Focus on Function in Inpatient Orthopedic Rehabilitation

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Reimagining Orthopedic & Spine Care

Agenda

- Into to PHRI
- Patient Population/CARF
- Orthopedic Continuum-evidence for success
- PHRI Evidence and Outcomes-Orthopedic Rehabilitation
- Success stories
- Next Steps

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52-Bed Free-Standing Rehabilitation Hospital

- All private rooms
- Licensed as an Acute Care Hospital
- 1:5 Nurse ratio
- Restorative healing environment
- 5 out of 7 days 3 hours of therapy services; or 900 minutes over 7 days
- Daily rounding of physicians
- Secured brain injury unit with private dining and therapy gym
- Large interdisciplinary gyms
- Transitional living apartment, designed to simulate a residential apartment, to prepare patients for their daily living tasks before they are discharged home
- Therapeutic courtyard with golf, basketball and varied surfaces
- Specialty programming dedicated to neuro, stroke, brain injury, spinal cord injury and amputation for transition to community

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Safety, Early Mobility, Efficient Recovery, Restoration of QOL

Treatment and management will begin immediately

A rehabilitation team lead by a PM&R physician will create a plan that is unique to the patients needs

Many care providers on the team: Physical therapist, occupational therapist, speech language pathologist, neuropsychologist, social worker/case managers, nurses and more

Team understands that Mobility and ADLs are harder for the patient now than prior to the Orthopedic related treatments.

PM&R lead team will utilize cutting-edge as well as time-tested treatments to maximize function and quality of life

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Inpatient Rehab Hospital

	Acute inpatient rehab hospital
	The national average length of time spent at an acute inpatient rehab hospital is 10 days.
	In an acute inpatient rehab hospital, you'll receive a minimum of three hours per day, five days a week, of intensive physical, occupational, and speech therapy. Your therapy is provided by rehab specialists who incorporate advanced technologies and approaches into your regimen.
	Physician care is provided 24 hours a day, seven days a week. A rehabilitation physician will visit you at least three times per week to assess your goals and progress.
	Nursing care is provided 24 hours a day, seven days a week, by registered nurses as well as Certified Rehabilitation Registered Nurses (CRRN). The nurse-to-patient ratio is one nurse to five patients.
	Your highly trained, multidisciplinary personal rehab team, consisting of rehabilitation physicians, internal medicine physicians, nurses, therapists, care managers, dietitians, psychologists and family members, work together to help determine goals and the best individualized treatment approaches.

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Patients Served

- The hospital must meet a 60% threshold of the following diagnoses (IRF PPS criteria):
  - Stroke
  - Spinal Cord
  - Congenital Deformity
  - Amputation
  - Major Multiple Trauma
  - Fracture of Femur
  - Brain Injury
- Neurological Conditions (MS, Parkinson's)
- Burns
- Rheumatoid Arthritis
- Systemic Vasculitis with joint inflammation
- Severe or advanced osteoarthritis involving 2 or more weight bearing joints
- Bilateral Joint replacement at one time

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Services Provided

- Physiatrist – Physical Medicine and Rehabilitation
- Consulting physician specialists
- Rehabilitation Nursing
- Physical Therapy
- Occupational Therapy
- Speech Therapy
- Nutrition Services
- Pharmacy
- Basic Laboratory and Radiology including Fluoroscopy
- Dialysis
- Respiratory Therapy
- Case Management
- Chaplain or Spiritual Support
- PAWS

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Our Culture

Our culture emphasizes:

- Quality and Safety
- Patient/Employee Experience
- Inclusion and Equity

OUTCOMES

- **Evidence based care**
- **Positive Impact in staff development**
- **Employee Engagement**

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Therapy Treatment Area

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Therapy Courtyard

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Kalani T's Story

4.211 Traumatic SCI-Paraplegia Incomplete
C6 unstable fracture & disc herniation; Asia B
C6-7 Anterior Cervical Discectomy & Fusion, and partial C6 Corpectomy

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Kalani's Outcomes

CASE SUMMARY

Admit Diagnosis: Spinal Cord Dysfunction - Traumatic **Discharge Setting:** Home

CMG Code: Traumatic Spinal Cord Inj. M <31.50 & A <61.50

Primary Payer: Not assigned

FUNCTIONAL LEVELS

06. Independent - Patient completes the activity by him/herself with no assistance from a helper.

05. Setup or clean-up assistance - Helper SETS UP or CLEANS UP; patient completes activity. Helper assists only prior to or following the activity.

04. Supervision or touching assistance - Helper provides VERBAL CUES or TOUCHING/STEADYING assistance as patient completes activity.Assistance may be provided throughout the activity or intermittently.

03. Partial/moderate assistance - Helper does LESS THAN HALF the effort. Helper lifts, holds or supports trunk or limbs, but provides less than half the effort.

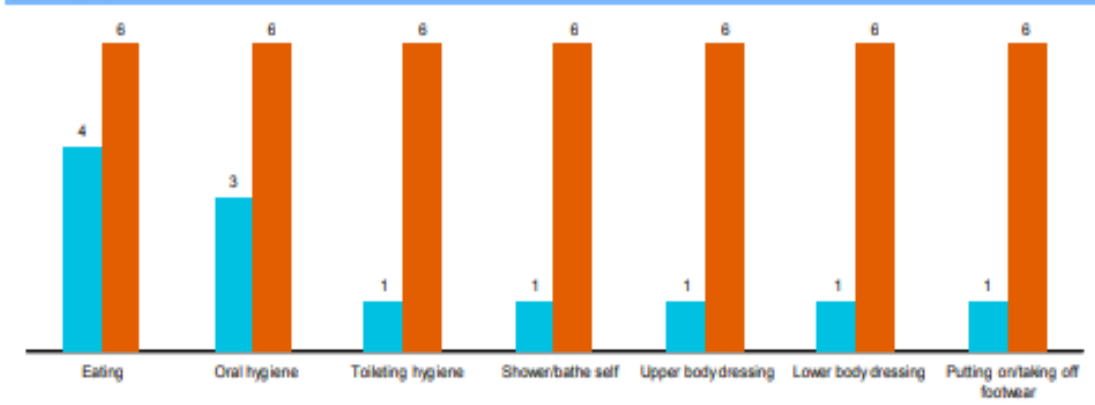
02. Substantial/maximal assistance - Helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the effort.

01. Dependent - Helper does ALL of the effort. Patient does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the patient to complete the activity.

OUTCOME SUMMARY

Admit Score Discharge Score

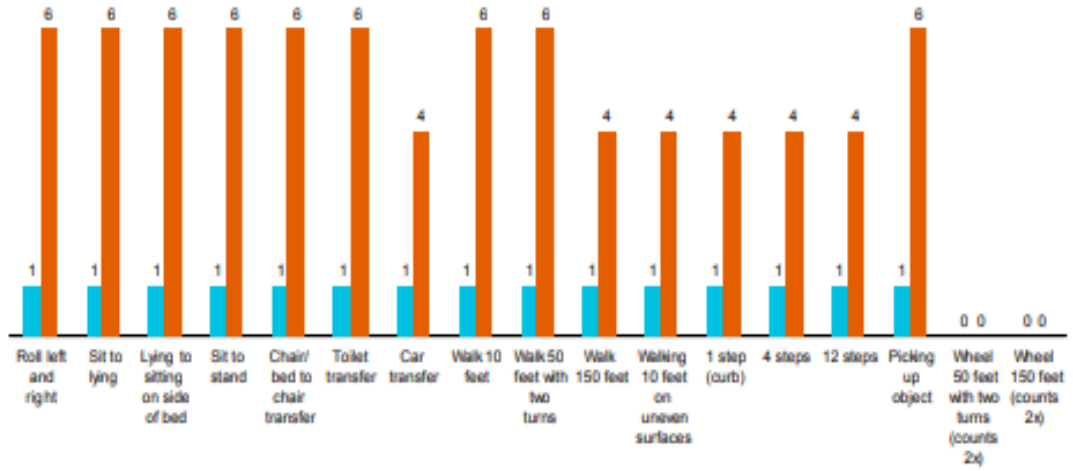
Self-Care



Self-Care Total

Self-Care Admit Score:	12
Self-Care Discharge Score:	42
Self-Care Functional Gain:	30

Mobility



Mobility Total

Mobility Admit Score:	15
Mobility Discharge Score:	78
Mobility Functional Gain:	63

Overall Admit Score: 27
Overall Discharge Score: 120
Overall Functional Gain: 93

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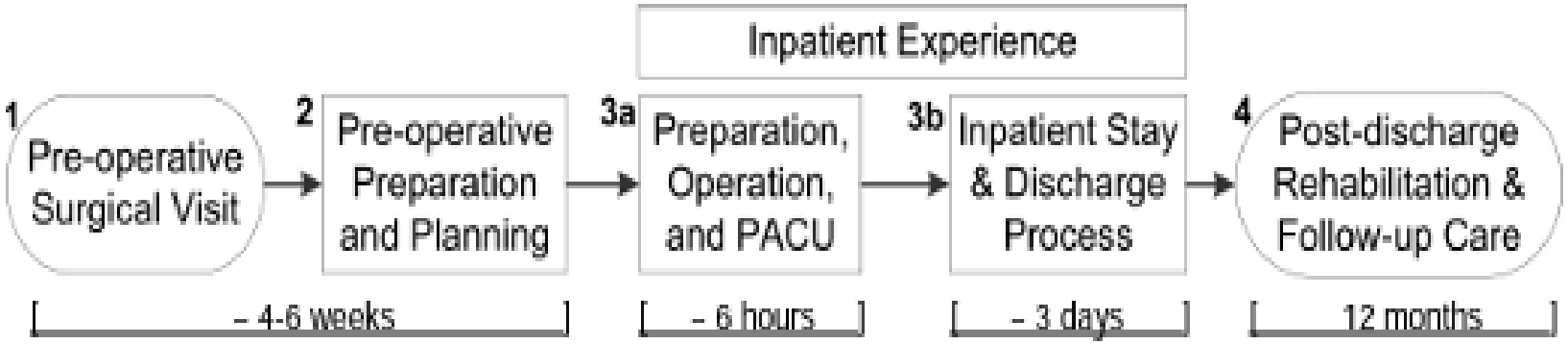
Orthopedic Continuum

- Acute Hospital
- Post acute: Inpatient Rehab Hospital
- Discharge to Community
- Home Health or Outpatient care

Institute of Healthcare Improvement



Selected Performance Metrics to Help You Gauge Your Performance	Total Knee Replacement		Total Hip Replacement	
	Top 10%	Median	Top 10%	Median
Length of stay [a, b]	2.9 days	3.3 days	3.4 days	4.2 days
30-day readmission rate [a, b]	2.5%	5.3%	4.3%	9.0%
In-hospital mortality [a, b]	0%	0%	0%	0.6%
Inpatient cost [a, c]	$11,700	$16,400	$12,800	$17,500
SCIP: Infection Prevention [d]	100%	98.3%	100%	97.8%
SCIP: VTE1 [d, e]	100%	95.7%	100%	95.7%
SCIP: VTE2 [d, e]	100%	94.1%	100%	94.1%

Source: [a] 239 Premier member hospitals with ≥300 TKA in a 2-yr period (10/1/09-09/30/11); [b] 276 Premier member hospitals with ≥150 THA in a 2-yr period (10/1/09-09/30/11). [c] 270 Premier member hospitals with ≥150 THA in a 2-yr period (10/1/09-09/30/11). [d] Hospital Compare SCIP data, from 1/1/11-12/31/11. [e] Data for all appropriate surgical types, not specific to TKR and THR.

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Benefits of Inpatient and Outpatient Orthopedic Rehabilitation

- A comprehensive, customized treatment plan designed to accommodate the patient's unique condition, challenges, physical state, and overall well-being.
- Less pain.
- Reduced risk of future injury and hospitalization.
- Boosted mood.
- Restored range of motion and physical function in an injured joint.
- Muscle strength around an injured joint to reduce the risk of future injury.
- Improved circulation after surgery to support healing and minimize the risk of blood clots.
- Faster return to normal activities.

