSTRACT

DISCHARGE OUTCOMES: AN EVALUATION
OF A FUNCTIONAL INDEX OF PHYSICAL ASSISTANCE

by

Jan R. Snell

The purpose of this study was to determine if there is a relationship between a functional score given to the patient on the day of discharge from an acute setting and the setting to which the patient is discharged. There were 102 subjects (58 female, 44 male) included in the study and their ages ranged from 20 to 91 years (mean age=61.6 years). The following data were collected on all subjects: age, gender, diagnosis, past medical history, duration of hospital stay, duration of physical therapy, reason for discharge, family support, type of insurance, and Physical Assistance Key (PAK) score on day of discharge. A significant difference in the means of the PAK scores was found between those who were discharged home and those who were discharged to inpatient rehabilitation (Rehab) or skilled nursing facility (SNF). Diagnosis was most significant when comparing those discharged home independently versus home with physical therapy and also those discharged to Rehab versus SNF. Function was found to be a consistent variable for matching a patient with an appropriate discharge destination when comparing home to inpatient care of Rehab or SNF.

Key Words: Discharge, Outcomes, Function, Physical assistance.

The American Hospital Association defines discharge planning as an interdisciplinary hospital wide process that should be available to help patients and their families develop a feasible posthospital plan of care.[1] Effective discharge planning is a multidisciplinary task requiring input from all persons involved in the care of a patient.[2,3,4,5] Studies have shown that discharge planning can help with reimbursement and decrease costs.[1,2,6,7] For example, Evans and Hendricks[1] noted that patients who needed more assistance with discharge placement tended to be discharged significantly sooner than those who were not identified early on in their stay. Other studies concluded decreased length of stay in the hospital and efficient patient care go hand-in-hand with decreased spending.[6,8] Poor discharge planning can lead to unnecessary hospital delays and misuse of funds.[6] Because of the present constraints on resources, each health care professional must be accountable for efficient and cost effective management of hospital resources. A study by Jahnigen et al.[9] demonstrated that a major factor in controlling health care costs is early intervention and discharge planning which reduce unnecessary nursing home placement.

Numerous studies identify functional classification systems that estimate the severity of the disability but overlook potential for recovery.[10] A variety of assessment tools have been developed to determine length of stay or discharge from the hospital. Factors such as age, past medical history, type of insurance, patient/family preference, physician preference, and cognitive deficits have been used traditionally in determining time and destination of discharge from the hospital. Thorngren et al.[11] and Cedar[4]

described more functional variables for discharge to home, yet these variables were not clearly defined and continue to be qualitative measures that risk a wide range of interpretation versus more specific objective measures.

Parsons et al.[12] conducted a retrospective, quantitative study using data from the Monica project that was completed by the World Health Organization on patients admitted for acute myocardial infarctions. The authors wanted to determine whether data such as pulse, past medical history, symptoms, and Q wave readings soon after admission could provide a dependable prognostic indicator of survival. These authors concluded that this prognostic indicator could stratify patients in the appropriate risk group for cost effectiveness. The results showed that it could be beneficial to use this type of prognostic index soon after admission to determine patients with a low risk of death and possible early discharge, but the authors suggested a prospective study to determine feasibility of this method.

Another quantitative measure of discharge planning from ambulatory surgery was developed by Chung[13] and was called the Post-Anaesthesia Discharge Scoring System (PADDS). This system uses the following commonly observed physical signs: (1) vital signs (blood pressure, heart rate, respiratory rate, and temperature); (2) ambulation and mental status; (3) pain and nausea/vomiting; (4) surgical bleeding; and (5) fluid intake/output.[13] The PADDS involves assigning a numerical value to each of the five variables so that progress is more easily assessed. Thus, a consistent method for determining home readiness is accomplished. PADDS also provides a technique for objective patient assessment that can direct care.

Stineman et al.[10] discussed the importance of developing a diagnostic tool or index for functional recovery in adult rehabilitation patients by combining information from various disciplines. They constructed a pilot index for clinical use called the RAM (Recovery ADL and Mobility) index. The main advantage of the RAM index was to summarize assessment from various services into a single value. Such an index can be used for planning of the patient's course of treatment, counseling/education of the patient and family, or to compare expected with actual outcomes. Thus, a patient's hospital course can more efficiently and accurately be planned from day of admission.

