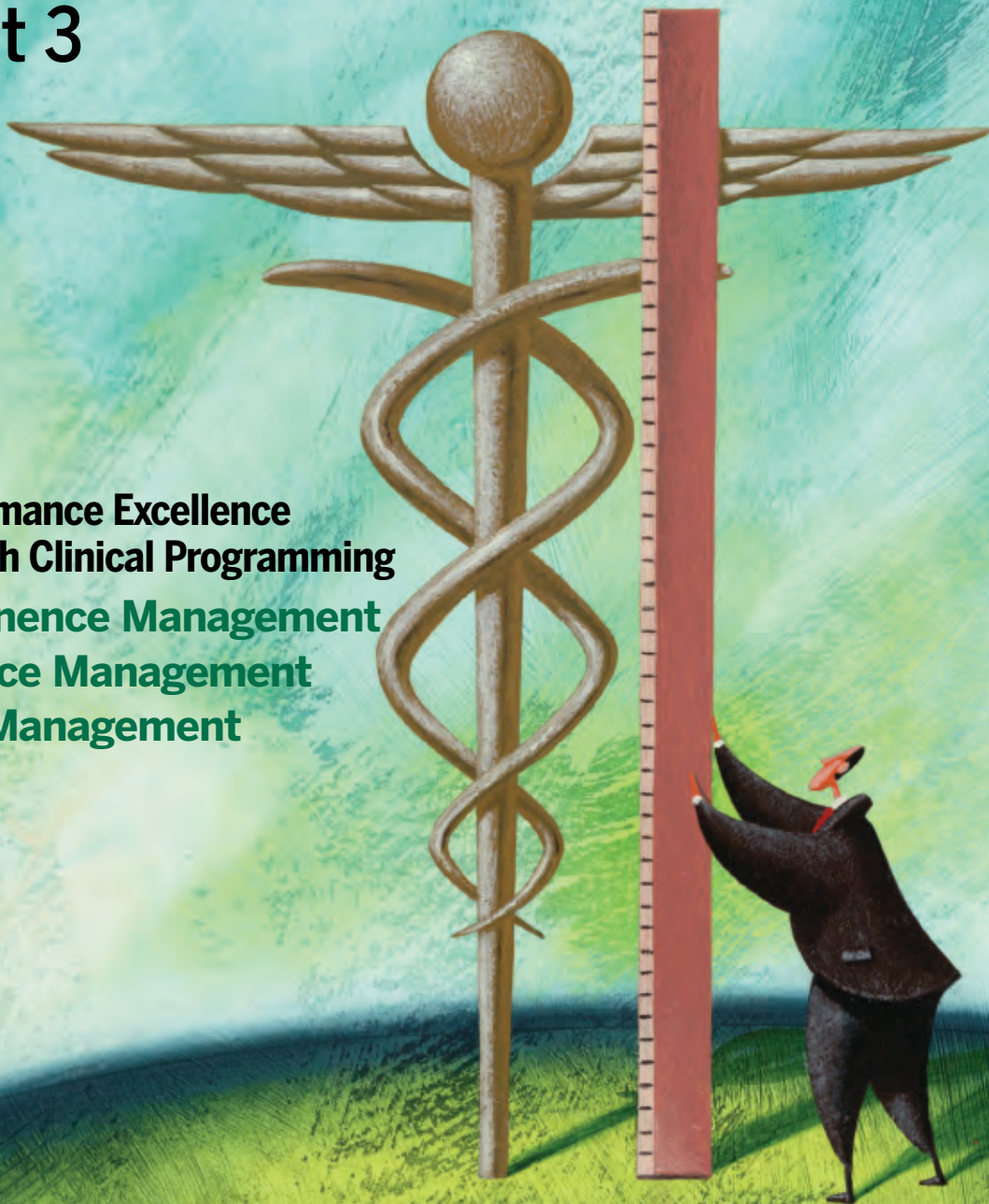


Rehab Perspectives September 2008

Preparing for P4P: Do You Measure Up?

Part 3

**Performance Excellence
through Clinical Programming**
Continenence Management
Balance Management
Pain Management





Redefining Therapy

This is the third part of our three-part series this year on Pay for Performance, Medicare's quest for cost-effective care. Whether it's called P4P, pay for performance or value-based purchasing, provider accountability is high on the agenda of the Centers for Medicare & Medicaid Services (CMS).