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Commission on Accreditation of Rehabilitation Facilities - CARF & Orthopedic Education

- Align education across Palomar Health continuum
- Care pathway development
- Reinforce PH Orthopedic education and recommendations at PHRI IPR
- Collaborate on quality, outcomes, and trends
- Connect our patients/members with critical community resources and support groups

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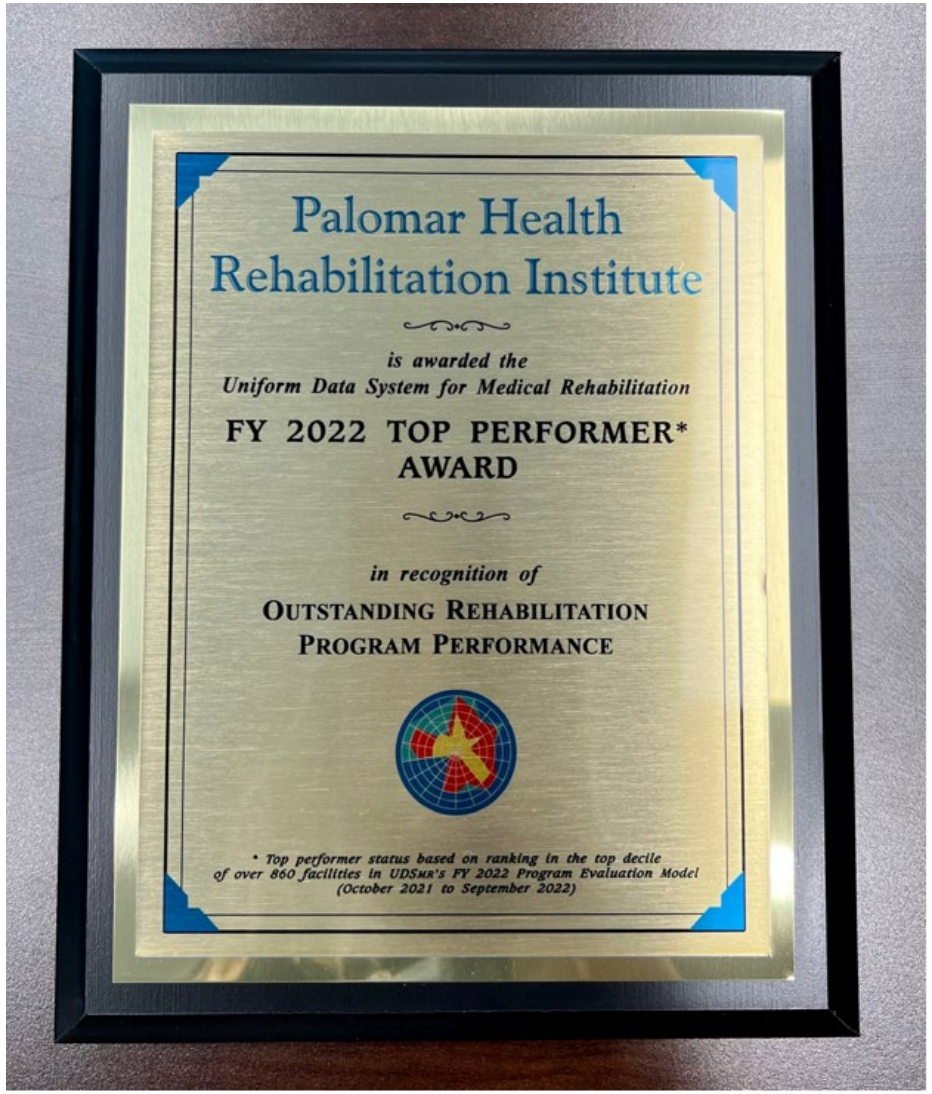
Our Benchmarks

- Reporting to:
  - CMS, HCAI, CDPH,
  - NHSN, TJC, CARF
- Uniform Data System
  - UDS ProDoc
- CMG-Case Mix Group
- CMI-Case Mix Index
- RIC-Rehab Impairment Category
- PEM-Program Evaluation Model



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Rehabilitation Impairment Categories

Continued

Rehabilitation Impairment Category	Associated Impairment Group Codes
16 Pain syndrome (Pain)	07.1 Neck pain
	07.2 Back pain
	07.3 Extremity pain
	07.9 Other pain
17 Major multiple trauma, no brain injury or spinal cord injury (MMT-NBSCI)	08.4 Status post major multiple fractures
	14.9 Other multiple trauma
18 Major multiple trauma, with brain or spinal cord injury (MMT-BSCI)	14.1 Brain and spinal cord injury
	14.2 Brain and multiple fractures/amputation
	14.3 Spinal cord and multiple fractures/amputation
19 Guillain-Barré (GB)	03.4
20 Miscellaneous (Misc)	12.1 Spina bifida
	12.9 Other congenital
	13 Other disabling impairments
	15 Developmental disability
	16 Debility
	17.1 Infection
	17.2 Neoplasms
	17.31 Nutrition (endocrine/metabolic) with intubation/parenteral nutrition
	17.32 Nutrition (endocrine/metabolic) without intubation/parenteral nutrition
	17.4 Circulatory disorders
	17.51 Respiratory disorders-ventilator dependent
	17.52 Respiratory disorders-non-ventilator dependent
	17.6 Terminal care
	17.7 Skin disorders
	17.8 Medical/surgical complications
	17.9 Other medically complex conditions
21 Burns (Burns)	11 Burns

Reprinted from Centers for Medicare & Medicaid Services (CMS), HHS. Medicare program; prospective payment system for inpatient rehabilitation facilities. Final rule. Fed Regist 2001;66(152):41345–41430.

Continued

Rehabilitation Impairment Category	Associated Impairment Group Codes
06 Neurologic (Neuro)	03.1 Multiple sclerosis
	03.2 Parkinsonism
	03.3 Polyneuropathy
	03.5 Cerebral palsy
	03.8 Neuromuscular disorders
	03.9 Other neurologic
07 Fracture of LE (FracLE)	08.11 Status post unilateral hip fracture
	08.12 Status post bilateral hip fractures
	08.2 Status post femur (shaft) fracture
	08.3 Status post pelvic fracture
08 Replacement of LE joint (Rep1LE)	08.51 Status post unilateral hip replacement
	08.52 Status post bilateral hip replacements
	08.61 Status post unilateral knee replacement
	08.62 Status post bilateral knee replacements
	08.71 Status post knee and hip replacements (same side)
	08.72 Status post knee and hip replacements (different sides)
09 Other orthopedic (Ortho)	08.9 Other orthopedic
10 Amputation, lower extremity (AMPLE)	05.3 Unilateral lower extremity above the knee (AK)
	05.4 Unilateral lower extremity below the knee (BK)
	05.5 Bilateral lower extremity above the knee (AK/AK)
	05.6 Bilateral lower extremity above/below the knee (AK/BK)
	05.7 Bilateral lower extremity below the knee (BK/BK)
11 Amputation, other (AMP-NLE)	05.1 Unilateral upper extremity above the elbow (AE)
	05.2 Unilateral upper extremity below the elbow (BE)
	05.9 Other amputation
12 Osteoarthritis (OsteoA)	06.2 Osteoarthritis
13 Rheumatoid, other arthritis (RheumA)	06.1 Rheumatoid arthritis
	06.9 Other arthritis
14 Cardiac (Cardiac)	09 Cardiac
15 Pulmonary (Pulmonary)	10.1 Chronic obstructive pulmonary disease
	10.9 Other pulmonary

Continued on next page

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Primary Rehab Impairment Categories

07 Fracture of LE 14%, 98 cases

08 Replacement of LE 2% 13 cases

09 Other Ortho 7.3% 51 cases

10/11 Amputation 1% 8 cases

04/05 SCI-traumatic TSCI 2.4% 17cases
non traumatic NTSCI; 3.3% 24 cases

17/18 Major Multiple trauma (MMT NBSCI 8% 57 cases , MMT BSCI, 3.4, 24 cases)

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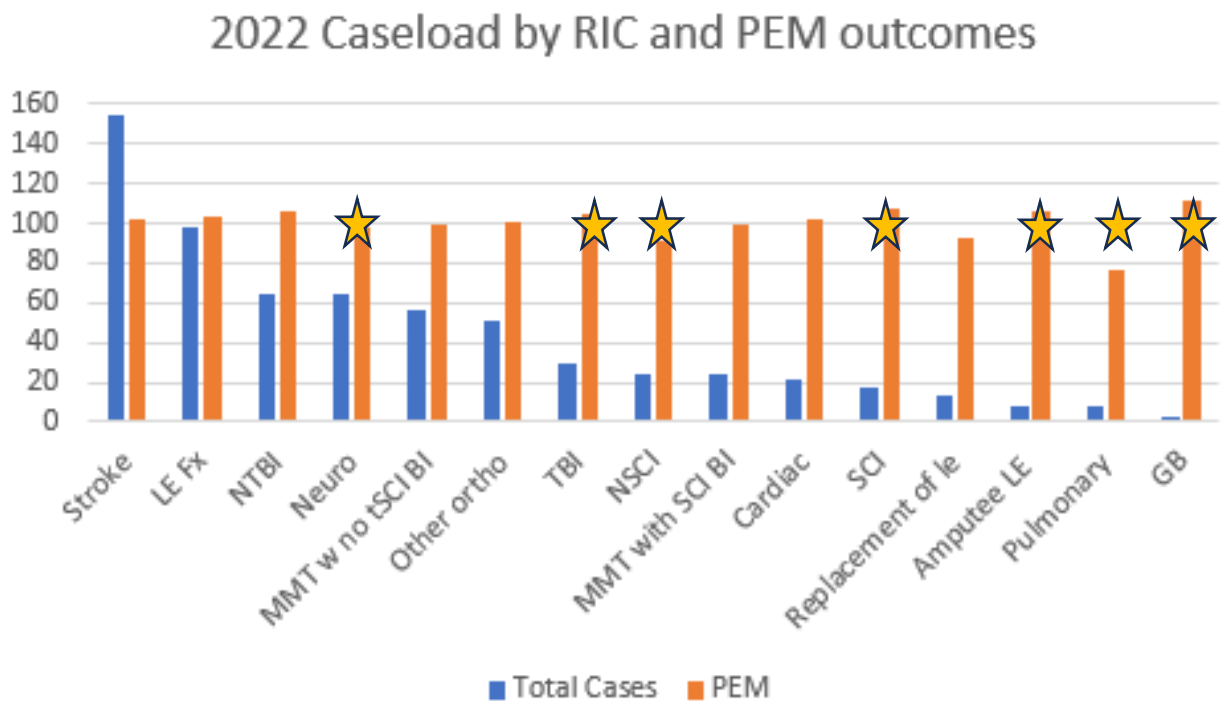
Program Specific CARF Tracking-PEM



	Total Cases	PEM
Stroke	154	102.1
LE Fx	98	104.1
NTBI	64	105.9
Neuro	64	97.4
MMT w no tSCI BI	57	99.5
Other ortho	51	100.9
TBI	30	104.5
NSCI	24	91.3
MMT with SCI BI	24	99.2
Cardiac	22	102.5
SCI	17	107.2
Replacement of le	13	92
Amputee LE	8	105.5
Pulmonary	8	76.1
GB	2	111.1

★ Orthopedic Care above PEM 92 = top Decile UDS

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Current Patient Populations

- Comorbidities
- Polypharmacy
- Complex social determinants of health, lacking home support
- Known healthcare disparities to access

