

Stroke Rehab

Amber Clark, MD discusses the role of PM&R in stroke rehabilitation and how PM&R assists patients and medical care teams in acute care while they are awaiting the next phase of their recovery process. She shares how this can help physicians continue to advocate for and improve the wellbeing of the stroke population.

**Featured Speaker:****Amber Clark, MD**

Amber Clark, MD Specialties include Physical Medicine and Rehabilitation.

[Learn more about Amber Clark, MD](https://providerdirectory.uabmedicine.org/provider/Amber+Clark/1564321?unified=clark&sort=networks%2Crelevance%2Cavailability_density_best)

[\(https://providerdirectory.uabmedicine.org/provider/Amber+Clark/1564321?unified=clark&sort=networks%2Crelevance%2Cavailability_density_best\)](https://providerdirectory.uabmedicine.org/provider/Amber+Clark/1564321?unified=clark&sort=networks%2Crelevance%2Cavailability_density_best)

Release Date: August 2, 2021

Expiration Date: August 1, 2024

Disclosure Information:**Planners:**

Ronan O'Beirne, EdD, MBA

Director, UAB Continuing Medical Education

Katelyn Hiden

Physician Marketing Manager, UAB Health System

The planners have no relevant financial relationships with ineligible companies to disclose.

Speakers:**Transcription:**

Melanie Cole: Welcome to UAB MedCast. I'm Melanie Cole. And today, we're discussing the role of physical medicine and rehabilitation in stroke rehabilitation. Joining me is Dr. Amber Clark. She's an assistant professor and a physical medicine and rehabilitation specialist at UAB Medicine. Dr. Clark, it's a pleasure to have you join us.

And this is a really great topic and kind of a new burgeoning field. So tell us a little bit about the role of PMNR in stroke rehabilitation. And even while you're doing that, tell us a little bit about physical medicine and rehabilitation in general.

Dr. Amber Clark: Absolutely. And it's great to be here. I'm always happy to really promote my specialty. And so first of all, physical medicine and rehabilitation was born out of a necessity That was seen when we had our soldiers coming back and we wanted to reintegrate them into society, there was really no specialty that assisted with that. our soldiers were coming back. They'd had amputations, they'd had brain injuries, they were different.

And the grandfather of physical medicine and rehabilitation worked towards correcting that issue. So he worked with physical therapist to address all of the deficits that our soldiers had. And that's what we really focus on in physical medicine and rehabilitation. We work with therapists, whether that's physical therapists, occupational therapists, and speech therapists. And we have three tenets in our specialty. It's improving independence, quality of life and restoring function. So yes, we are one of the newer specialties in the history of medicine, but I would say our birth was really in the 1920s.

So with that said, stroke rehabilitation, we like to get involved in stroke rehabilitation really at day one. With those same tenets that I previously mentioned, improving independence, quality of life, restoring function, stroke rehabilitation is a continuum. So we have the acute care settings where patients just had a stroke, the primary team is working to medically manage the stroke from their standpoint. But with rehab, we get in. Yes, the primary team is managing the primary stroke, but there are other complications looking at a rehab perspective that can happen after strokes. One of those being spasticity development.

Another being the point that our patients often have premorbid conditions before they come to the hospital. So in my experience I've seen, we have kind of resurgence of musculoskeletal issues, especially in the side that has been involved. So whether they've had a previous biceps injury or rotator cuff insufficiency, that's heightened or they're starting to already get shoulder pain just based off the fact that the affected side is no longer really getting the input that it needs and we can start have gravity taking place so we can get subluxation, so that's painful.

I mentioned spasticity. And spasticity was a great thing because that tells us that the patient is starting to recover from the stroke, but sometimes people get stuck there in that spasticity phase. So what spasticity can start to do, it can start to cause pain, it can start to interfere with therapy. And, if it gets bad enough, it'll start to interfere with hygiene. And so the role there is to really notice and act fast if I see that happening, so that when we're looking at the continuum, so after acute care, we have post-acute stroke recovery, we can do outpatient home health. We just want to get at the forefront of these complications happening on this continuum.

Melanie Cole: Well, it certainly is important. And as you say, getting them really into this type of rehabilitation right away on day one, which is also what they started doing after heart attack. You know, that was something that it was bed rest for a long time. But now really, they are getting up and doing cardiac rehab right away, day one. So we've seen the change. We've seen the importance of this. Does everyone need that same rehabilitation following a stroke? Do they need inpatient rehabilitation or are there other options? Is it mostly something that started in patient and then they continue it just like cardiac rehab with phases?

Dr. Amber Clark: So the answer to that is no. And that's not to say that every patient doesn't need some level of rehabilitation. But inpatient rehabs, there are certain criteria. There are things we're looking at for patients to qualify. Now, I will concede and say that definitely studies have shown that patients do very well or tend to do better when they are immersed in an inpatient rehab setting. And there are distinctions made between these levels of rehab. Inpatient rehab being three hours of therapy a day, where patients need to show that they meet two out of three of the therapy modalities or disciplines that we offer being speech therapy, physical therapy and occupational therapy.

But there are also again other criteria that we're looking at along with their medical complexity and the thinking about, number one, how they're doing already on the acute side with the therapist and prognostication of it. So we have some patients that do have a stroke and stroke patients, depending on the severity of course, can really progress rapidly. So I can see someone one day and I'm like, "Okay. Maybe they could benefit from inpatient rehab." Or one or two days later, they're up and walking more than household distance, which is 60 feet, they are not needing a lot of assistance whatsoever. And at that particular point, no, inpatient rehab would not be the best for them. They could discharge home with either having home health or they could go straight to outpatient therapy.

