ProCARE NEWS

ProCare Therapy Services Newsletter 1st Quarter 2016

Welcome to Spring!

Spring has sprung, and its been a wet one! Keep your umbrella and a smile handy. All of us at ProCARE hope you had a very Happy Valentines Day, St. Patrick's Day, Easter, and of course, *every* day!

We have all been busy, and much is going on in the world of healthcare, as well as in our own network of facilities. We are excited about this year, and look forward to seeing more of each of you.

We are also keeping a close watch on the regulatory changes coming this year, from the new section GG on the MDS, to the Medicare move toward bundled payment and pay-for-performance. We will keep you updated!

Please extend a warm ProCARE welcome to a few of the newest members of the ProCare team! Jenna Jones, SLP, Garland; Robin Wilcox, SLP, Walnut Ridge; Mark Leon, PT, Southern Trace; Amanda McQuay, COTA, Pocahontas; Sondra Reed, PTA, Seven Springs; Nichole Terry, SLP, Belle Meade; Meagan Rosel, SLP, Southern Trace

"Optimism is the faith that leads to achievement.

Nothing can be done without hope and confidence"

— Helen Keller

Ashley Mathews, SLP Mr. Pete Harris and Shana Welch, OTA enjoy a successful lunch! Article inside.

In This Issue

Rehab Realization: Q&A

Is the CJR (Comprehensive Joint Reform) mandated for all SNFs? Actually, the CJR follows the location of the hospital where the hip or knee joint replacement surgery was provided. Only hospitals within 67 geographical regions across the country are assigned the mandate. The SNF falls under the CJR guidelines only when they receive patients from those hospitals. Some hospitals and surgical groups are voluntarily altering their practices and expectations, thus therapists should examine all joint replacement orders carefully and closely communicate with hospital and facility admission and discharge coordinators. (Only SNFs with a quality star rating of 3 or better, for at least the last 7 months, can even accept official CJR post-surgical patients.)

Why is the CJR implemented at all? Replacing fee-for-service and volume models of payment with payment systems based on outcomes and payment bundling methodologies, was mandated by the IMPACT Act. ***The CJR is one alternative payment model that helps meet the Administration and Medicare goal of having 30% of all payments made via alternative models by 2016, and 50% by 2018.***

Could the Rapid Recovery model or the CJR Comprehensive Joint Reform movement or the IMPACT Act affect my treatment? Yes. We will not always have control of timelines, discharge dates, length of stay or even therapeutic goals. In this model, patients will frequently be moved to outpatient or home health very, very quickly. We have a duty to get that patient as safe, strong and functional as possible within that time.

What is different? Now, without the benefit of time, we may be required to treat more like acute care therapists. Indeed, we may not have the opportunity to get a patient to functional independence, so we *must* focus intensely on body systems and functional components.

And, since we are on the subject...

ARE YOUR TREATMENTS WIMPY?

Let 's be real. Some of us geri-treat. Too often, we in geriatrics have been reluctant to push our patients quickly, for fear of refusals, pain, or simply elder sympathy. Push your patients! Our treatments must change; our interventions must change; we cannot provide the same intervention day in and day out. Patients must not only improve functionally in relation to their surgery, but improve their gross physical condition. Higher intensity therapy is essential for avoiding post discharge decline, post-discharge injurious falls, and for minimizing returns to the hospital. The body is a system; treat it.

Do patients sit in supported sit throughout treatment? Never forget, the trunk is the basis of support, and postural mechanism and strength is vital to functional recovery. Dynamic treatment should rarely occur in supported sit. Aggressively strengthen the whole body; measure and document intervention and progress. Compare affected *and* unaffected side; we must treat bilaterally and attend to symmetry and function! When *you* go to the gym, you steadily and significantly increase the weight to make gains. Do the same for your patient! Use increasing weights and resistive exercise and bands, and incorporate into normal movements. Do *not* geri-treat!