Clinical excellence in rehabilitation is a key measure of the quality of care in nursing homes. When patient improvement can be measured after therapy intervention, nursing homes have a quantifiable basis for claims of success. In the P4P environment, such measurability is crucial when it comes to getting reimbursed.

CMS has identified specific quality indicators on its Web site in order to make quality transparent for consumers. An excellent rehab program can positively impact those quality indicators and give consumers a way to evaluate how nursing homes are doing. A rehab partner with expertise in geriatric rehab and that has demonstrable outcomes can position a facility as a community leader in patient care.

But how does one go about providing clinical excellence in rehabilitation? Isn't hiring good therapists enough?

In this issue of Rehab Perspectives, we'll explore how clinical programming around the most common geriatric risk factors—incontinence, falls, and pain—can take rehab to a higher level.

Aegis' RCA program (Restore, Compensate, Adapt) redefines the concept of therapy. It is the foundation for all clinical programming and provides a three-pronged approach: restore function, compensate when function cannot be restored so patients can maintain quality of life, and adapt the environment and equipment to help patients reach their goals.

Clinical programming based on RCA improves the lives of geriatric patients, a claim that can be proven with measurable clinical outcomes.

As ever, Aegis is your rehab resource.

Martha Schram
President
Aegis Therapies

Contents



- 3** Anticipating Vulnerability
Clinical programming takes a proactive approach to care
- 6** We've Got You Covered!
Core clinical programs for long-term care

Rehab Perspectives

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Anticipating Vulnerability

Clinical programming takes a proactive approach to care

At Sunny Skies Nursing Home, Mr. Jones could have experienced seven episodes of incontinence yesterday. Mrs. Smith might have fallen trying to rise from her wheelchair in the afternoon, and Mrs. Brown may have refused to get out of bed all day.

But those incidents didn't happen.

Fortunately, Sunny Skies understands the role of therapy in improving the lives of its patients. And fortunately, its therapy partner knows that geriatric rehab is more than a reactive clinical response to an incident; it is a proactive approach to patient care through comprehensive clinical programming.

Mr. Jones, Mrs. Smith, and Mrs. Brown were lucky. Sunny Skies' therapy partner is committed to clinical programming that addresses the risk factors before an incident occurs. Using a whole-facility team approach, clinical programming provides a framework for therapists and staff to interact and examine all facets of the patients' lives to assess risk, provide treatment, and determine how to prevent incidents from happening again.

Mr. Jones was in the continence management program. He was given exercises and treatment to strengthen his pelvic floor musculature and was able to restore the muscle tone needed to maintain continence. Mrs. Smith was in the falls program. She had been evaluated as a risk, and because her arms weren't strong enough to push her up from her wheelchair, she was taught how she could compensate and learn a new way to move from sitting to standing without injury. Working through the protocols of the pain program, therapists identified that Mrs. Brown was neither lazy nor depressed but that she preferred lying in bed because sitting in her wheelchair hurt her back. A simple adaptation to the wheelchair allowed her to sit in a different position and alleviated her back pain, allowing her to get up and about in the facility and participate in daily life again.

Determining vulnerability

The elderly are vulnerable on many levels, not just because of the particular incidents that send them to therapy. Incontinence, falls, and pain are the most common risk factors that individuals face in the process of aging; preventing those problems is the core of good care. "It's almost irresponsible to say that you are a medical facility for geriatric people and yet you ignore a comprehensive approach to incontinence, pain and the risk for falls," says Bill Goulding, national director of outcomes and reimbursement for Aegis Therapies. "They are the most common risk factors for the elderly, so you have to deal with them in a responsible manner. The question is, are you going to do it on an ad hoc basis when a patient is in crisis, or do you think more globally, more proactively, and create a program that will



Rehabilitation involves more than physical manipulation and exercise. A clinical program assesses a problem's source and helps prevent its recurrence.



not only deal with the incident, but can help all patients to avoid that experience or risk?”

What's in a clinical program?

A clinical program is built around two questions: Why did this happen and how can we prevent it from happening again to this patient and to all other patients? “When people think of rehab, they usually think of physical manipulation and exercise,” says Goulding. “That’s a disservice to the patient. The mental process of clinical programming is that you are not only going to move limbs, but you are going to consider every way to improve the patient.”