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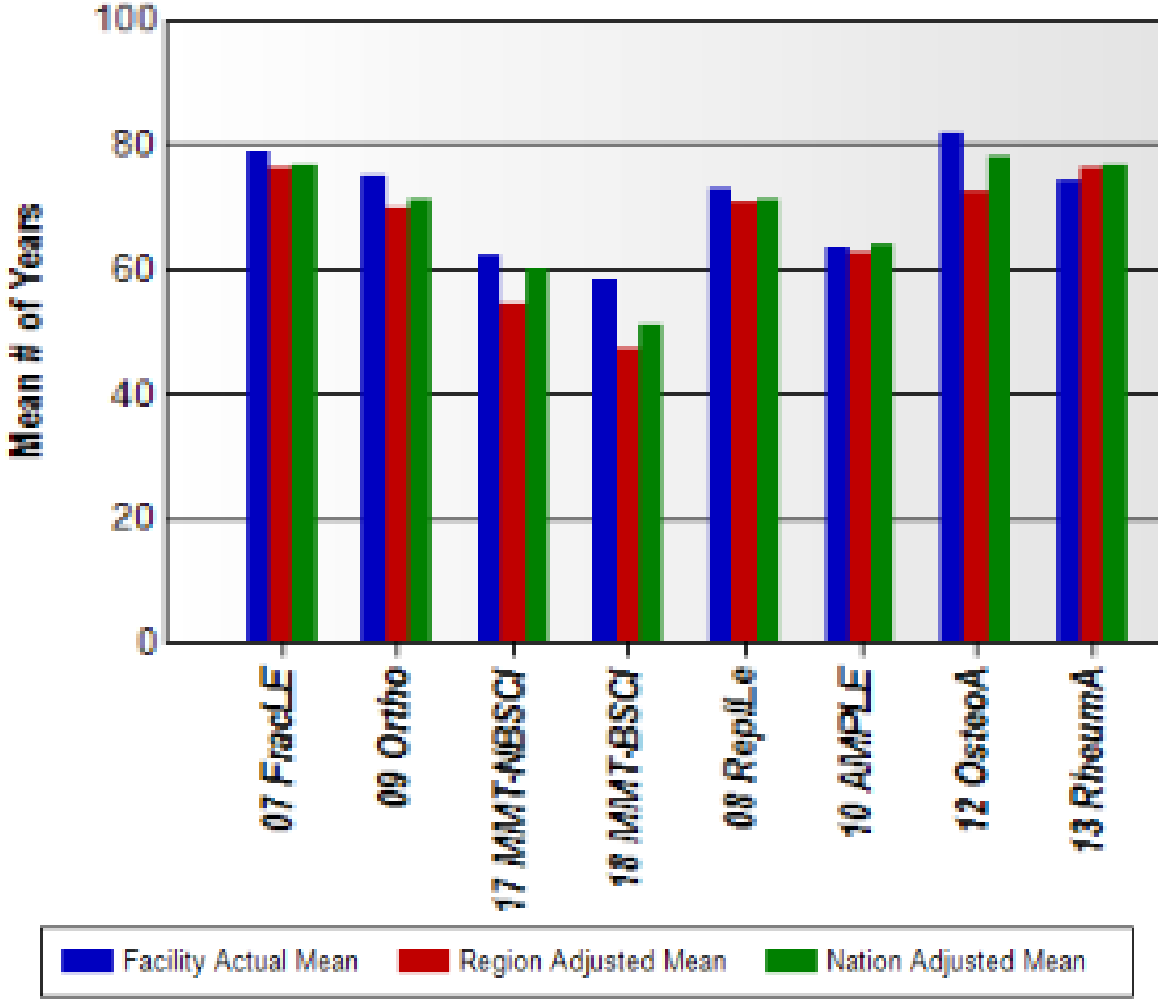
Comparison of Age by RIC



RIC Group / CMG	Facility # Cases	Facility Mean Age	Region Mean Age	Region Adjusted Mean Age	Nation Mean Age	Nation Adjusted Mean Age	Confidence Interval based Nation
All	228	72.6	67.1	67.7	69.5	69.6	67.7 - 71.5
⊞ 07 Fracture of LE (FracLE)	97	78.0	78.3	78.2	78.7	78.6	74.2 - 78.9
⊞ 09 Other Orthopedic (Ortho)	50	75.0	70.4	69.9	71.9	71.3	67.2 - 75.3
⊞ 17 MMTrauma noBSCI (MMT-NBSCI)	42	62.3	54.7	54.5	60.8	60.0	54.8 - 65.2
⊞ 18 MMTrauma w/BSCI (MMT-BSCI)	20	58.3	48.3	47.1	51.0	50.9	
⊞ 08 Replacement of LE (ReplLe)	13	72.9	71.2	70.9	71.8	71.2	
⊞ 10 Amputation, LE (AMPLE)	4	63.5	61.2	62.7	62.4	63.8	
⊞ 12 Osteoarthritis (OsteoA)	1	82.0	73.2	72.8	77.4	78.0	
⊞ 13 Rheumatoid, other (RheumA)	1	74.0	57.1	78.5	65.9	77.0	

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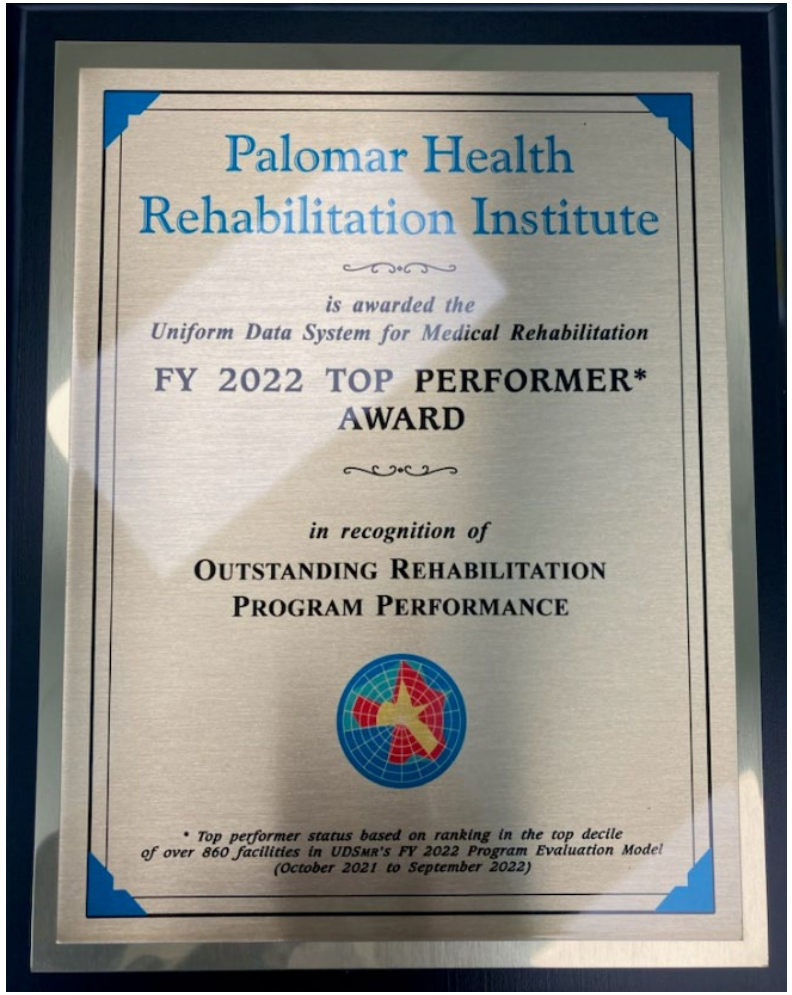
2022 PEM: All Patients



Facility: MZ35 - On-Demand PEM Version 2 Tracking Report - Cases Discharged: Last Year (01/01/2022–12/31/2022)

CMG Target Year: 2023 Primary Payer: All

Program Evaluation Model (PEM) Version 2 Tracking Report

Indicator	Total Cases	Cases In Measure	Patients that Meet or Exceed Target	Observed Score	Expected Score	SubScore	Weight	Weighted Subscore
Discharge Self-Care	704	612	516			84.3 %	10	**8.4**
Discharge Mobility	704	612	529			86.4 %	10	**8.6**
Change in Self-Care	704	612		15.7	12.9	122.0 %	10	**12.2**
Change in Mobility	704	612		38.2	29.9	127.8 %	10	**12.8**
Functional Efficiency	704	612	537			87.7 %	20	**17.5**
Discharge to Community	704	702		85.5 %	82.4 %*	103.7 %	30	**31.1**
Discharge to Acute Care	704	702		7.4 %	8.4 %*	101.1 %	10	**10.1**
Facility PEM Version 2 Total Score								100.7

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What are Quality Indicators (aka Care Tool)?

- Functional status assessment that is based on the patient's need for assistance when performing self care and mobility tasks.
  - Items are focused on admission performance, discharge goals, and discharge performance.
  - First three days, last three days- calendar days not 24-hour periods
- Patient assessments must be conducted in compliance with facility, federal and state requirements.
- Assessment data can be obtained by direct observation or information gathered from reliable resources.

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Why are they so important?

- QIs help us determine the burden of care.
- Acuity is captured through our documentation.
- Determine the length of stay for each patient.
  - Case Mix Group(CMG) Code:
    - Tier, RIC, Motor admission + age for some

What are we Coding?

- Cognition & Cognitive Patterns
- Hearing, Speech, and Vision
- Bladder and Bowel
- Self Care
  - Eating
  - Oral hygiene
  - Toileting hygiene
  - Shower/bathing
  - Upper body dressing
  - Lower body dressing
  - Footwear
- Mobility
  - Rolling left to right
  - Sit to lying
  - Lying to sitting on the side of the bed
  - Sit to stand
  - Chair/bed-to-chair transfer
  - Toilet transfer
  - Car transfer
  - Walk 10ft, 50ft, 150ft
  - Walk 10ft on uneven surfaces
  - 1, 4, 12 steps
  - Picking up object
  - Wheelchair mobility 50ft, 150ft

Self Care Mobility Section GG Items Assessment (www.aota.org)

6: Independent—Patient/resident safely completes the activity by themselves with no assistance from a helper.
5. Setup or Cleanup Assistance—Helper sets up or cleans up; patient/resident completes activity. Helper assists only prior to or following the activity.
4. Supervision or Touching Assistance—Helper provides verbal cues and/or touching/steadying and/or contact guard assistance as patient/resident completes activity. Assistance may be provided throughout the activity or intermittently.
3. Partial/Moderate Assistance—Helper does less than half the effort. Helper lifts, holds, or supports trunk or limbs, but provides less than half the effort.
2. Substantial/Maximal Assistance—Helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the effort
1. Dependent—Helper does ALL the effort. Patient/resident does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the patient/resident to complete the activity.

07: Resident Refused
09: Not Applicable—Resident did not perform this activity prior to current injury, exacerbation, or injury.
10: Not Attempted—Due to environmental limitations.
88: Not Attempted—Due to medical condition and safety concerns.

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Evidence for Inpatient Rehab in Orthopedics

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Benefits of IPR for Orthopedic Recovery

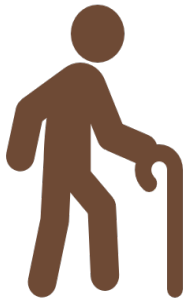
- **Patient Care:** The IRF fosters functional recovery
- **Medical Education:** The IRF provides the ideal setting for interprofessional medical education and interdisciplinary care
- **Research:** The IRF provides the necessary infrastructure for originating research on complex and long-term disabling conditions, allows for the longitudinal study of patients' evolving healthcare needs, and allows for the impact of rehabilitation interventions.
- **Studies** indicate that even with their complex problems, patients have the capacity to improve their participation in life with appropriate rehabilitation treatment that addresses the full continuum of their problems.[1]

1 Perret, et al.. The Value and Role of the Inpatient Rehabilitation Facility: Association of Academic Physiatrists Position Statement. American Journal of Physical Medicine & Rehabilitation 100(3):p 276-279, March 2021.

How IPR level of Rehabilitation Affects Recovery2-4

Reduction in recovery times

Short- and long-term functional gains



Pain reduction, earlier return of mobility

[2] Functional Outcomes of Posthospital Care for Stroke and Hip Fracture Patients Under Medicare - Kane - 1998 - Journal of the American Geriatrics Society - Wiley Online Library
[3] Effectiveness of intensive rehabilitation on functional ability and quality of life after first total knee arthroplasty: a single-blind randomized controlled trial1 - Archives of Physical Medicine and Rehabilitation (archives-pmr.org)
[4] http://www.josonline.org/pdf/v22i3p383.pdf

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Intensive v. Conventional Rehab

- Meta-Analysis,15 RCTS
  - Improved self rated state of health
  - Pain Reduction
- The trials identified reported 18 randomized comparisons of intensified orthopedic rehabilitation and conventional orthopedic rehabilitation.
- There is **strong evidence that intensified rehabilitation improves self-rated state of health** when compared with conventional rehabilitation at mid-term and long-term follow-up.[5]
- **Conclusions:** The relevant studies provide evidence that intensified rehabilitation improves self-rated state of health and reduces pain intensity in rehabilitants with musculoskeletal disorders.

[5]Bethge M et al., [Efficacy of intensified inpatient rehabilitation in musculoskeletal disorders: systematic review and meta-analysis]. Rehabilitation (Stuttg). 2008 Aug; 47(4):200-9

Prehab and Rehab for Major Joint Replacement

- **What:** review of timing of rehab
- **Initiated within 2 weeks post surgery**
  - **Improved Pain, ROM**
    - **Strength and ADL's (lower strength of evidence)**
- **Comparative effectiveness review** that provides an evidence summary for prehabilitation and rehabilitation for major joint replacement. The review suggests that rehabilitation programs in the acute and post-acute phase following total knee arthroplasty (TKA) may result in comparable improvements in outcomes of pain, range of motion, and activities of daily living (ADL) . Acute-phase rehabilitation programs resulted in similar satisfaction with care [6].