Consider: Therapists are coaches, not coddlers. Remember who you are! Frequently, therapists in SNF's underweight their treatments; do you? Establish clear and specific baselines beyond simply the initial level of assistance. Determine and document max weight baselines. *Increase* them aggressively. What is the actual range of motion? Improve it.

Scar management, Edema, Pain: Address scar tissue, swelling, and pain management must be a clear focus. Clinically describe the scar; describe your interventions; document discharge results. Measure swelling/Edema. Take circumference measurements distal to proximal, every 2 centimeters from a consistent baseline point; compare to the unaffected leg. Describe interventions and provide discharge measurements. Pain level must be measured and documented with a consistent scale from evaluation through discharge. Describe your pain interventions and results. Use modalities. Document which modality is used, the settings, changes, and patient's response. Describe modality effect on therapy participation, on function, on pain, and on swelling or healing, as indicated. Use every tool at your disposal to maximize your patient's participation and benefit!

What about Outcomes and the CARE Tool?

The CARE Tool outcome measurements are part of the IMPACT Act's mandate to create consistent measurements across healthcare settings. We at ProCARE have already incorporated the CARE Tool into our documentation. Section GG is the new (Minimum Data Set) MDS section that uses CARE tool measurements. CMS will fully implement section GG in the MDS this year, in all SNFs. Nursing and therapy must work together to provide coherent of patient function, timely assessment of both admission and discharge, and to complete patient discharge documentation immediately, so that patient status can be quickly transferred to the next healthcare provider.

All that we do should be with the goal of enhancing and improving the well-being of our patients, regardless of the limitations placed upon us. We must adapt our treatments to maximize the safety and well-being of our patients!

We Love Success!

ProCARE gives a shout out to the rehab team at Courtyard, and to Mr. Pete Harris!

Thanks to the evaluative assistance and treatment of Ashley Mathews, SLP and Shana Welch, OTA, Mr. Harris received a special eating utensil that uses computer chip and stimulation to overcome essential tremors.

Mr. Harris developed significant coordination and self-feeding problems secondary to incoordination and tremors associated with Parkinson's Disease.

Now, following therapy and the use of recommended specialized equipment, provided by the facility, Mr. Harris is eating free and easy!

Shout out to the entire Courtyard and ProCARE family! Way to CARE!
*photo p.1

The Easter Bunny hops into Southern Trace!

CLINCIAL CORNER

Speaking of CJR…..KNEES AND HIPS!

Knees and Hip surgeries were specifically targeted by CJR , because they are among the most costly items for Medicare reimbursement. Some reminders...

Hip and Knee replacement and repair surgeries are generally very effective, and failure is rare. The most common reasons for knee failure are infection, stiffness, continued pain, wear, instability, and loosening of the implant. The most frequent reasons for hip failure and revision are for repetitive dislocation, infection or mechanical failure. Despite the effectiveness of these procedures, they are costly for Medicare, and related recovery and rehabilitation is under close outcome scrutiny.

Hip replacement surgery has come a long way. Many patients today qualify for newer surgical procedures that minimize the need to cut through muscle, greatly accelerating healing. The three usual hip surgery approaches are Posterior, Anterior and Lateral. The most restrictions are presently with a posterior approach, however each has specific precautions. Therapists must know the type of procedure performed, the surgical incision, healing status and the specific risk factors present. Most Hips are weight bearing as tolerated, however MD orders, including range of motion guidelines should be verified and followed.

Knee replacements often present with greater acute pain than Hip surgeries. Edema and pain must be managed. Range of motion and terminal knee extension are always key issues. Full range of motion is the goal of each surgery, and it is achieved with all successful recoveries. Patients frequently must be educated and encouraged to complete therapy treatment and reach the range of motion goals, in the face of acute discomfort.

Hip Replacement Exercises

Quad Sets- Increases the strength in quadriceps muscle without straining your joint replacement.