Inpatient acute care may benefit from an objective system that can combine the assessments of many disciplines into a quantitative measure that can be understood by all. Lohman's Outcomes Specialty Systems/Software, or L.O.S.S., combines the scores from the areas of physical therapy, occupational therapy, and speech therapy and determines a single value for the patient's functional status. This particular study used the Physical Assistance Key (PAK) portion of the software to score the patient based on basic activities of daily living such as transfers, personal care, locomotion, and excretory management.

The purpose of this study was to determine if there was a relationship between the PAK score given to a patient on the day of discharge and the destination at discharge from an acute care setting. Age, gender, diagnosis, past medical history significance, duration of hospital stay, duration of physical therapy, presence of family support, and PAK score were the variables used throughout the data analysis to determine the most significant factor in matching a patient to their most appropriate destination at discharge.

Method

Subjects

For the period from February 1, 1997 to March 31, 1997, consecutive acute

patients receiving physical therapy at Loma Linda University Medical Center (LLUMC)

were assessed on the day of discharge from the acute setting and assigned a PAK score.

Informed consents were signed by each subject allowing for the following

information to be recorded from the chart: age, gender, diagnosis, past medical history,

duration of hospital stay, duration of physical therapy, reason for discharge, if there is

family support, and type of insurance. All subjects were being discharged to one of the

following four areas: skilled nursing facility (SNF), inpatient rehabilitation (Rehab), home

with physical therapy, or home independently.

PAK Score

The PAK score includes evaluation of transfer activities, self-care activities,

locomotion, and excretion management. The key for scoring is based on a number system

for level of independence (Appendix A). A person who is unable to complete task would

be scored a 0 and independent without an assistive device would be scored a 6 for each

component of the key. Possible PAK scores range from 0 to 108 total points.

Testers

The two testers were physical therapists employed at LLUMC's acute level of

care. Both testers primarily treat in the area of acute inpatient care and frequently perform

discharge assessments. Both testers were oriented to the PAK and then the test was

implemented without further instruction. Intertester reliability was evaluated by both

testers assessing the patient and recording the PAK score independently for 18 randomly chosen patients. The correlation between the tester's scores was r = 0.98.

Data Analysis

A one-way ANOVA was used to compare the means of the PAK score, duration of hospital stay, and duration of physical therapy among the four destinations at discharge. A Duncan multiple range test was performed to determine if there was a significant difference in means for each of the three variables among destinations at discharge. A Chi-square test for independence evaluated the relationship between the discharge destination and the physical therapists' recommendation for discharge. Discriminant analyses were performed to determine which variables were the most significant or best predictors of discharge destination. The following variables were used for each discriminant analysis: age, diagnosis, duration of physical therapy (PT), duration of hospital stay, family support, gender, PAK score, and significance of past medical history.

Results

The subjects in the study are described in Tables 1.1, 1.2, and 1.3. There were a total of 102 subjects (44 male, 58 female) and their ages ranged from 20 to 91 years. Subjects with an orthopedic diagnosis for hip, knee, or back totaled 58 out of 102 subjects, with the remaining 44 subjects with diagnoses in the areas of trauma, cancer, vascular, neurological, or general. The most commonly found types of insurance were Medicare, Loma Linda Faculty Medical Group Insurance (LLFMGI), Pre-paid service (PPS), and Medi-Cal accounting for a total of 69 subjects. Three-fourths of the sample were found to have family support. The mean duration of PT for the subjects was 5.1

days and mean duration of hospital stay was 8.7 days. The mean PAK score for the total group was 70.5. The majority of the patients were sent home independently (n=42) with the smallest number of patients going to Rehab (n=6).

Table 1.1. Frequencies of population descriptors

	Frequency
Gender	
Male	**44**
Female	**58**
Diagnosis	
Ortho - Hip	**26**
Ortho - Knee	**20**
Other	**56**
Ortho - Back	12
Trauma	13
Cancer	10
Vascular	5
Neuro	11
General	5
Type of Insurance	
LLFMGI	**13**
Medicare	**43**
PPS	**8**
Medi-Cal	**5**
Other	**33**
Family Support	
Yes	**76**
No	**26**

Table 1.2. Frequencies of populations descriptors by discharge destination.