And I know a lot of times we want to push for inpatient rehab, but it's not always the most appropriate setting for these patients. And honestly, at the end of the day, too, as it is a hospital, we're still putting our patients at risk of catching hospital-acquired infections and things like that. So as I mentioned before, it's definitely a continuum, but no, every patient does not need inpatient rehab.

Melanie Cole: So then tell us a little bit more about acute care while they're awaiting the next phase of the recovery process. So when are you consulted? And tell us a little bit about how the process works for referring physicians.

Dr. Amber Clark: So I am consulted when the primary team deems that it's appropriate. Ideally, as I mentioned before, we like to be involved from the beginning. So particularly with stroke patients, and typically there are two questions that can be asked. Usually, when we are consulted, the primary question being asked is is this patient appropriate for inpatient rehab?

Sometimes it's hard to answer that question because the patient hasn't yet been seen by physical therapy or occupational therapy or speech therapy, because those are important points of information that we're also looking at to include in our assessment and to make the appropriate recommendation. But again, we like to get consulted earlier in the phase, in stage one.

And some of the things that we can also be consulted for is to really counsel patients and counsel their families on rehab prognostication. So what patients can expect as they move on this continuum in rehab and managing that spasticity and addressing musculoskeletal issues even as I mentioned.

I've done trigger point injections on patients. Again, just because they had a stroke it doesn't mean that all other pre-morbid issues go out of the window. And as physiatrists, we are especially trained in being experts not only in the nervous system, but also the musculoskeletal system as well. And we have a wealth of knowledge, and kind of merging those two together. So from that, we're able to see more than what we see on the surface with patients. And that's all aiding in the quality of life, even on the acute care side.

So we'll get the consult. I'll go see the patient. If the question is if they qualify for inpatient rehab, I'll assess them. If therapy has already seen them, I'll look at those notes. If they are showing that they're already appropriate, I'll let the team know that. If the patient is "low level," meaning like they are requiring a lot, a lot of assistance from our therapist, maximum assistance, total assistance and it is obvious at this particular moment they wouldn't be able to withstand three hours of therapy a day. I may make suggestions like we could look into a lower level of rehab, like a skilled nursing facility where they get maybe one or two hours of therapy a day and work their way up. Or it could be the case like this patient is walking 210 feet, they're completely independent with grooming. They're modified independent, which means that they're independent, but may just need an assistive device. If they're at that level and showing that they are well enough to go home and be safe at home, I'll make that recommendation as well. But all the while I'm also thinking about what are other barriers this patient may have, are there things that we're missing that needs to be addressed. And, if they do discharge home or even to another inpatient rehab facility or skilled nursing facility, I make sure that there's follow up in my stroke recovery clinic, just to make sure nothing falls through the cracks. So I found that that is an issue as well.

Melanie Cole: Such important points. And it's so interesting to me, Dr. Clark, how really it's all come together, this multidisciplinary approach. And you mentioned physical therapy and occupational therapy or speech therapy, there's all these different departments working together. As we wrap up, really how can physical medicine and rehabilitation continue to advocate for and improve the wellbeing, as you mentioned there are comorbid conditions, for the stroke population and just kind of reinforce the importance of that multidisciplinary approach at UAB Medicine.

Dr. Amber Clark: Yeah, I think we as physiatrists and PMNR in general, one of the things that we need to do is continue to show our colleagues the multiple things that we can offer. Particularly here at UAB, I know a lot of our colleagues in different departments recognize that we have an inpatient rehab facility. And when they think of staying in rehab, that's what is thought about. But we have a wealth of outpatient clinics here to serve the population that we treat. So we have musculoskeletal clinics. We have spina bifida clinics. Of course, we have stroke clinics. We have spinal cord injury clinics, traumatic brain, and we have all of those are very multidisciplinary. We have rehab psychologist here that we work very closely with not only in our inpatient rehab facility, but we also refer a lot of patients on the outpatient basis as well.

And I would like to encourage my colleagues and physicians in other departments how they can be advocates as well for the stroke population. One would be, we are very blessed to have a strong team in our department here at UAB. But that's not the case all around Alabama or really within the United States. So if you have a patient that clearly has some sustained deficits and they have not fully recovered after stroke, I'd encourage you to reach out and see what physiatrists are in the area that may be able to assist your patients. And then also empowering patients to have listed questions when they go to these providers.

A lot of times, and I've done the same thing, like when I'm going to my physician, you'll have a list of questions in my head. And if I don't write it down, I'll forget. And a lot of times and we're dealing with patients that have disabilities and we know that strokes are actually the leading cause of long-term disability within the United States and that two-thirds of stroke survivors actually go on to have lasting deficits, that's important.

So we want to empower our patients that, yes, you may have had a stroke. But you have the ability to advocate for yourself. It's okay to ask questions and go from there. I think that those are two things that I would definitely suggest.

Melanie Cole: What great information. Thank you so much, Dr. Clark, for joining us today and really telling us how PMNR is involved in stroke rehabilitation. And a physician can refer a patient to UAB Medicine by calling the MIST line at 1-800-UAB-MIST, or they can always visit our website uabmedicine.org/physician.

That concludes this episode of UAB MedCast. Please always remember to subscribe, rate and review this podcast and all the other UAB Medicine podcasts. I'm Melanie Cole.

powered by:  [doctorpodcasting \(http://doctorpodcasting.com\)](http://doctorpodcasting.com)