That means thinking beyond textbook therapy. “The challenge in working with the geriatric population is that issues that would appear to be common-knowledge for therapists coming out of school are compounded by medical complexities, cognitive ability, and other issues of aging,” says Donna Diedrich, PT, GCS, regional director of clinical services for Aegis Therapies. “Therapists need special training to look beyond the presenting issue—pain, falls or incontinence—and to examine everything that is impacting the patient within his environment. You can’t look at it in a vacuum. It’s not enough to say that a fall doesn’t have to do with therapy because the patient got up and started walking again. The issue is how could we have prevented the fall? A well-integrated clinical program takes all of those pieces and puts them into the training. It’s a consistent, comprehensive approach.”

Education is the key—organizing the available knowledge about a problem or condition and teaching therapists how to apply that knowledge. Online learning resources, availability of peer discussion, and a structured approach provide a solid knowledge base for therapists. “There are a lot of great clinicians out there, but if you don’t have the material organized in a systematic fashion, something is left behind,” notes Brian Boekhout, PT, regional director of clinical services for Aegis Therapies. “A therapist may have all the knowledge on the clinical application of a product, but there must also be a way to identify patients, create a systematic clinical approach, interact with the facility staff, and document. Simply having knowledge in a given area isn’t enough. Clinical programming takes in the whole picture.”

Essential to success is the interdisciplinary team approach that involves all departments of the nursing home—nursing, dietary, activities, and even maintenance. Reviewing policy, examining equipment, analyzing the environment, and looking at options for treatment are all part of the process. “Therapy can provide training for the facility staff. There has to be a commitment that cuts across disciplines and employers,” says Goulding. “Typically, CNAs are very

receptive. It makes them feel empowered to realize that they can truly improve the quality of life of their patients.”

The departure point for a good clinical program is the world in which the patient lives. For example, a falls program may begin with an equipment evaluation to make sure that wheelchairs, walkers and assistive equipment are safe. “It will take a review of policy, for example, to help us decide when to put on a Posey vest or a lap belt on a patient,” says Goulding. “Maintenance issues may be affecting patient safety. An examination of flooring, railings, thresholds, stairwells and lighting may reveal areas that can be improved. The pharmaceutical aspect should be examined as well: Combinations of certain drugs can increase risk of falls.”

Of course once a program is in place, it’s not enough to just assume it is working. There must be some way to measure outcomes. “A therapy company should be able to provide evidence of outcomes from its programs,” says Diedrich. “For example, at Aegis, we have a therapy tool called the Rehabilitation Outcomes Measure (ROM), which allows us to score baseline testing and then to track outcomes. Pain, incontinence and balance are just a few of the functional outcomes we measure. We have millions of patient records that show our program interventions have been successful.”

A world beyond restoration

Sometimes you have to lift your eyes from the prescribed world in front of you to gaze out at the horizon and take in the big picture. In the geriatric therapy world, that means discovering ways to help the patient when functionality cannot be restored.

The basic philosophy that underlies all clinical programming at

Quality Indicators Impacted by Therapy

- Falls
- Cognitive impairment
- Bowl/Bladder incontinence
- Incontinence
- Catheter insertion
- Fecal impaction
- Weight loss
- Tube feeding
- Problem behavior
- Moderate/Severe pain
- ADL help increase
- Movement ability decrease
- Decline in range of motion
- Pressure ulcers
- Depression



Simply because a program exists does not mean it's working. Providers must make an ongoing, consistent effort to measure resident outcomes, experts note.



Aegis Therapies is RCA—Restore, Compensate, Adapt. “RCA has something to offer every patient in the building,” says Mark Besch, vice president of clinical services for Aegis Therapies. “It is a clinical philosophy that ensures that we are not wearing blinders and only doing therapy as restoration. There is a much broader continuum upon which we can treat these patients. If therapy only treats those who can be ‘fixed,’ then two-thirds of the patients are going to be missed—patients whose quality of life could have been improved dramatically.”

Therapy doesn’t end when function can’t be restored. “Think about compensatory ways to enable a patient to complete a task,” says Besch. “If a patient can’t feed himself, maybe we can prop his elbow so he doesn’t have to use the full range of motion in the shoulder. Strategies might include using a reacher, a walker, a cane; you’ve given patients an alternate way to perform tasks that they wanted to do independently.”