	Home Independently	Home with PT	Rehab	SNF
Destination at Discharge	42	22	6	32
Recommendation of PT	38	24	6	34
Family Support Yes No	39 3	20 2	3 3	14 18
Gender Male Female	20 22	11 11	3 3	22 10
Diagnosis Ortho - Hip Ortho - Knee Other	3 3 36	9 5 8	1 0 5	13 12 7

Table 1.3. Means and standard deviations of population descriptors

	Mean	Standard Deviation
Age	61.6	16.9
Duration of Physical Therapy	5.1	6.7
Duration of Hospital Stay	8.7	17.0
L.O.S.S. Score	70.5	18.3

One-way ANOVA showed a significant difference in mean PAK scores ($p<0.001$) among the destinations at discharge (Table 2). The mean PAK scores were 82.6 for home independently, 77.6 for home with PT, 53.9 for SNF, and 48.8 for Rehab. A Duncan multiple range test (Table 3) showed a significant difference in mean PAK scores between the groups that were discharged home and those that were discharged to a SNF/Rehab ($p=0.001$). However, no significant difference was noted between Rehab and SNF or between home with PT and home independently.

Mean duration of hospital stay and mean duration of PT (Table 2) were not significantly different among the various discharge destinations ($p=0.59$, $p=0.53$ respectively). Those who were discharged home with PT had the highest mean duration of hospital stay of 12.6 days while those who were discharged home independently had the lowest mean of 6.9 days. For duration of PT, Rehab had the highest mean of 7.0 days and home independently had the lowest mean of 4.0 days. One-way ANOVA found mean age to be a significantly different among the discharge groups ($p<0.001$). Age was significantly different between the discharge groups of home independently (53.1 years) and SNF (72.2 years). The mean age for the group home with PT was 60.0 years and for the Rehab group was 69.8 years.

Table 2. Comparison of mean PAK score, duration of hospital stay, and duration of physical therapy by discharge destination.

	Destination of Discharge from the Hospital								p-value
	Home Independently		Home with PT		SNF		Rehab		
	mean	SD	mean	SD	mean	SD	mean	SD	
PAK Score	82.6	11.7	77.6	12.2	53.9	13.4	48.8	12.1	.00
Duration of Hospital Stay	6.9	4.7	12.6	34.0	7.6	9.8	12.0	8.2	.59
Duration of PT	4.0	3.2	6.1	10.8	5.4	6.7	7.0	5.6	.53
Age	53.1	15.8	60.1	15.6	72.2	12.8	69.8	15.6	.00

Table 3. Duncan multiple range test for significance between groups.

Destination at discharge from hospital	N	Subset for alpha = 0.001	
		1	2
Rehab	6	48.83	
SNF	32	53.88	
Home with PT	22		77.55
Home Independently	42		82.57

Recommendations of discharge by the physical therapist were in agreement with the actual destination of discharge 92.2% of the time (Table 4). Those who were discharged home independently showed the highest disagreement of 3.9%.

Table 4. Destination at discharge from hospital vs. PT recommendations.

Destination at Discharge from the Hospital	Recommendation of PT				
	Home with PT	Rehab	Home Independently	SNF	Total
Home with PT	**19.6%**			2.0%	21.6%
Rehab		**4.9%**		1.0%	5.9%
Home Independently	3.9%		**37.3%**		41.2%
SNF		1.0%		**30.4%**	31.4%
Total	23.5%	5.9%	37.3%	33.3%	**100.0%**

Stepwise discriminant analyses were performed to predict the destination at discharge. The first analysis sought to predict all four destinations using the independent variables of age, diagnosis, duration of PT, duration of hospital stay, family support, gender, PAK score, and significance of past medical history. The PAK score, diagnosis, and family support entered in the given order were found to be significant in classifying

the four groups with 64.7% of the cases correctly classified (Table 5). The greatest

misclassification was in discriminating between home independently and home with PT.

The second analysis, which divided the destinations into those discharged home

and those who went to SNF/Rehab, determined that the PAK score and family support

were the most significant in classifying the groups with 88.2% of the cases correctly

classified (Table 6). Those discharged home were predicted to be discharged to

SNF/Rehab for 9.4% of the cases. Those discharged to SNF/Rehab were predicted to go

home 15.8% of the time.

However, when the group discharged home was sub-divided into home

independently versus home with physical therapy, diagnosis was the only significant

variable for classifying the groups (Table 7). The cases were correctly classified 64.1%

of the time for home with PT and home independently.

The final analysis consisted of subdividing those discharged to Rehab or SNF

(Table 8). Diagnosis was again the significant variable with 78.9% of the cases correctly

classified. The analysis showed that patients were sent to Rehab when SNF was

predicted in 33.3% of the cases and Rehab was predicted when SNF was used on 18.8%

of the cases.

Table 5. Discriminant analysis of all four destination groups with the independent variables of PAK score, diagnosis, and family support most significant in matching groups with destination.

