Memorial Rehabilitation Institute
Post-Acute Care Network

Going Beyond.

Fall 2019

In this Issue

New Leadership Partnership Sets the Stage for Rehab's Future Success

Dr. Novick

Dr. Salerno

At Memorial Rehabilitation Institute, helping patients "Go Beyond" is not just a motto, it's something we set out to accomplish every day. Our outstanding team of physicians consistently "Go Beyond" for our patients and the profession itself. It's the reason Memorial Rehabilitation Institute has garnered national recognition for implementing innovative healthcare initiatives.

The institute's leadership team has been instrumental in growing the specialty. In fact, we are happy to announce a new leadership partnership that will help us achieve continued growth and success for the months and years to come.

Alan Novick, MD and James Salerno, MD have stepped into new leadership roles. Dr. Novick is now the Chief of Memorial Rehabilitation Institute. He will have oversight of physician clinical operations for Memorial Rehabilitation Institute and will oversee Memorial's post-acute care network. He will also collaborate with Memorial Manor, Home Health and the Rehabilitation Institute's Quality Department, as well as the CARF accreditation process and clinical effectiveness.

"This is an exciting leadership partnership and excellent opportunity for Memorial Rehabilitation Institute to grow as a nationally recognized leader in the industry…"

Dr. Salerno, who began his new role in September, is now Chief of Physical Medicine and Rehabilitation. In this role, Dr. Salerno will oversee Memorial's Physical Medicine and Rehabilitation physicians and physician extenders (APRNs). He will provide clinical coverage and patient clearance for rehabilitation admissions and collaborate with the Office of Research for PM&R clinical research. He also will continue to be the physician lead for the Medically Complex Rehabilitation Program at Memorial Regional Hospital South.

Both Dr. Novick and Dr. Salerno will report directly to Aharon Sareli, MD, Chief Physician Executive. This is an exciting leadership partnership and excellent opportunity for Memorial Rehabilitation Institute to grow as a nationally recognized leader in the industry, which bodes well for our patients and the entire Memorial Healthcare System.

Educating our Community on the Signs and Symptoms of Concussion

By Matthew L. Fazekas, MD, FAAP, Joe DiMaggio Children's Hospital Department of Orthopaedics U18 Sports Medicine

We know kids often participate in a variety of physical activities. Sports such as soccer, lacrosse and football are just a few of the many contact sports that make teens and young athletes vulnerable to suffering head injuries and concussions. Even children involved in recreational sports such as bike riding, skateboarding or rollerblading could be at risk for a concussion.

As a part of the Joe DiMaggio Children's Hospital U18 Sports Medicine program, it's our mission to educate parents and sports participants to recognize the signs and symptoms of a concussion as well as the events and situations where and when a concussion may occur.

We educate our parents on the signs and symptoms of a concussion, including an injury that results in a subsequent headache, mental fog, dizziness or confusion. If such an injury occurs, we urge parents to ensure the child is immediately pulled from the sport and evaluated by a healthcare professional.

Dr. Matthew Fazekas, Medical Director of Joe DiMaggio Children's Hospital Concussion Clinic and a sports medicine physician with [U18] Sports Medicine, discusses the CDC guidelines when lecturing to families, first responders and school athletic professionals.

Joe DiMaggio Children's Hospital Concussion Clinic is led by a world-class team of physicians who are board certified in sports medicine, pediatric neurology, pediatric physical medicine rehabilitation and pediatric neuropsychology. They also work closely with a team of certified vestibular therapists.

The Concussion Clinic is designed as a "one-stop shop" where pediatric patients can receive a full neurological examination. Here, individuals may also undergo neurocognitive testing and start a process of return-to-learning and return-to-sports, as directed by the physician.

For more information about the Concussion Clinic, visit JDCH.com/concussion.

Our First Outpatient Pediatric Specialty Center Opens in Wellington

By Eugenia Tuyn, DPT, MSRD, CLT, Director of Rehabilitation U18, Coral Springs and Wellington

Our hospital recently expanded its reach into Palm Beach County by opening its first pediatric specialty outpatient center in Wellington, Florida. This 30,000-square-foot facility is home to a variety of pediatric medical specialties, including neurology, pulmonology, endocrinology, orthopaedics, U18 sports medicine, general surgery and otolaryngology. In addition to these specialty medical departments, on-site diagnostic imaging services, an outpatient surgery center and comprehensive pediatric rehabilitation services are also available. The center showcases themes of sports, arts, games and dreams with each service we provide, supporting our philosophy, believing in the healing Power of Play.