[6] Evidence Summary_Comparative Effectiveness Review No. 248: Prehabilitation and Rehabilitation for Major Joint Replacement (ahrq.gov)

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Inpatient Orthopedic Rehab Designed with Geriatric Principles

Who: 4,780 patients

17 RCTS

Orthopedic geriatrics v. usual care.

Outcomes:

- Improved Functional improvement,
- decreased admission to nursing homes,
- decreased mortality.
- **Conclusion:** Inpatient rehabilitation specifically designed for geriatric patients has the potential to improve outcomes related to function, admission to nursing homes, and mortality.[7]

[7] Bachmann et al. Inpatient rehabilitation specifically designed for geriatric patients: systematic review and meta-analysis of randomized controlled trials 2010 Apr 20:340:c1718.

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Impact of IPR in Thailand Prospective Multisite study [8]

- 2,081 patients across 14 hospitals
- Outcomes
  - Stroke and SCI impacts for effectiveness and efficiency
  - Intensive Rehab most effective and efficient for Barthal Index improvement
  - Efficiency of intensive programs statistically same across diagnostic groups.

[8]Kuptniratsaikul V, Wattanapan P, Wathanadilokul U, et al. The Effectiveness and Efficiency of Inpatient Rehabilitation Services in Thailand: A Prospective Multicenter Study. Rehabilitation Process and Outcome. 2016;5. doi:10.4137/RPO.S34816

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2022 Outcomes

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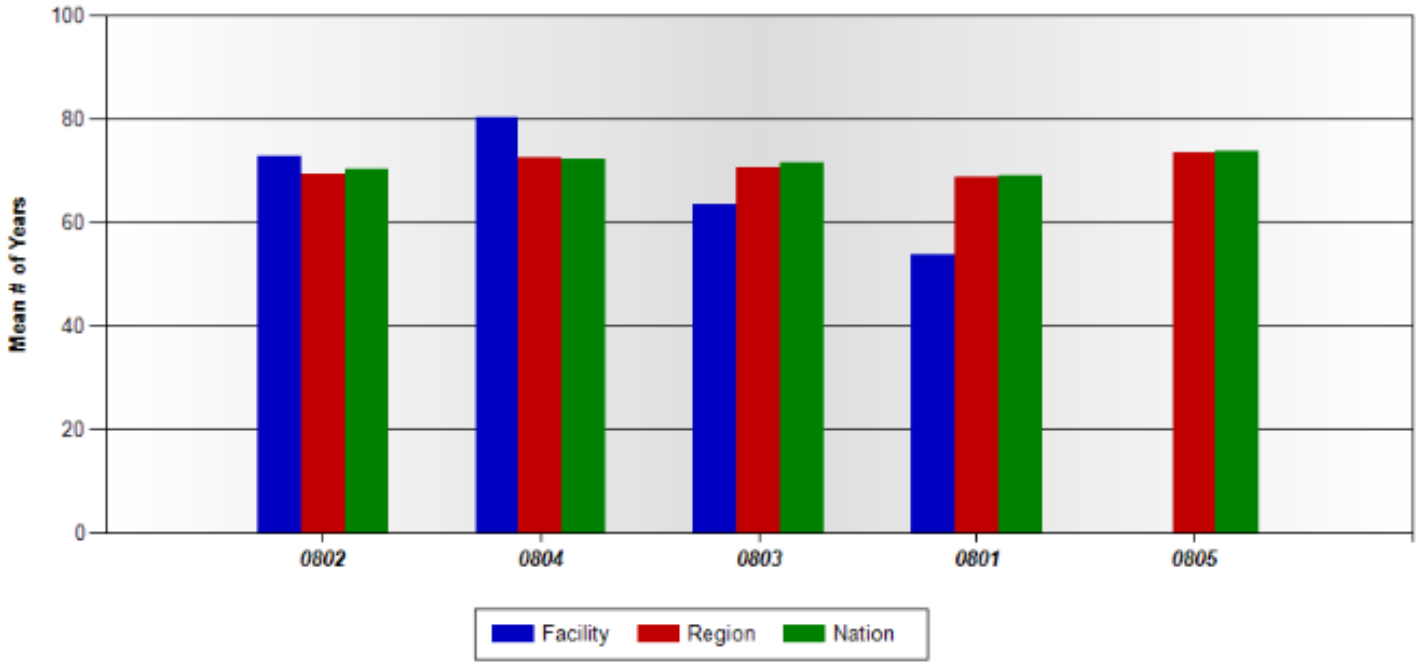
Comparison of Avg. Age by CMG for RIC – 08 Replacement of LE



CMG	Facility # Cases	Facility Mean Age	Region # Cases	Region Mean Age	Nation # Cases	Nation Mean Age
All	13	72.9	1,216	71.2	15,545	71.6
0802	5	73.0	201	69.6	2,645	70.4
0804	5	80.4	306	72.5	4,127	72.2
0803	2	63.5	235	70.9	3,246	71.5
0801	1	54.0	250	68.9	2,515	69.3
0805	0	0.0	224	73.6	3,012	73.8

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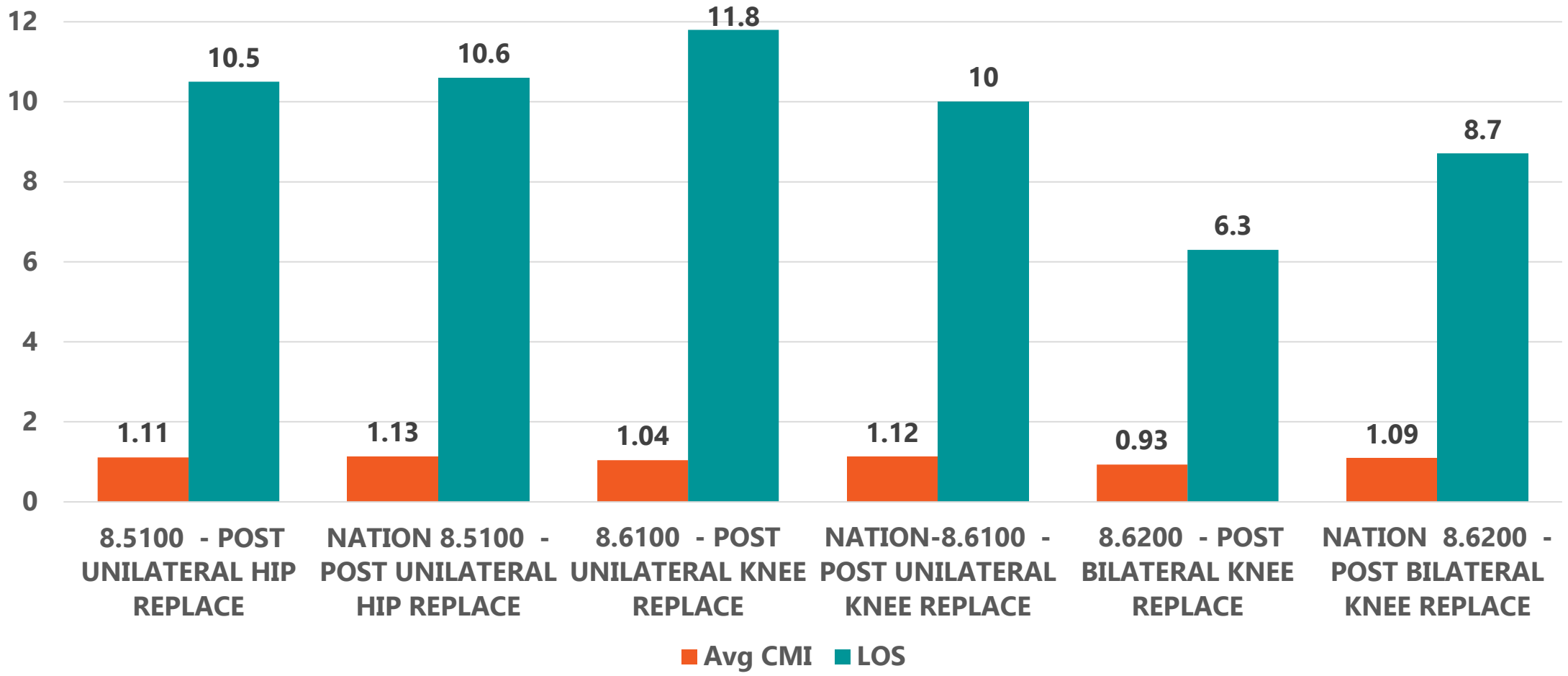
Joint Replacement LOS and CMI v. nation



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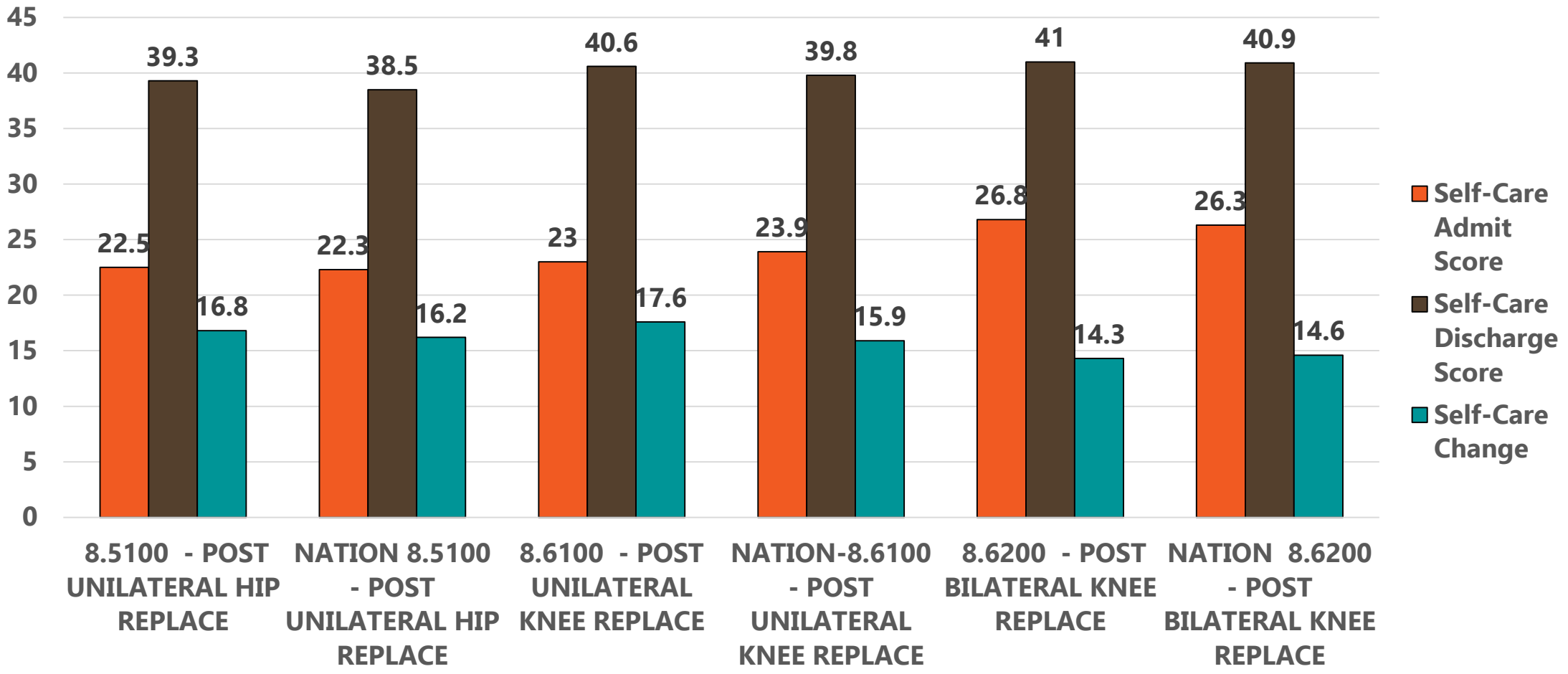
Joint Replacement Self Care Scores