Actual Group	Number	Predicted Group Membership			
		Home with PT	Rehab	Home Independently	SNF
Home with PT	22	**11** **50.0%**	1 4.5%	7 31.8%	3 13.6%
Rehab	6	0 .0%	**4** **66.7%**	0 .0%	2 33.3%
Home Independently	42	9 21.4%	1 2.4%	**31** **73.8%**	1 2.4%
SNF	32	6 18.8%	6 18.8%	0 .0%	**20** **62.5%**

Table 6. Discriminant analysis of groups divided into home or SNF/Rehab with the independent variables of PAK score and family support most significant in matching groups with destination.

Actual Group	Number	Predicted Group Membership	
		Home	SNF/Rehab
Home	64	**58** **90.6%**	6 9.4%
SNF/Rehab	38	6 15.8%	**32** **84.2%**

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Table 7. Discriminant analysis on home groups divided by receiving PT or not with the independent variable of diagnosis being most significant for matching groups with destination.

Actual Group	Number	Predicted Group Membership	
		Without PT	With PT
Without PT	42	**26** **61.9%**	16 38.1%
With PT	22	7 31.8%	**15** **68.2%**

Table 8. Discriminant analysis on groups discharged to Rehab and SNF with the independent variable of diagnosis being most significant for matching groups with destination.

Actual Group	Number	Predicted Group Membership	
		Rehab	SNF
Rehab	6	**4** **66.7%**	2 33.3%
SNF	32	6 18.8%	**26** **81.3%**

Discussion

This study examined the relationship between a patient's function using a PAK score and the destination at discharge. There was a difference in the PAK scores among the destinations at discharge of the patient particularly between those discharged home and those who went to Rehab or a SNF. The physical therapist's recommendation at time of discharge was strongly related to the actual discharge destination based on this study. This finding supports the relationship between level of function and discharge destination since the recommendations that the physical therapists make for discharge are generally based on the level of independence of the patient. If a functional score is significantly related to discharge destination, then it could possibly be a useful tool for discharge planning in an acute care system.

From a clinical standpoint this research is important because health care is in great need of an objective system to determine plan of care and assist with discharge planning for the patient. Function was demonstrated to significantly match a patient to an appropriate destination at discharge from an acute setting. An advantage of using the PAK score in discharge planning would be the ability to represent the patient's function with a single value that was easily understood by all involved in the planning. Many other factors such as diagnosis, family support, and age were associated with the patient's discharge destination. Therefore, a single score should not be the only factor in determining a destination at discharge.

From a physical therapists' perspective, an index such as the PAK could benefit our profession in many other ways. Those with less experience could be assisted by giving them a more objective system to use for documentation and goals. The transfer of information from one therapist to the next or to others outside of our profession would be standardized and more easily understood. Also, research that uses chart review for data collection would have standardized and more consistently complete data.

Diagnosis was the predictor of whether or not a patient actually received physical therapy when going home or whether they went to Rehab versus a SNF. This leads us to the conclusion that various services are consistently ordered based on why the patient is admitted into the hospital and not necessarily based on need. Doctor preference, common beliefs of case management, and patient preference can be important factors in determining discharge, but they may miss the whole picture of the individual patient. However, the patient's level of function alone can also be a misrepresentation of the patient's true needs. For example, one patient was admitted for a total hip replacement but had a significant history of rheumatoid arthritis. This subject's PAK score was a 59 on the day of discharge which would suggest, based on this study, that a SNF or Rehab was appropriate. Instead, this patient was discharged home with physical therapy at what was found to be their previous functional level.

Another example of how evaluation of function alone should not determine discharge was one patient who was admitted after a motor vehicle accident with numerous broken bones. The goal of therapy was to get this patient to the highest level

of function temporarily with the understanding that the subject was to remain non-weight bearing on three out of four limbs for six to eight weeks. This patient's PAK score was a 53, but the patient went home without PT until the weight bearing status changed and further PT could be performed.

This study was limited in several ways. The data was collected using a PAK score in the acute care setting only. Also, a large number of the diagnoses were in the orthopedic population, with only small samples of other diagnoses. An important future study of this tool would involve earlier assessment in the patient's hospital stay to determine if the PAK score could assist in predicting the patient's discharge destination. Additional studies could be performed using the PAK for discharge outcomes in areas such as outpatient rehabilitation, subacute, or SNF.