Glut Sets- Used to increase circulation and strengthen muscles of your buttocks, which you use when walking and moving. Again this exercise engages your muscles without moving your hip or knee.

Ankle Pumps- Used to strengthen calf muscles and improve blood circulation. A rolled towel can be placed under ankle to improve technique.

Hip and Knee Flexion (Heel Slide) - Important to recovery because they stimulate quadriceps and hamstrings to improve knee and hip ROM. As strength is built, knee and hip ROM becomes more comfortable.

Hip Abduction- Weak hip abductors can negatively affect your posture and gait. These exercises are used to strengthen these muscles and stabilize the legs and pelvis.

Knee Extension (Long Arc Quad) - Increases knee flexibility ROM and improves quadriceps strength.

Short Arc Quad- Performed to strengthen and improve motion of this important muscle set for gait and ADLs.

Standing Hip Flexion- This exercise helps to lubricate the hip joint and to stabilize the hip muscles. This further prevents injury to hip and provides ankle and knee stability.

Squats- Proper technique is extremely important with this exercise. This exercise engages all muscle groups in the legs, especially the quadriceps, gluteus and hip abductors.

E-Stim may be used to decrease pain, improve strength and functional independence.

Research demonstrates a rehabilitation program combined with e-stim for patients following hip replacement significantly reduced pain by up to 95%.

E-stim with physical rehabilitation was shown to be effective in restoring hip ROM, enhancing ADL performance such as walking or climbing stairs and in enhanced muscle strengthening.

Recent study concluded low frequency electric muscle stimulation is appropriate and effective to maintain and/or increase the strength of operated leg to achieve symmetry between lower extremities and promote functional independence.

Another study on effectiveness of e-stim of quadriceps and hamstrings in adjunct with therapeutic exercise concluded e-stim is effective in deceasing pain and increasing strength, range of motion and quality of life. Precautions and best practices must always be followed.

Diathermy with Hip Replacement-

Muscle weakness and limited range of motion are major issues. Diathermy may be used to decrease pain, improve ROM, joint flexibility and increase blood flow.

Diathermy allows the body to generate heat within the targeted tissue, rather than applying direct heat to the body. Increased heat promotes blood flow and healing.

Diathermy contraindications and precautions and best clinical practice should be exercised at all times.

IMPACT ACT of 2014

Beginning this year, 2016, CMS is implementing data sets and systems with uniform terminology across the four PAC settings and collecting data, as a result of IMPACT Act 2014. (Improving Medicare Post-Acute Care Transformation Act) The data sets will examine critical areas of function, including self-care, mobility, and history of falls; cognitive function, including depression and dementia; medical conditions and comorbidities, such as diabetes and pressure ulcers, and including impairments such as incontinence.

Congress signed the IMPACT Act into law in October 2014. The Act was intended as an effort to modernize Medicare Payments to Post Acute Providers (PACs) and to provide an accountable, quality driven payment and service model. This includes receiving thirty percent of Medicare payments via alternative models by 2016, and fifty percent by 2018.

The IMPACT Act specifically targets interoperability and access to standardized data across health care providers, discharge planning, patient outcomes, and patient access to appropriate setting. CMS was mandated to develop and implement quality measure domains with standardized assessment data, as well as outcome measures applicable to all providers, from hospital to discharge to the community.

PACs will use and submit standardized assessment domains, data and terminology in their required assessment instruments and data collection. Domains include: Skin integrity and changes; Functional status, cognitive function, and changes in function and cognitive function; Medication reconciliation; Incidence of major falls; Transfer of health information and care preferences when an individual transitions; Resource use measures, including total estimated Medicare spending per beneficiary; Discharge to community; and All-condition risk-adjusted potentially preventable hospital readmissions rates.

The CJR is a component of the IMPACT Act that is an effort to provide pay-for-performance, and the outcome measures of the CARE Tool is an example of standardized assessment measures across PAC providers.

Contact Us

Give us a call for more information about our services, more information about your facility... or more information about *you!*

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