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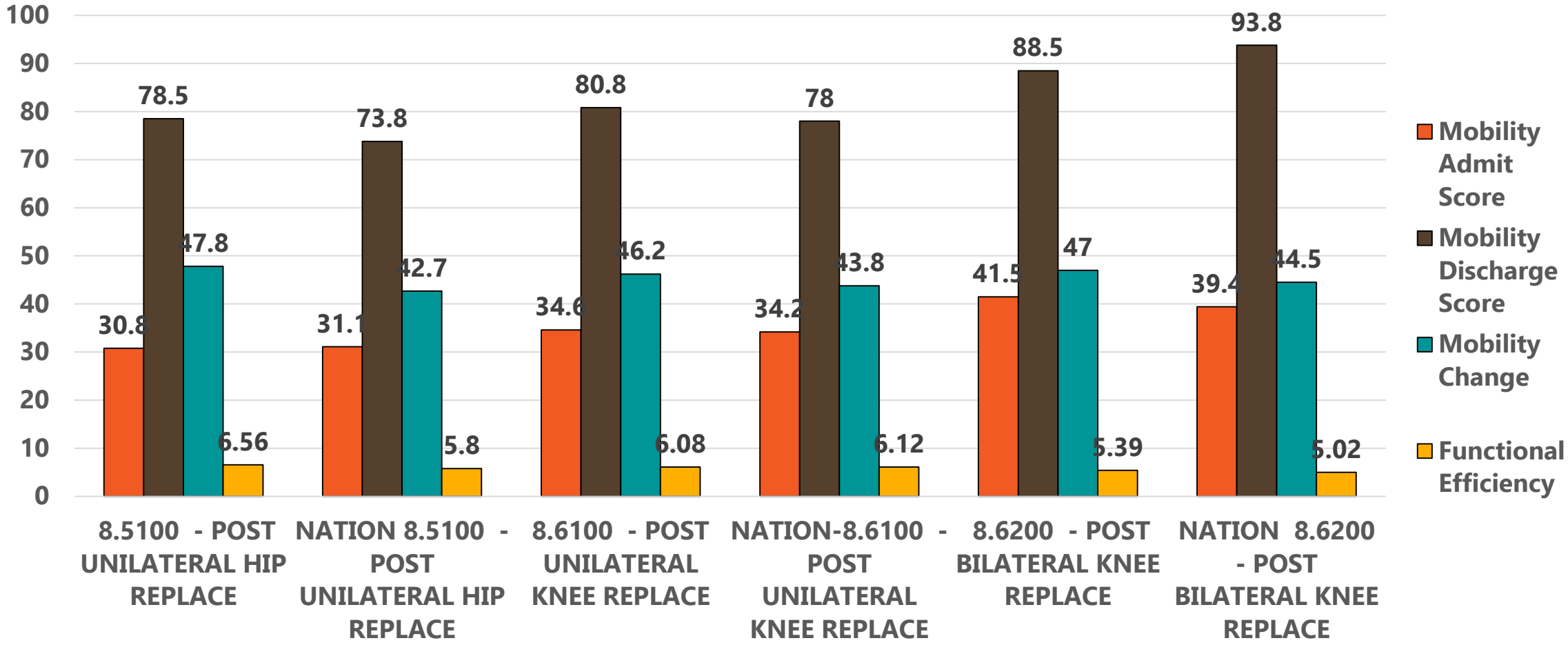
Joint Replacement Mobility v. Nation



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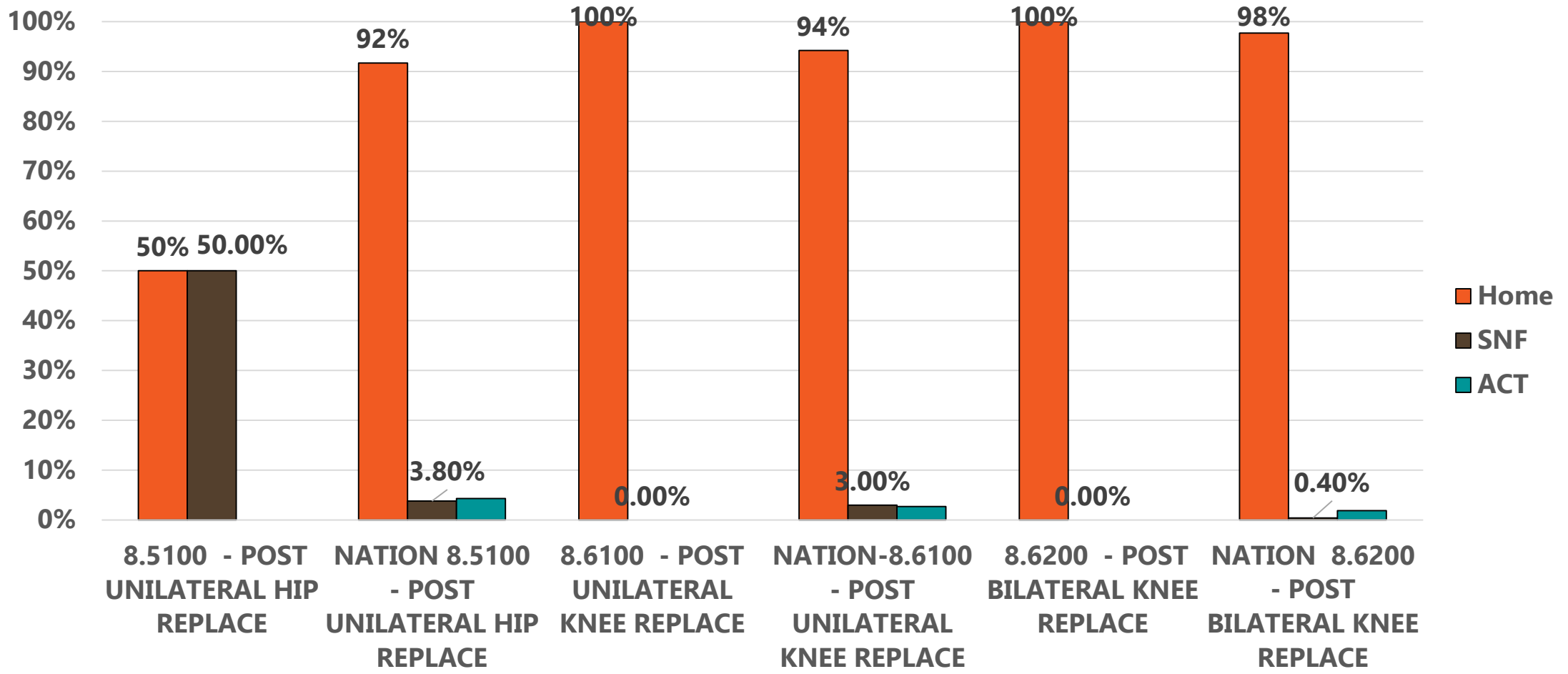
Joint Replacement Discharge setting v. Nation



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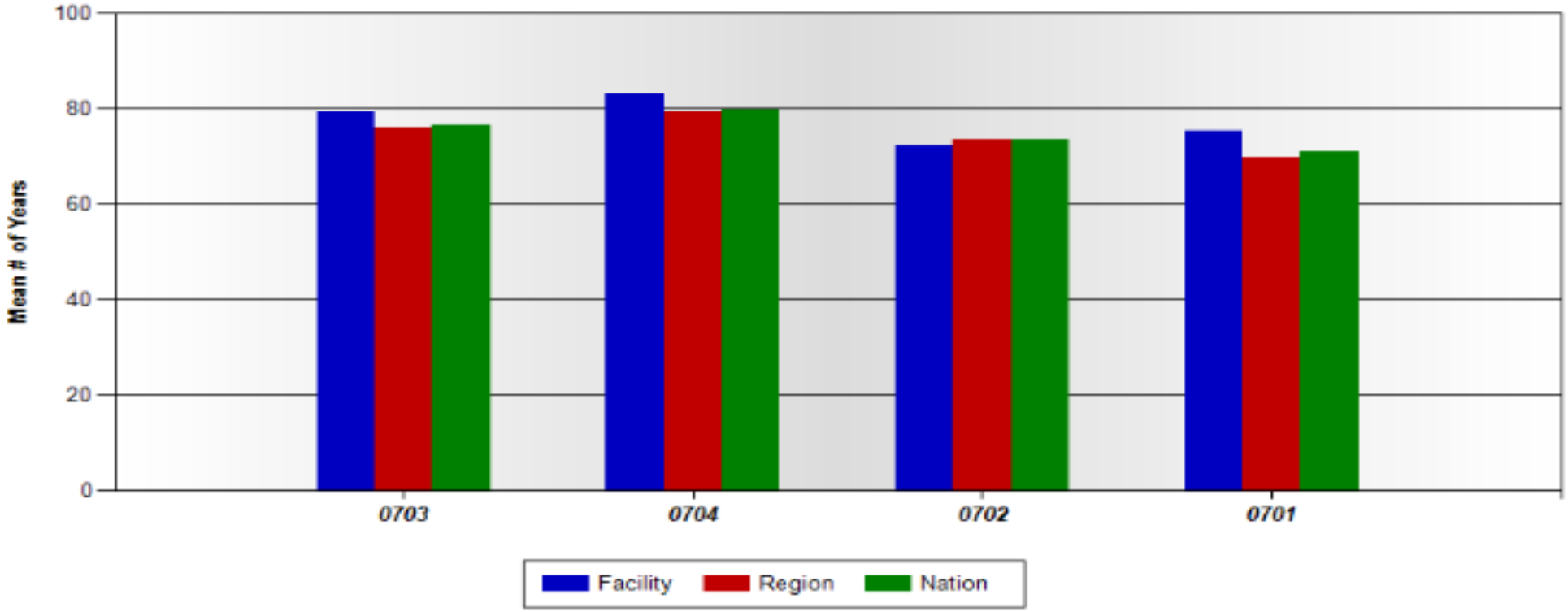
Comparison of Avg. Age by CMG for RIC – 07 Fracture of LE



CMG	Facility # Cases	Facility Mean Age	Region # Cases	Region Mean Age	Nation # Cases	Nation Mean Age
All	97	79.0	4,521	76.3	48,379	76.7
0703	36	79.6	1,466	76.2	16,155	76.5
0704	33	83.2	1,717	79.6	18,467	79.7
0702	19	72.4	849	73.4	9,059	73.7
0701	9	75.4	489	69.7	4,698	71.2

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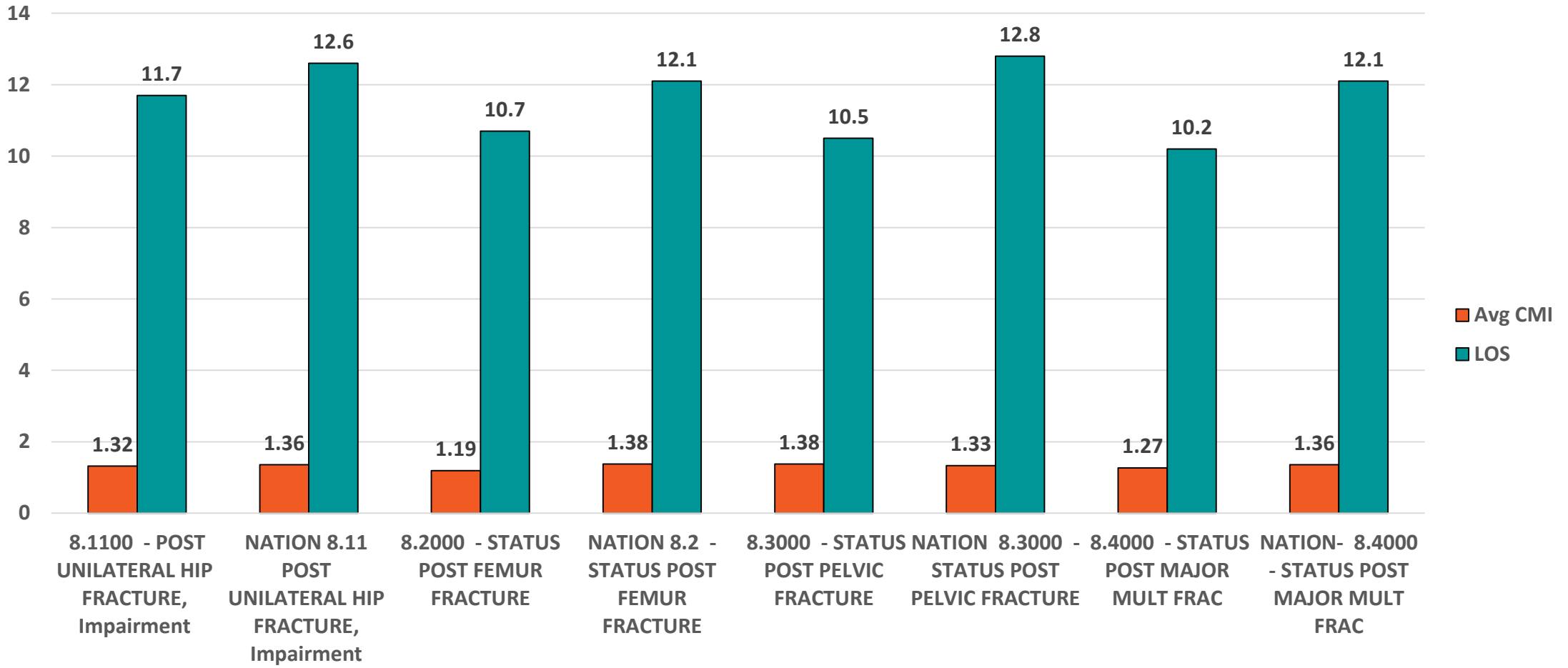
Fractures CMI and LOS