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APPENDIX A

L.O.S.S.™ Physical Assistance Key (PAK):
[Basic Activities of Daily Living (BADL)]

Blue Cross of California Suggested Ratings:

0 - Unable: Patient is unable to complete the task with or without assistance of one person.

1 - Maximum Assistance: Patient completes the task with limited participation and most of the effort coming from another person.

2 - Moderate Assistance: Patient completes the task with equal effort of one person and the participation of the patient.

3 - Minimal Assistance: Patient completes the task by supplying more than 50% of the effort.

4 - Supervision Required: Patient completes the task but requires verbal cues, preparation, and monitoring for occasional physical assistance to complete the task safely.

5 - Independent with Device: Patient completes the entire task including preparation without physical assistance but requires the use of a device.

6 - Independent without Device: Patient completes the entire task including the preparation without physical assistance or use of a device.

N - No Basis for Rating: Severity rating not applicable to this particular disability, or unable to specify or observe, nor is information available from other sources.

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L.●.S.S.™ Physical Assistance Key (PAK): **[Basic Activities of Daily Living (BADL)]**		

	☐ **Transfer Activities**	**ICIDH** **WHO**	*International Classification of Impairments, Disabilities, and Handicaps,* **World Health Organization, Geneva, 1980.** Exclusion: Excretion (32), bathing (33), and transport (47). pp 161
☐	☐ Transfer from Lying	D 46.0	Supine to/from Sit. Inclusion: Rising from and lying down on bed. pp 161
☐	☐ Transfer from Sitting	D 46.1	Sit to/from Stand. Inclusion: Getting in and out of chairs or wheelchair. pp 161
☐	☐ Transfer from Toilet	D 32.0	Inclusion: Transferring self to and from a lavatory, toilet or bed side commode. pp158
☐	☐ Bathing Transfer	D 33.0	Inclusion: Transfering self to and from bath. pp 158
	☐ **Personal Care Activities**		Inclusion: **Self-Care Activities:** Individual's ability to look after themself in regards to basic physiological activities, such as excretion, feeding, hygiene, and dressing. pp 156
☐	☐ Self-Feeding	D 38	Inclusion: The ability to drink, eat, chew, and swallow by ones self. pp160
☐	☐ Bathing	D33	Inclusion: All over wash, washing the body and the back, and drying self thereafter. pp 158
☐ ☐	☐ Using a Bath ☐ Using a Shower	D 33.1 D 33.2	Inclusion: Other difficulties in using a bath tub or shower, such as manipulation of controls. Exclusion: Bathing diabilities (33), and transfer disabilities (33.0). pp158
☐	☐ Post-excretion Hygiene	D 34.4	Inclusion: The ability to care for faecal and urinary excretion hygiene-related tasks. pp 158
☐	☐ Self-Grooming	D 34	Inclusion: The ability to wash face and hair, and brush and comb hair. pp 158
☐	☐ Self-Dressing -Lower	D 35.1	Inclusion: The ability to put on skirts or trousers. pp 159
☐	☐ Self-Dressing -Over Arms	D 35.2	Inclusion: The ability to put on a jacket. pp 159
☐	☐ Self-Dressing -Over Head	D 35.3	Inclusion: The ability to put on blouses, shirts, and nightdresses. pp 159
	☐ **Locomotion**		Inclusion: An individual's ability to execute distinctive activities associated with moving himself and objects, from place to place. pp 161
☐ ☐	☐ Walking ☐ Self-Transport: Wheelchair	D 40 D 47.7	Inclusion: Ambulation on flat terain. pp 161 Inclusion: The ability to transport self from place to place, with use of a wheelchair. pp 162
☐	☐ Traversing	D 41	Inclusion: Negotiation of discontinuities in terrain such as the occasional step between different levels and uneven terrain. pp 161
☐	☐ Stair Climbing	D 42	Inclusion: Negotiation of stairs and similar man-made obstacles. pp 161
☐	☐ Postural	D 58	Disturbance of Balance. Inclusion: Difficulty in attaining or maintaining postures (such as disturbance of balance). pp 164
	☐ **Excretion Management**		Inclusion:
☐	☐ Faecal Management	D 31.3	Inclusion: Faecal incontinence. pp 157
☐	☐ Urinary Management	D 31.4	Inclusion: Urinary incontinence. pp 157
☐	**Physical Assistance Total Score:**		The PAK score is based on a 108 total points scale. If any item is rated "N" (no basis for rating), the base score will be changed accordingly. Only use "N" if absolutely necessary. Enter 1 if unable to rate due to risk. Please leave no blanks.