Our Wellington-based rehabilitation team includes physical therapists as well as occupational and speech therapists who have received specialized training in pediatric sports injury management and pediatric neuro-developmental disabilities. Our multidisciplinary outpatient rehabilitation program provides opportunities for patients to stay within our healthcare system by capitalizing on the benefits of a closely integrated approach to care. Our physicians and therapists work together to provide patient- and family-centered, personalized care for every patient we serve.

The U18 sports medicine program provides a comprehensive approach to pediatric sports injury management and prevention. Our physical therapists provide sport-specific rehabilitation for the pediatric athlete and dancer. Our concussion clinic encompasses a multidisciplinary approach to head injury management. Additionally, our rehabilitative team also partners with community youth organizations and area high schools to offer educational seminars, coaches' clinics and specialized programs to help prevent and manage injuries. Our therapists host workshops in performing arts and dance medicine to help educate dancers and instructors on proper technique and injury prevention.

Pediatric neuro-development rehabilitation is provided in a warm comforting environment to increase the child's potential for success. Treatment and healing are intertwined with quality medical expertise to provide an exceptional patient- and family-centered experience.

Expanding on the "Power of Play" philosophy, Joe DiMaggio Children's Hospital has two leading-edge gyms – a large sensory-based gym equipped with suspended equipment and a physical therapy gym to focus on developmental milestones. Speech therapy is an integral part of the craniofacial clinic and a cochlear implant program is now offered at the center as well.

Interventional Pain Medicine Provides Treatment Options for Pain Without Using Opioid Medications

By Jackson Cohen, MD, Medical Director, Interventional Pain Medicine

It's estimated that approximately 20 million people in the United States are living with significant chronic pain, including neck, lower back, joint and nerve pain. Fortunately, the approach to these conditions has evolved and improved over the past 20 years, paving the way for more effective pain relieving interventions for patients than ever before.

Chronic pain can be defined as any source of pain that has been present for longer than three months. Previously, patients with severe chronic pain would often be started on opioids early in the treatment process, eventually leading to their dependence on these medications. This practice is no longer recommended, as the risks and side effects of chronic opioid use often outweigh the benefits. Indications do exist for certain types of patients to start opioid use, namely those who suffer from chronic pain due to cancer and palliative-care related issues. It may also be used in chronic non-cancer pain where all other treatment options have been exhausted. However, it is firmly established that opioids for chronic non-cancer pain should not be considered the first line of therapy.

A key driver for the use of interventional pain procedures is its ability to alleviate pain before it develops chronicity. By breaking the pain cycle, the body has the opportunity to heal itself before a chronic pain state develops. This is crucial because chronic pain is far more difficult to control than acute pain. We use a physiatrist's approach in our interventional pain practice to diagnose and treat spine, musculoskeletal and nerve pain. This allows us to offer very specific treatment plans that directly target the source of a patient's pain. We focus on evidence-based procedures such as epidural steroid injections, nerve blocks, joint injections and trigger point injections to provide pain relief early in the disease process. By combining these procedures with physical therapy exercises, patients are given the highest chance to improve their condition naturally, without the use of opioids or other medications.

For pain that has lasted for more than six months and that has been unresponsive to the above treatments, there are still interventional options that can help patients avoid major surgery or the use of opioids. Radiofrequency ablation treatments can provide longer-lasting relief for patients who have experienced only short-term relief with nerve blocks. Spinal cord stimulation can be a life-changing procedure for chronic pain sufferers who have failed to experience relief with previous treatments, including surgery. Minimally invasive treatments for lumbar stenosis are also available for patients who are not considered surgical candidates. Ultimately, if surgery is the best option, patients will feel confident in proceeding with this major decision knowing they have exhausted all appropriate non-surgical treatments first.

The interventional pain team at Memorial Rehabilitation Institute uses procedures that provide timely pain relief for patients and emphasizes the importance of physical therapy as a vital part of the long-term treatment plan.