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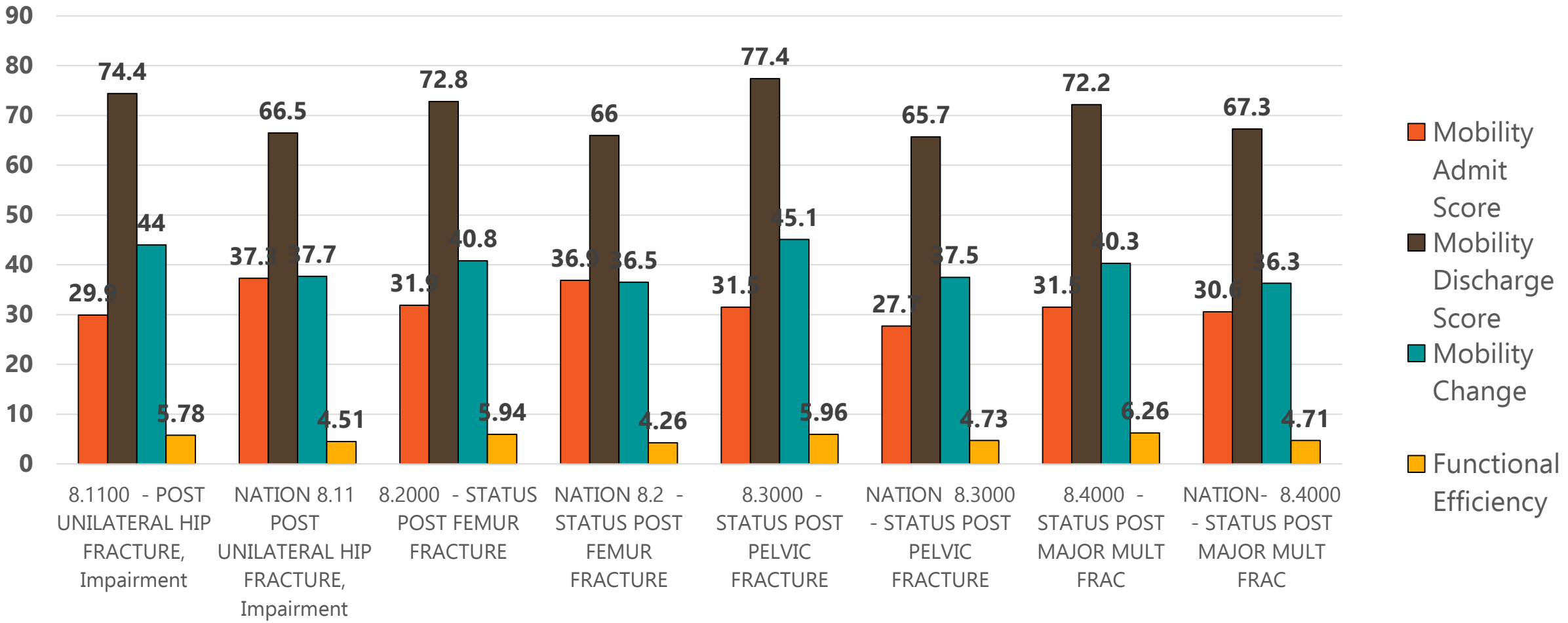
Fracture Mobility



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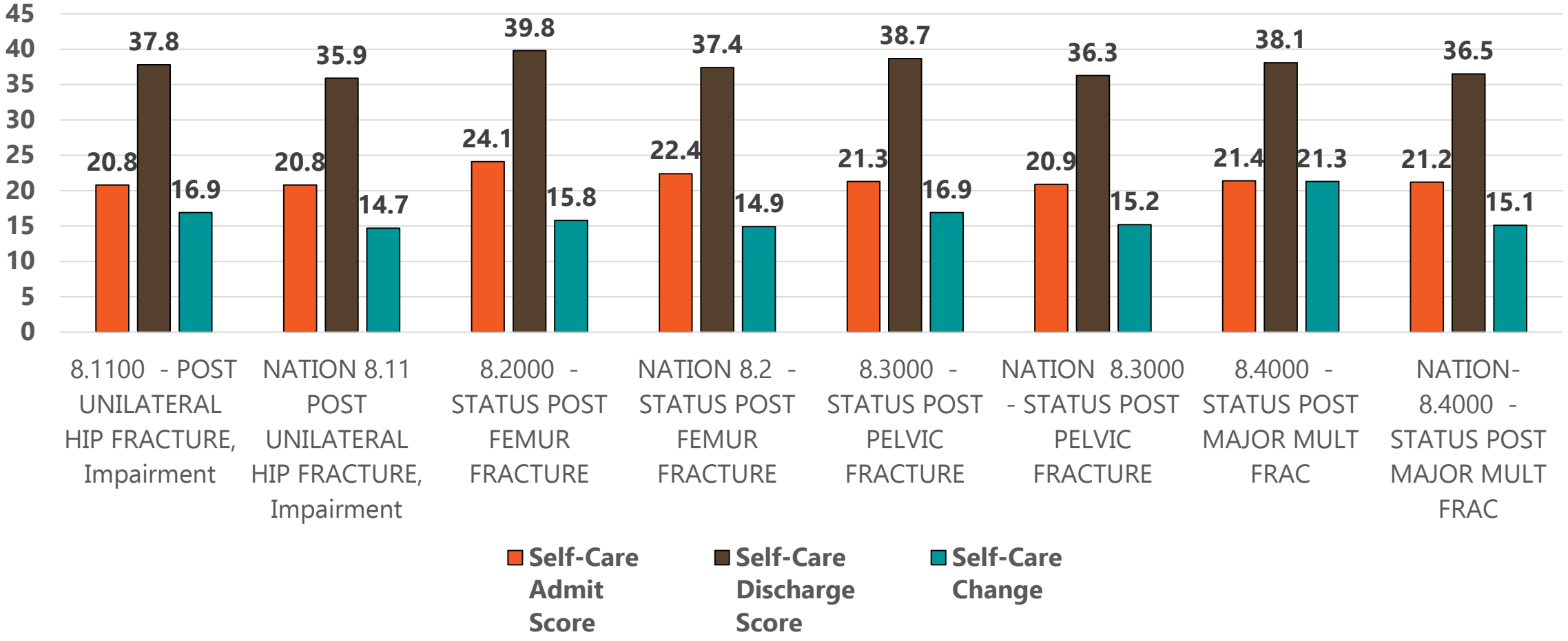
Fracture Self Care v. Nation



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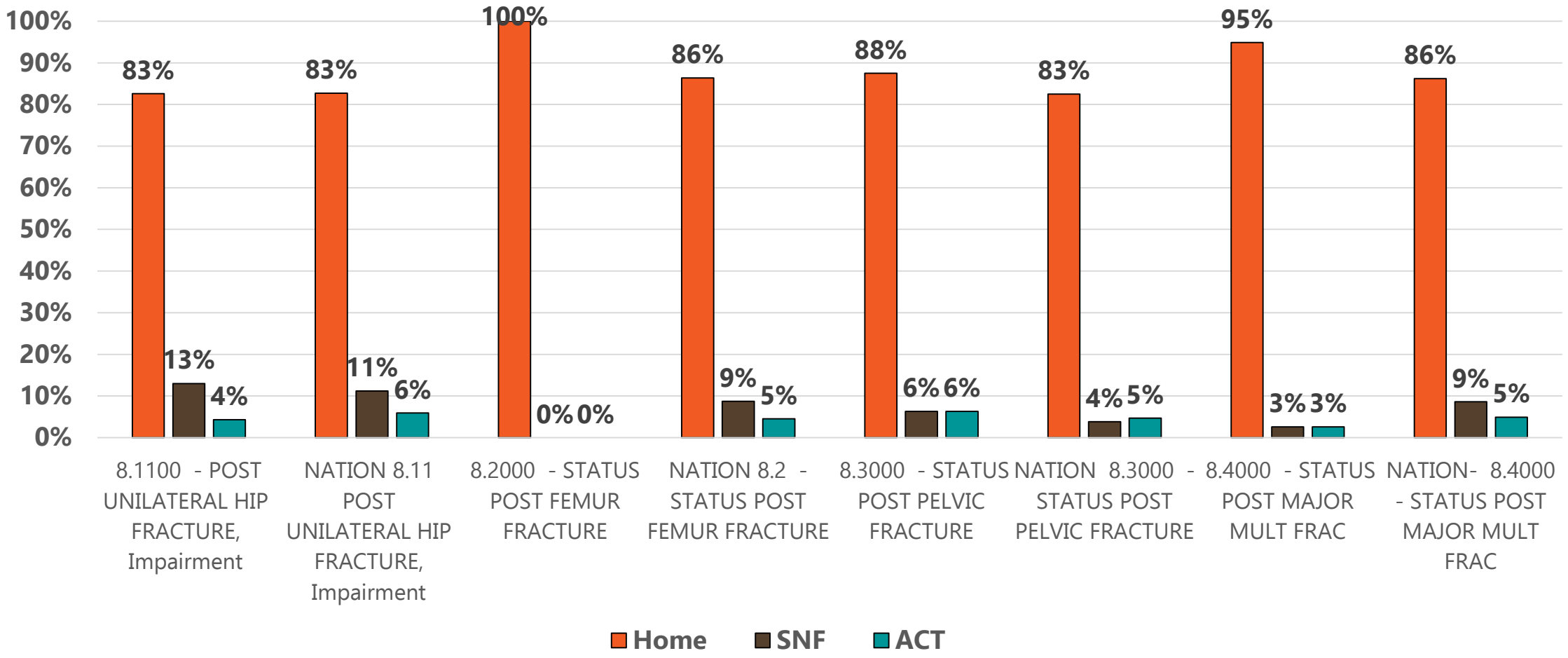
Fracture Discharge Setting v. Nation