The restore, compensate, and adapt philosophy treats therapy as a continuum of care. “It’s not uncommon to find most therapy programs are focused on restoration of prior skills,” says Diedrich, “Compensatory and adaptive programs are often not considered within the scope of therapy. The patient may be discharged from treatment without consideration of those other needs and opportunities.”

The advantage of this type of a clinical philosophy is it allows therapists to look at patients as a whole, not just at the ability to restore them to a functional level they once had. “We may begin with restoration,” says Diedrich. “Then we look at where the patient is now and how we can help with a change in approach to their care or an environmental change.”

Boosting those quality indicators

Good clinical programming can have a significant impact on quality indicators. When Minnie was looking for a place for her 89-year-old mother, Maude, she went to the Internet to research facilities. At www.nursinghomecompare.com and on CMS’ Web site, she found that all nursing homes were not the same when it came to quality indicators.

“CMS has mandated that performance information be public knowledge and uses quality indicators to rate facilities,” says Besch. “For example, any consumer can see how many people in a facility have urinary incontinence or have fallen. These are public metrics.”

CMS has indicated that quality indicators may be used to evaluate facilities in the coming Pay-for-Performance world. Rather than deal with crises in quality indicators in tense quality assurance meetings, facilities with strong, comprehensive clinical programs in place can

be assured that they have a proactive and more effective approach. Clinical programming may well be the engine that not only drives up scores on quality indicators, but also drives reimbursement as well.

The marketing factor

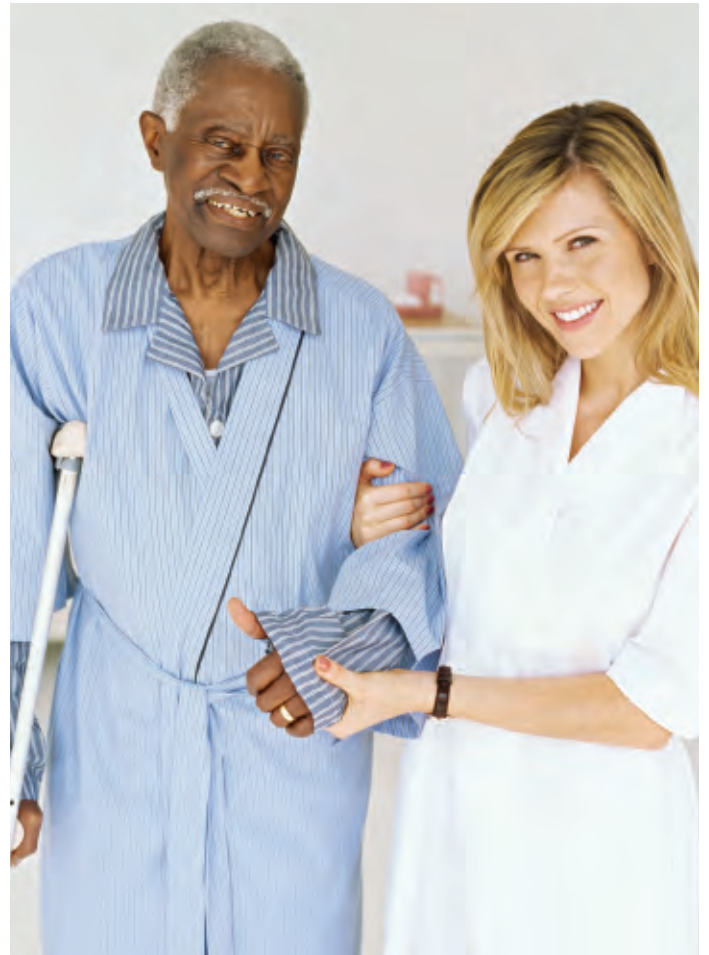
Clinical programming has benefits for a facility beyond raising the quality of patient care. It can be a marketing delineator, setting your facility above the competition. “From a market standpoint, so many of the facilities and rehab programs out there are what I call vanilla,” says Aegis’ Boekhout. “You need to do something to drive the public to your door. I’ve always felt that solid clinical programs answer a lot of problems. In addition to the quality rehab that facilities and clinicians are looking for, you get good communication with physicians and physician buy in. You are interacting with patient families, so you are creating a name in the community.”