The interventional pain team at Memorial Rehabilitation Institute uses procedures that provide timely pain relief for patients and emphasizes the importance of physical therapy as a vital part of the long-term treatment plan. Furthermore, we are committed to patient education with anticipatory guidance, empowering patients to understand their condition, what limitations they can expect and what alternative activities they can engage in. By effectively managing pain, we can help improve overall function and quality of life for our patients, allowing them to return to, and participate in, the things they love.

Patient is Thankful for Her 'New Normal'

"Stand tall, Mama," said a patient care assistant at Memorial Rehabilitation Institute at Memorial Regional Hospital South. The assistant's encouragement was succinct but powerful, and the words urged Fran not to give up, but instead to move forward in her recovery process. Thanks to Memorial's comprehensive stroke therapy services and the dedicated healthcare team that cared for her, Fran once again can walk, drive a car, prepare a meal and laugh like the world depends on it.

"The compassion and care here are just phenomenal. From Regional through South to rehab, every PCA, every nurse, every therapist, even Isabel and Maxi, who came in to clean the rooms – I just can't say enough good things," says Fran.

On January 19, 2019 – the day her body went numb – she "just started feeling very not myself." Suddenly, her coordination was off, she couldn't think clearly and every action was a struggle. The EMTs suspected a stroke, and a CAT scan at Memorial Regional Hospital's Emergency Room confirmed a right-side brain bleed. The left side of Fran's body registered sensations like pain or touch but was completely unmoving. She was asked to draw a clock and was unable to realize the left portion (7 to 11). It was as if that side of the world, as well as the old Fran, had ceased to exist.

Once she was stable, she was transported to Memorial Regional Hospital South, where her rehabilitation began almost immediately. A team of physical, occupational, speech and recreational therapists evaluated her impairments and strengths and established a treatment protocol that would best facilitate her recovery. They began by teaching her how to accomplish day-to-day tasks, like bathing and dressing, without the full function she was used to.

"You really get an entirely new perspective on how difficult it can be to navigate a normal day. Before this, I had been running three to five miles a day for 42 years. All of a sudden I needed two people to get me out of bed and take me to the bathroom," says Fran.

Three weeks passed before movement returned to her fingers and toes. Rehabilitation was tough physically and mentally but eventually brought tangible results. Fran's emotional recovery, however, depended more on exercises in subtlety: a therapist's intuitive gesture or a well-timed visit from Mesa, the therapy dog.

"In recreational therapy, they placed me in a cooking group. I was so impaired at that time. They had me chopping walnuts, and I went into a crying spell. One of the occupational therapists saw how upset I was, took me out in the hallway in my wheelchair, gave me a box of tissues and told me that she was going to send a mentor to me (Jillian). Jillian had also been a runner and knew that was something I thought I might never be able to do again. So that's just one example of the acts of kindness that they have here and the compassion," she recalls.

Staff members encourage loved ones to participate in therapy sessions, as well. Memorial fosters the safe and supportive environment for patients. So while Fran regained functionality, her husband, Kevin, trained to be her caregiver.

"I watched what the therapists did in OT and PT," says Kevin. "It's important for the spouse to see what they're doing and kind of emulate it."

Fran left rehab five weeks after the stroke. In addition to all they had learned in the hospital, both Fran and Kevin were taught how to avoid the risks that can lead to stroke. Though never diagnosed with hypertension, Fran recognizes now that, in retrospect, her blood pressure was higher than it should have been. Today she's on blood pressure medication and keeps a close eye on her husband's numbers. Life is different, but good.

"It's a little bit of a new normal. They teach you that once you've had one stroke, you're three times more likely to have another one. You have to go on with life and do everything you can to avoid the things that put you at risk. I have found since the stroke I'm thankful every day for all that I can do," Fran says. "I don't take anything for granted."