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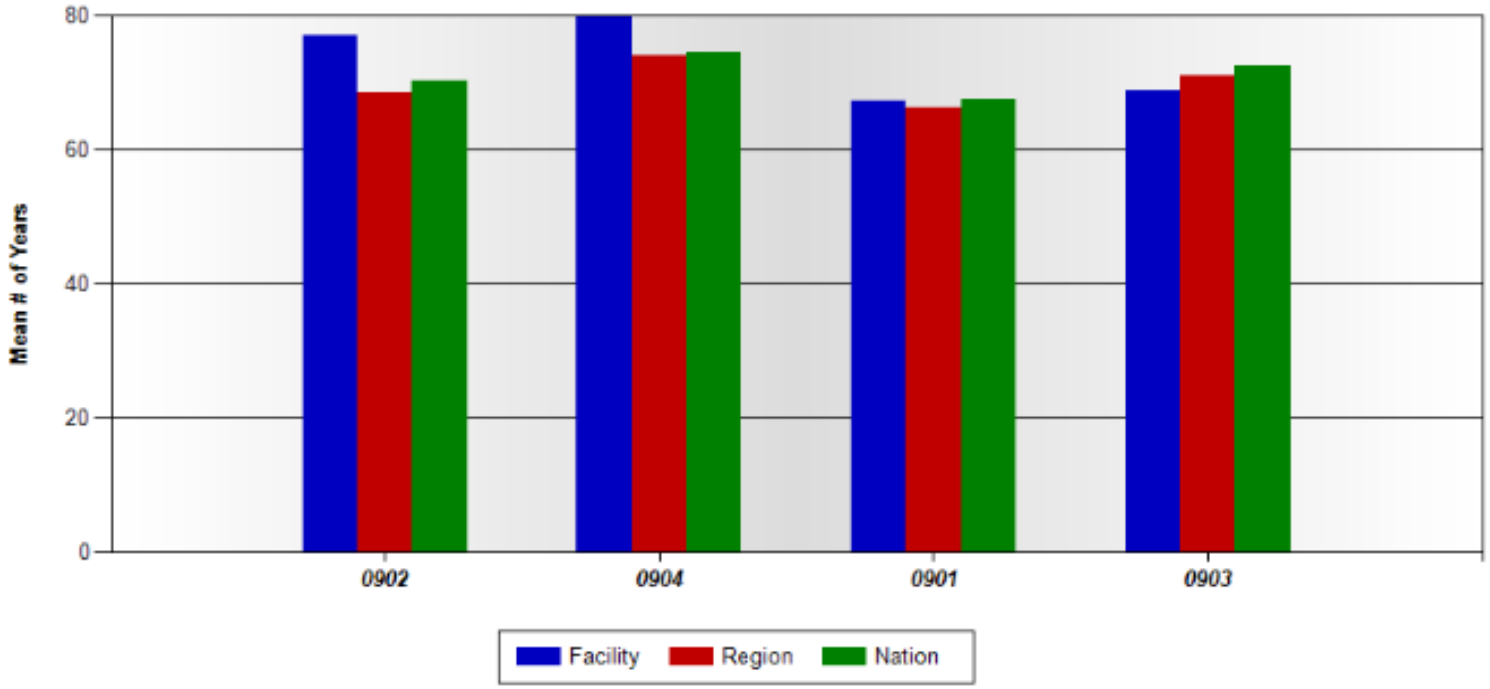
Comparison of Avg. Age by CMG for RIC – 09 Other Ortho



CMG	Facility # Cases	Facility Mean Age	Region # Cases	Region Mean Age	Nation # Cases	Nation Mean Age
All	50	75.0	3,131	70.4	34,779	71.9
0902	23	77.1	1,111	68.6	10,985	70.4
0904	12	79.8	931	74.2	11,854	74.6
0901	8	67.3	430	66.2	4,588	67.6
0903	7	68.9	659	71.1	7,352	72.5

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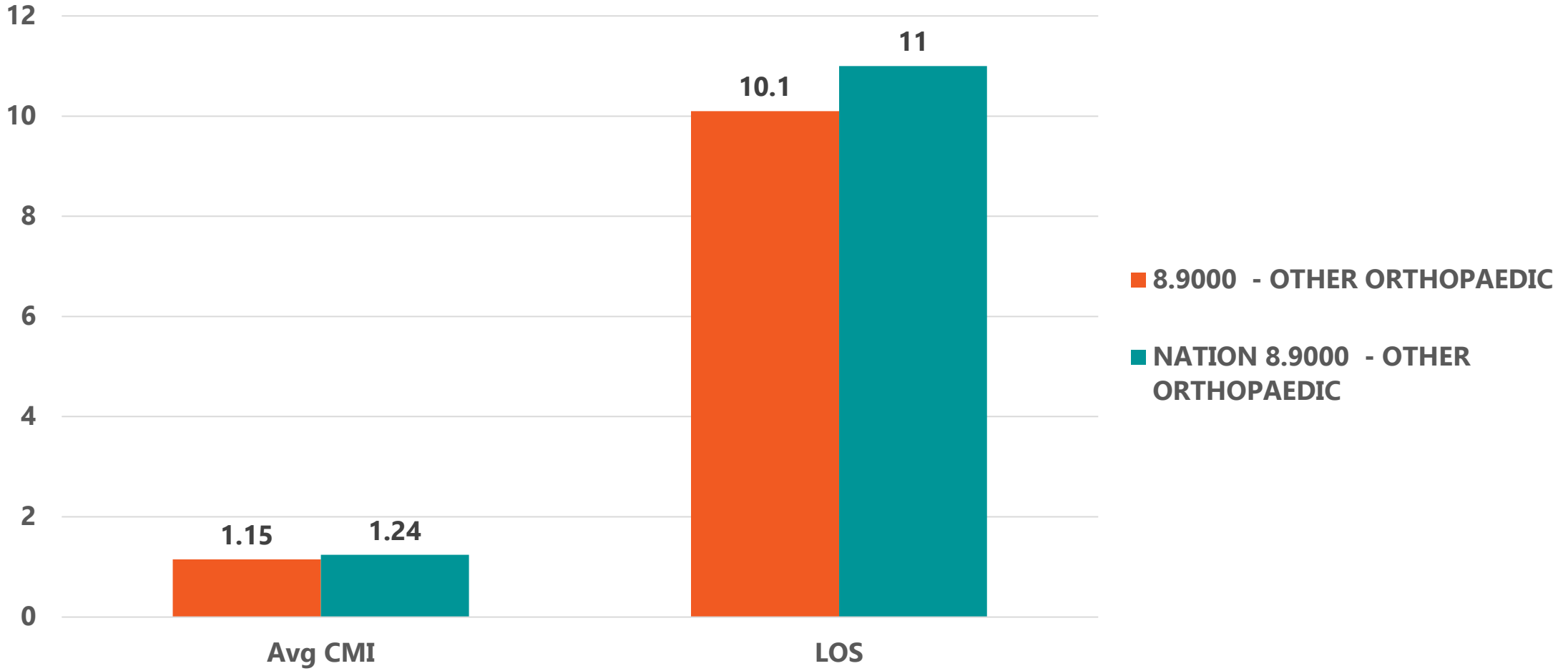
Other Ortho CMI and LOS



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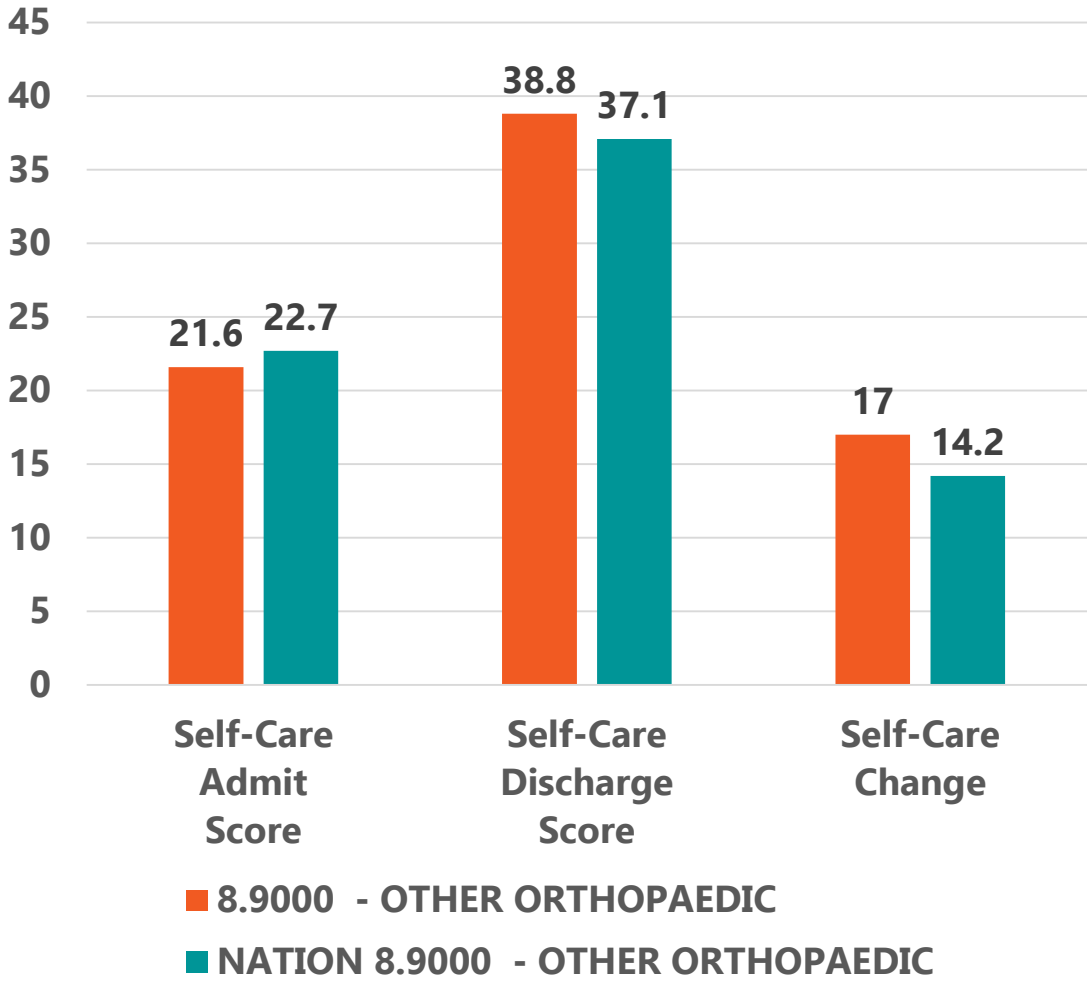
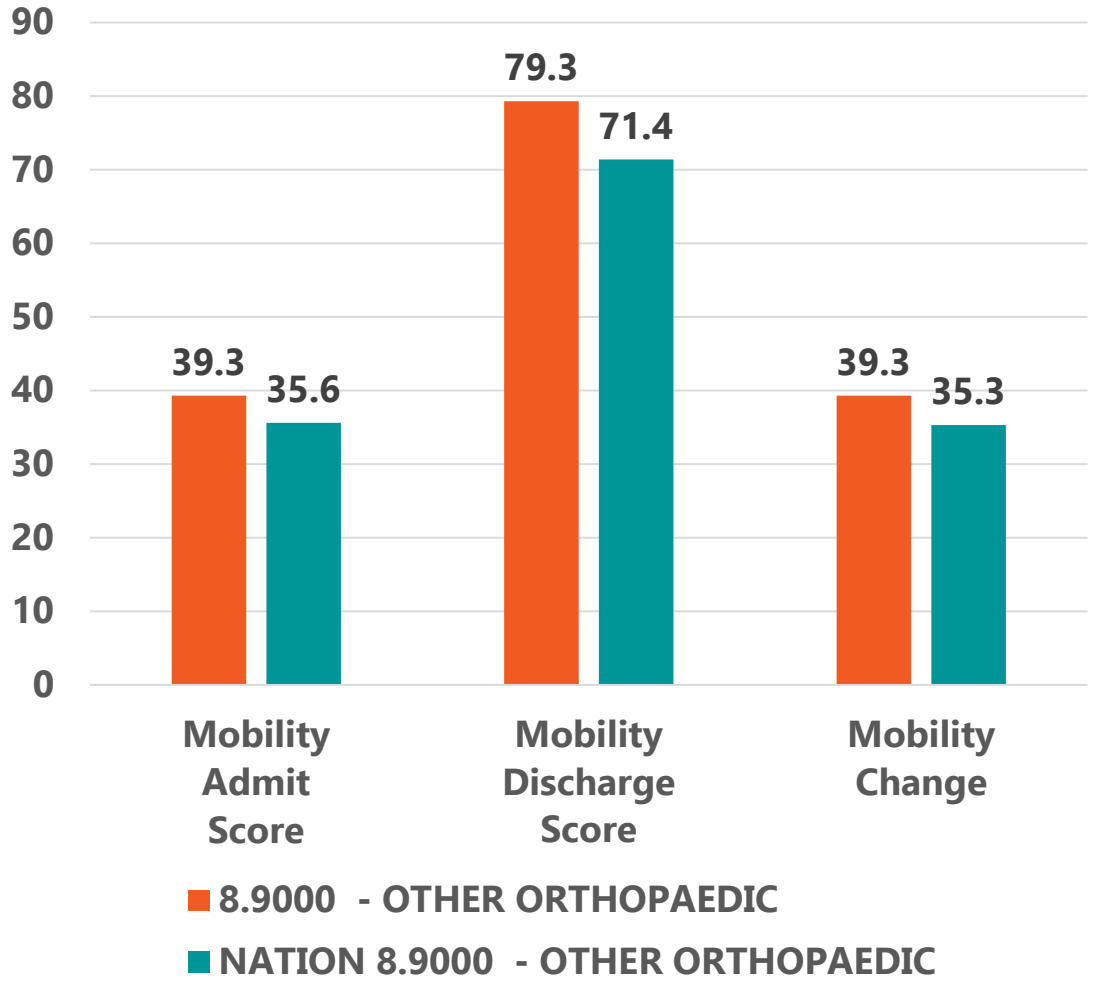
Self Care and Mobility Change v. Nation