A not-to-be-ignored benefit is the ability to attract therapists.

“Therapists want to be part of something innovative,” says Boekhout. “The more advanced your clinical practices, the better your chances of pulling in those high quality therapists.”

A well-run clinical program drives employee satisfaction, clinical results, and patient satisfaction. Physicians know they are sending their patients to a well-thought-out, top-notch, complete program. It drives census through marketing.

“Clinical programming is the trunk of the tree,” says Boekhout. “Without it, the tree doesn’t grow.” ■



Clinical programming can be a marketing advantage that separates your facility from the competition. It can also lead to more satisfied residents—and staff.

How Good is Your Clinical Program?

- Are therapists trained in a holistic approach that goes beyond restoration?
- How much special training do therapists receive?
- Are information resources (online and through peers) easily available?
- Are all departments of the facility included in training and education?
- Are therapists trained in how to document compensatory and adaptive treatment?
- Are outcomes from the clinical program measured?
- Is clinical programming used as a marketing tool?



We've Got You Covered!

Core clinical programs for long-term care

CONTINENCE MANAGEMENT

Dottie, whose laughter and sense of fun had once enlivened all group activities in her nursing facility, had become a recluse, refusing to leave her room. It wasn't the onset of a disease that changed Dottie's life. It was urinary incontinence (UI).

"Aside from medical issues, one of the big issues in UI is social isolation and embarrassment," says Barb Christensen, regional director of clinical services for Aegis Therapies. "People often stop participating in activities and become depressed. But there is no reason that anyone ever needs to be wet."

Therapists trained in a comprehensive clinical program for UI have numerous tools at their disposal to treat incontinence. "We have an excellent success rate by implementing our interdisciplinary program," says Christensen. "Nursing doesn't have to spend a lot of time changing clothes and facilities don't have to pay so much for diapers. A clinical program for urinary incontinence is a win-win situation."

Jasmine Monroe, OTR, at Good Samaritan Center in Jefferson-town, KY, knows that to be true. Her therapy department meets with nursing every few weeks to identify patients for the urinary incontinence program.

"Our quality indicators have improved," she says. "And the facility has seen a reduction in the number of incontinence products the patient goes through."

Components of the Program

Working with nursing to identify patients, therapy can provide a range of treatment options from exercise to behavior modification to electrical stimulation.

"First, you have to figure out why patients are wet, verify the type of incontinence they have, and then assess their cognitive level and their environment," says Christensen. "Then you determine what you can do to restore continence and explore other options you have to keep them dry."

The program often begins with a bladder diary to record how often a patient needs to void or how often she is wet. Prompted voiding or a bladder retraining program, where the time between voids is successively increased, can be implemented with nursing.

"You can also train the bladder by strengthening the pelvic floor muscles and you can teach a bladder control protocol which involves deep breathing and a series of Kegel exercises," explains Christensen.

Exercises for the diaphragm, back, hip, and abdominals all have an

effect on the pelvic floor. After a 30-day period of traditional exercises, CMS will allow the use of external electrical stimulation to strengthen the pelvic floor muscles, which has a proven record of effectiveness.

An overactive autonomic nervous system can cause bladder dysfunction. "We can quiet the resting level of the autonomic nervous system through diaphragmatic breathing, visualization, and body-mind quieting," notes Christensen. "It's all intended to help them reduce the urges and increase the amount of time between voiding."

Mark Besch, vice president of clinical services for Aegis Therapies, says that UI clinical programming is impacting the degree of continence. "Because we've been able to train beyond the normal course of education for therapists, the results of the clinical program for UI have been impressive," he says.



Core clinical programs for long-term care address several key components of resident health. These include continence, balance and pain management.



BALANCE MANAGEMENT

The numbers are shocking. As reported in the *Journal of the American Medical Association*, the average 100-bed nursing home reports 100 to 200 falls a year. As many as three out of four residents fall each year and many fall more than once. Without a comprehensive balance management program, a nursing home is at risk for a big hit to its quality indicators, as well as increased exposure to litigation.

Falls occur for many reasons. Unfortunately, most nursing homes react to a fall instead of anticipating it.

“The aim of clinical programming in balance management is to identify patient risk and prevent the fall from happening,” says Brian Boekhout, PT, regional director of clinical services for Aegis Therapies. “The formal program gives you guidelines on how to proceed through the thought process of identification, screening, and evaluation, as well as tests and measures to show deficit areas and areas of improvement.”