Fran, left, with husband Kevin

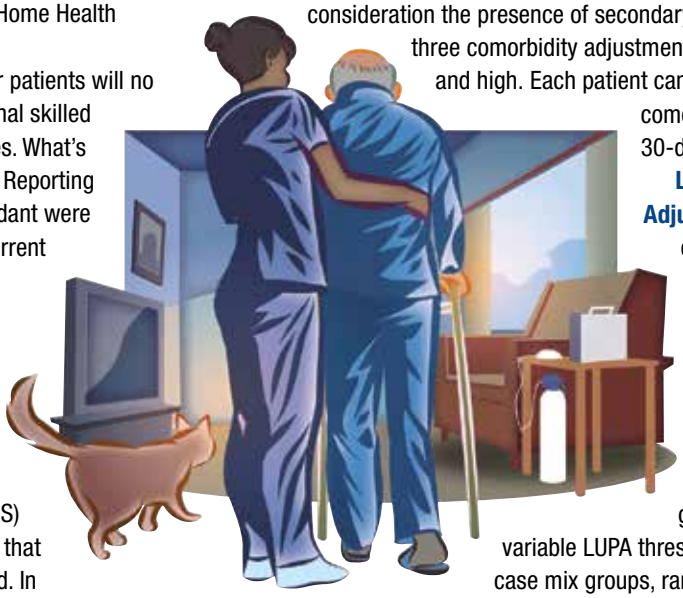
Preparing for Home Health Payment Reform

By Meryl S. Comiter, MA, PT, FACHE, Administrator, Memorial Home Health Services

Reimbursement changes will continue to sweep through various post-acute settings over the next few months. In Home Health, some of these changes are the most significant we have seen to date. These changes are occurring as we move toward value-based care, increased competition and reduced administrative burdens placed on physicians.

Home Health Payment Reform is scheduled to begin in January 2020. These reforms are the result of a Bipartisan Budget Act (PL115-123) signed into law by President Trump on February 9, 2019 that included a requirement for the United States Secretary of Health and Human Services to reform the current home health payment system, implementing a 30-day episode for payment. Today, Home Health episodes are based on a calendar of 60 days.

Physicians ordering home health services for their patients will no longer have to estimate the length of time for additional skilled services if a patient requires recertification of services. What's more, seven measures from the Home Health Quality Reporting Program that were considered unnecessary or redundant were removed altogether. This change, moving from the current 60-day calendar to a 30-day billing cycle, is required to become budget neutral. The proposed rule would also implement a Patient-Driven Groupings Model (PDGM) and shift away from the current Home Health Groupings Model (HHGM). The PDGM model would eliminate the use of "therapy thresholds" or the number of therapy visits a patient receives. The Centers for Medicare and Medicaid Services (CMS) proposes to continue to monitor agency behaviors so that therapy services are still provided as clinically needed. In addition, PDGM defines the components to assimilate patient characteristics into various groupings to generate the Home Health Resource Group (HHRG) for payment.



The main changes related to moving toward PDGM are as follows:

Changes to the billing cycle (30-day billing period versus 60-day episode of care)

Admission source groupings – patients either admit to home health from an "institutional" or "community" setting. A community admission source group is applied if no acute or post-acute stay occurs within the 14 days preceding home healthcare.

Episode timing groupings – 30-day periods are classified as "early" or "late" depending on when they occur within a sequence of 30-day periods. The first 30 days is classified as "early" and subsequent 30-day periods in the sequence (second or later) are classified as "late."

Clinical groupings – a variety of patient clinical characteristics define 12 clinical groups. These groups include: musculoskeletal rehab; neuro/stroke rehab; wound-post-op aftercare and skin/non-surgical wound care; complex nursing interventions; behavioral health care; medication management; teaching and assessment (MMTA for surgical aftercare); cardiac/circulatory; endocrine; gastrointestinal and genitourinary (GI/GU); infectious disease, respiratory and other.

Functional impairment groupings – functional levels are assigned based on responses to certain OASIS items. Criteria for assignment into the three functional impairment levels may differ across each clinical group. The functional impairment level groups are low, medium and high.

Comorbidity adjustment groupings – this grouping takes into consideration the presence of secondary diagnosis codes. The three comorbidity adjustment levels are none, low and high. Each patient can qualify for only one comorbidity adjustment per 30-day period of care.

Low Utilization Payment Adjustment (LUPA) – To create LUPA thresholds in each 30-day period of care, CMS proposed to set the LUPA threshold at the tenth percentile value of visits or two, whichever is higher for each payment group. This creates a variable LUPA threshold for each of the 432 case mix groups, ranging from two to six visits per case group.