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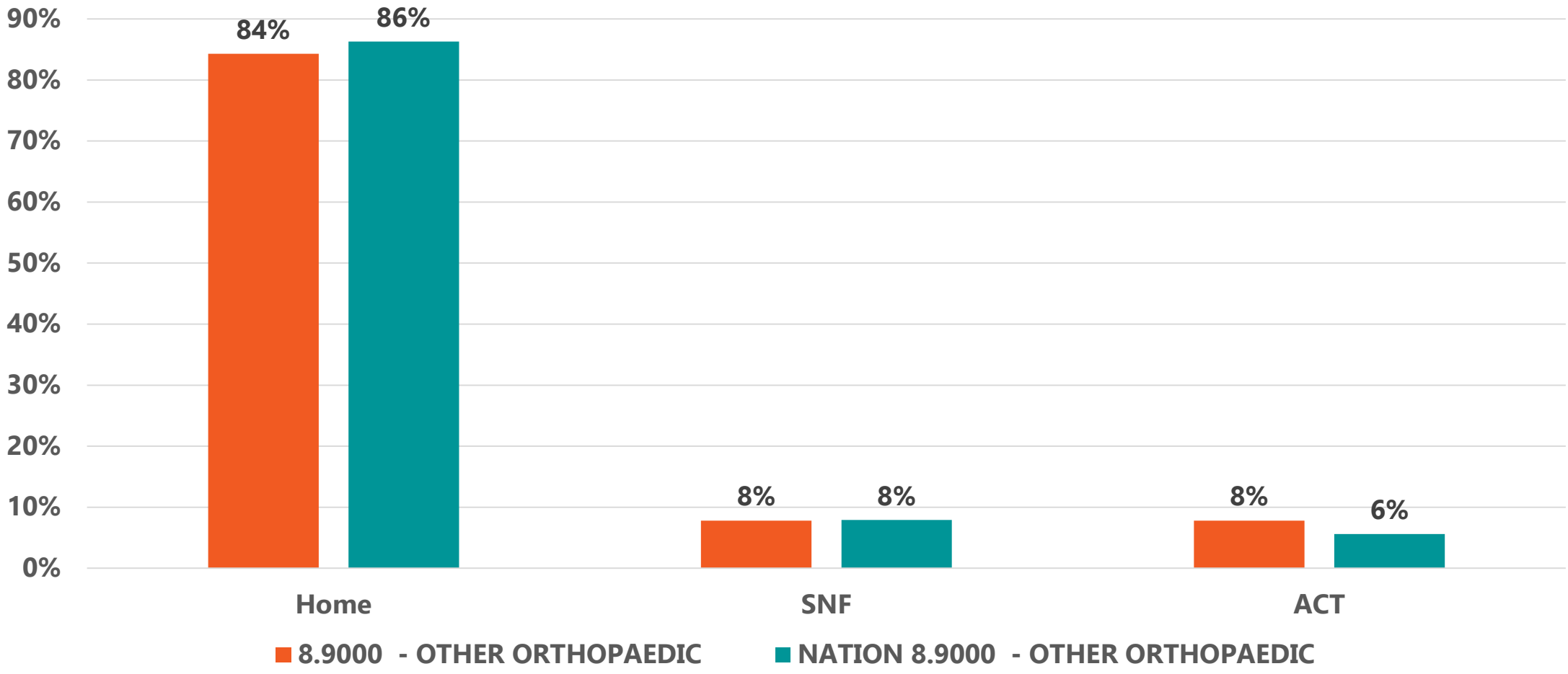
Other Ortho DC Setting v. Nation



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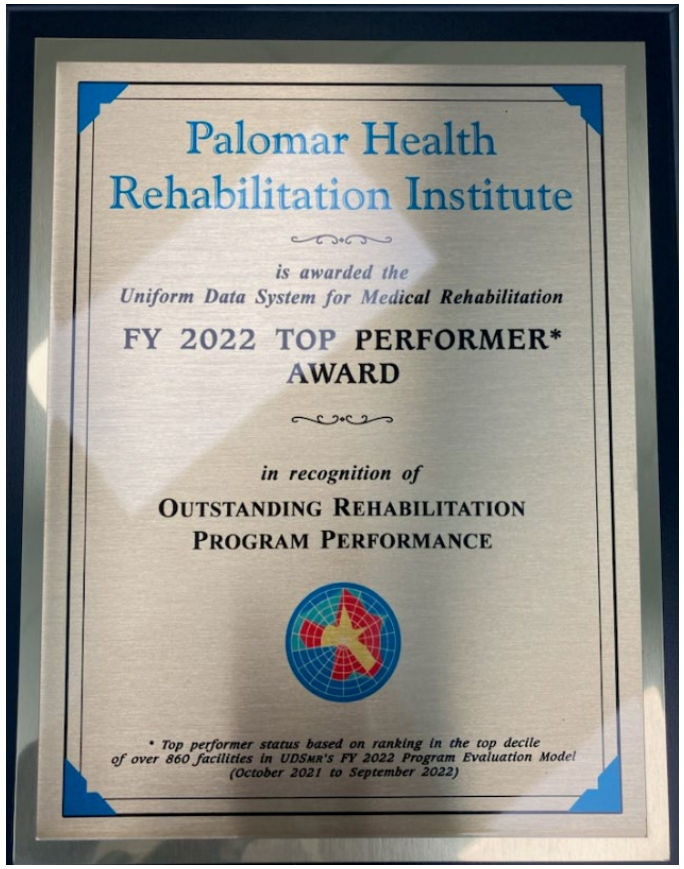
2022 PEM: All Patients



Facility: MZ35 - On-Demand PEM Version 2 Tracking Report - Cases Discharged: Last Year (01/01/2022–12/31/2022)

CMG Target Year: 2023 Primary Payer: All

Program Evaluation Model (PEM) Version 2 Tracking Report

Indicator	Total Cases	Cases In Measure	Patients that Meet or Exceed Target	Observed Score	Expected Score	SubScore	Weight	Weighted Subscore
Discharge Self-Care	704	612	516			84.3 %	10	**8.4**
Discharge Mobility	704	612	529			86.4 %	10	**8.6**
Change in Self-Care	704	612		15.7	12.9	122.0 %	10	**12.2**
Change in Mobility	704	612		38.2	29.9	127.8 %	10	**12.8**
Functional Efficiency	704	612	537			87.7 %	20	**17.5**
Discharge to Community	704	702		85.5 %	82.4 %*	103.7 %	30	**31.1**
Discharge to Acute Care	704	702		7.4 %	8.4 %*	101.1 %	10	**10.1**
Facility PEM Version 2 Total Score								100.7

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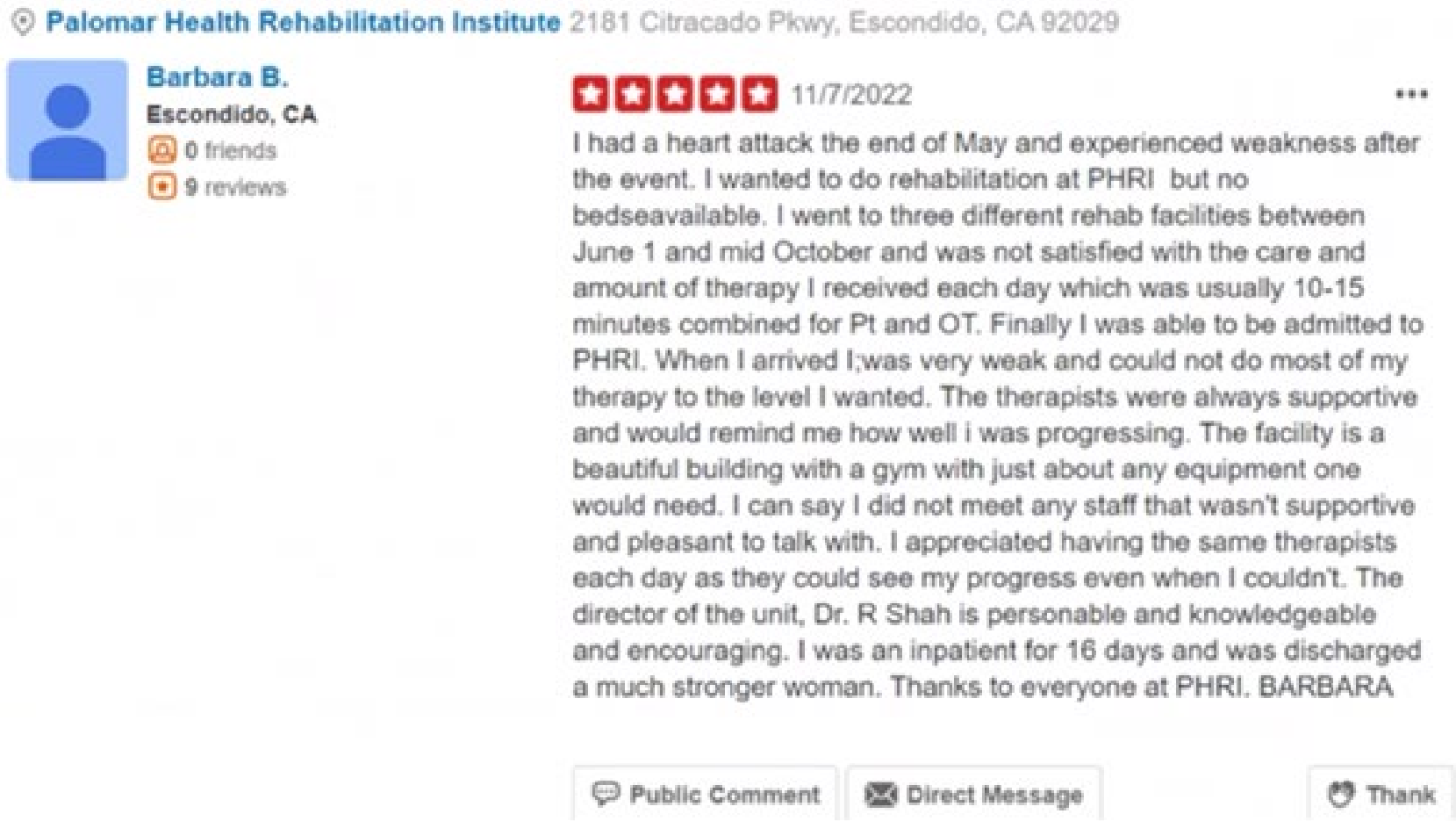
5/5 Review



Palomar Health Rehabilitation Institute 2181 Citracado Pkwy, Escondido, CA 92029

Barbara B.
Escondido, CA
0 friends
9 reviews

11/7/2022

I had a heart attack the end of May and experienced weakness after the event. I wanted to do rehabilitation at PHRI but no bedseavailable. I went to three different rehab facilities between June 1 and mid October and was not satisfied with the care and amount of therapy I received each day which was usually 10-15 minutes combined for Pt and OT. Finally I was able to be admitted to PHRI. When I arrived I;was very weak and could not do most of my therapy to the level I wanted. The therapists were always supportive and would remind me how well i was progressing. The facility is a beautiful building with a gym with just about any equipment one would need. I can say I did not meet any staff that wasn't supportive and pleasant to talk with. I appreciated having the same therapists each day as they could see my progress even when I couldn't. The director of the unit, Dr. R Shah is personable and knowledgeable and encouraging. I was an inpatient for 16 days and was discharged a much stronger woman. Thanks to everyone at PHRI. BARBARA

Public Comment Direct Message Thank

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2022 Reputation.com /Press Ganey

Location (1)	Reputation Score
Best In Class	884
Industry Average	516
Palomar Health Rehabilitation Institute (3844)	840

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Collaborations

- Community resources
- Orthopedic rehabilitation related best practices
- Orthopedic Physician Champions
- QOL
- Reinforcing best practices patient resources from continuum
- Education
- Reinforcing quick return to all post discharge OP care plans

Success Videos

- Kalani

- Adam
  - Adam's Success story – https://www.youtube.com/watch?v=2mWB5cZiRuQ
  - Continuum Success- https://www.youtube.com/watch?v=PjMTYvVNRII

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Q&A

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PHRI Journal Club

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