Components of the Program

A falls program is based upon a strong partnership between the facility and therapy.

“You have to have a team approach,” says Monica Smith, rehab program manager for Aegis Therapies. “When nursing, therapists, the social worker, the pharmacist and the physician work together, that’s when we see a reduction in falls. It has to be a comprehensive, team approach.”

Because prevention is a key component of a falls program, it’s important to evaluate both the patient and his environment. Analysis includes both intrinsic factors—the internal condition of the patient, which includes weakness, low blood pressure, orthostatic hypotension, etc.—and extrinsic factors, which include environmental elements such as lighting, furniture placement, equipment, etc.

“A clinical program teaches us how to look beyond the obvious,” says Donna Diedrich, PT, GCS, regional director of clinical services for Aegis Therapies. “For example, if a patient falls on the way to the bathroom, a team that has in-depth training across all three disciplines can identify if there is a need for PT to address balance, OT to address toilet transfers and hygiene, and SLP to address communication skills.”

Once the reason for the risk of a fall is ascertained, the therapist can use his or her training to identify behavior modification. For a patient who gets dizzy when standing, for example, the therapist can teach the patient ways to avoid the fall by doing ankle pumps or slowly rising from the chair while counting to a certain number. If the patient doesn’t have adequate cognition, therapists can teach the caregiver to help him rise slowly to a count. Treatment could be something as simple as a change of equipment—a walker that is higher or lower, an elevated commode.

“These are areas that, without a comprehensive program, may be overlooked,” notes Diedrich.

PAIN MANAGEMENT

Pain slips through the cracks of most nursing facilities’ programming. It’s often missed by staff because of patients’ cognitive and communication barriers. Multiple comorbidities and medications can mask pain. Patients often don’t report pain because of cultural and social barriers. And sometimes pain just makes people afraid.

“If we’re not really looking for pain, a lot of times we’ll miss it,” says Jackie Maynor, clinical specialist and occupational therapist at Golden Living Center in Pell City, AL. “Many times, as therapists, we’re looking at the basics—strength, endurance and ADLs—and

sometimes we are not identifying that pain component and how it impacts what we are doing. The advantage of a clinical program is that it focuses on identifying the pain.”

Facilities often fail to consider that their rehab partner can help manage their residents’ pain.

“Without education in pain management techniques, pain is sometimes used as a reason to stop treatment,” says Diedrich. “Comprehensive clinical programs facilitate nursing, therapy and physicians to work together while enabling patients to accomplish their individual goals.”

Components of the Program

The first line of defense in a clinical program for pain is to work with nursing to identify behavior that is an indication of pain. An understanding of pain pathways and how pain is sensed is crucial to understanding an individual’s experience of pain. Edema, loss of ADLs, decline in activity participation, constant grimacing—all are clues to a patient who hurts.

“It’s a two way street working with nursing,” adds Maynor. “We train nurses and CNAs in what to look for.”

Pain that is managed pharmacologically often results in negative side effects because of patients’ reactions and drug interaction. Therapists can coordinate treatments with nursing to optimize medication dosages around the rehab schedule. There are also numerous non-pharmacological alternatives. For example, exercise, soft tissue massage, positioning, range of motion, and relaxation strategies can all be used to reduce pain.

Treatment can be augmented with electrotherapy—diathermy, ultrasound, and electrical stimulation.

“Electrotherapy has made a huge difference, particularly with our contracture management,” says Maynor. “A lot of times tissues are so tight because patients have been sitting in a certain way, or holding an extremity in a certain way. If you can use the modalities to help with the pain as well as lengthen those tissues, you can provide a better stretch. Using electrotherapy, we are getting much better results than we were getting before.”

“Many therapists tend to discharge or postpone treatment for patients in pain,” says Aegis’ Smith. The solution: treat the pain. ■

A 360 Approach to Staffing

Every healthcare company faces staffing challenges sooner or later. The challenge isn’t just in finding qualified candidates, however – it’s imperative that a consistent level of care is maintained during the transition.

Taking a 360 approach to your staffing needs can help make the entire process easy and seamless.

It’s essential that your staffing partner be

- Reliable
- Trustworthy
- Competitive
- Dynamic

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