Memorial Home Health is proactively working to prepare for these changes and evaluating operational processes. Significant education for referral sources has been initiated as CMS will also be potentially disqualifying certain admissions known as "questionable encounters" (QE). In these episodes of care, the primary diagnoses coded as the primary reason for home health care were unspecified or symptom codes. Today, the QE's make up approximately 15 percent of all home health admissions.

The move to PDGM will require an integrated team of referral sources, coders, billers and clinicians to adapt to the reimbursement changes. Significant staff and physician education will be required to capture all of the required specificity elements on initiation of treatment and to ensure that all required elements are included. Memorial Home Health will embrace the changes and continue to practice in a manner that is clinically appropriate and patient and family centered.

The Length of Stay Efficiency Model

By Jon D. Hennemyre, Administrator, Memorial Manor

In the late 1980s, patients with traumatic brain injury (TBI) stayed in an inpatient rehabilitation setting for approximately six to eight weeks on average. A traumatic spinal cord injury (SCI) patient could typically be in rehab for at least three months. In today's environment, which focuses on efficiency, the average length of stay for all rehab diagnoses has decreased to 12-15 days. To provide the best quality of care as efficiently as possible, rehab settings must focus on improving function on a daily basis and meeting long-term goals quickly.

In 2016, Memorial Rehabilitation Institute noticed a steady increase in patients' length of stay (LOS), averaging 13.1 days compared to the national average of 12.5 days (UDSPro). Two diagnoses stood out as outliers compared to national average LOS: TBI (+4 days) and Traumatic SCI (+5 days). A task force was developed to look at potential opportunities to streamline processes and improve efficiencies for these diagnoses.

Both TBI and SCI patients have some of the most complicated and multifactorial discharge situations. Patient needs could include percutaneous endoscopic gastrostomy (PEG) feedings and tracheostomy care, which require extensive caregiver training and multiple pieces of medical equipment.

The taskforce studied the unique needs of these populations and developed several initiatives that would not only address the discharge needs of these patients, but the rehab population as a whole. First, the team agreed, whenever possible, to set the estimated discharge date at the first team conference. This allows for prompt ordering of equipment and services and ensured that the team focused on achieving long-term goals in a timely manner. Next, a Length of Stay report was created that would be distributed to all key players by the Prospective Payment System (PPS) coordinator Monday through Friday by 7:30 am. The report notes each individual patient's current length of stay with the national average for their individual case mix group. If the patient is expected to stay beyond the national average for their case mix group, staff are asked to describe specific goals they can achieve with the extra days.

One of the most effective initiatives was the creation of a daily discharge huddle, designed to review all discharges one to three days out and define any pending issues or barriers to discharge. The huddle, which takes no more than 15 minutes, is attended by the nurse manager from each unit, all case managers and their supervisor, a pharmacist and the therapy supervisor/director. Each discharge case is presented and discharge issues are resolved or assigned to team members to subsequently address. Emails are then sent throughout the day to update team members until the issues are resolved. One key element added later was to include the presence of a wound care nurse at time of discharge. This healthcare professional was instrumental in helping teach the patient how to change a wound dressing or how to use a wound vacuum at home, issues that had been identified as key challenges post-discharge. Our wound care nurse now assists with patient training and the drafting of wound care orders for discharge.

The last change implemented was to pair a specific case manager to a specific physician. In the past, patient assignments were based on room numbers. By assigning one case manager/social worker to one physician, we were able to leverage this partnership to streamline discharge challenges and improve communication.

All of these initiatives combined were a huge success. In just 24 months, we were able to reduce our overall average patient length of stay from 13.1 to 11.4 days for all diagnoses. For the specific outlier diagnoses, the gains were even more impressive. For the traumatic brain injury patients, the length of stay at the start of 2016 was 18.9 days, and by 2018, that figured had dropped to 13.8 days. Similarly, for patients with traumatic spinal cord injury patients, the average length of stay in 2016 was 30.1 days, which decreased to 19.8 days by the end of 2018. The quality of care, as measured by the functional independence measure (FIM) change over the patient days for the same timeframe, improved by 27% for the TBI patients and 15% for the SCI patients.

As ever increasing pressure from regulatory agencies and insurance companies becomes the norm, rehabilitation facilities must rise to the challenge of providing excellent care with a focus on quality, efficiency and effectiveness. Memorial Rehabilitation Institute was able to successfully implement and sustain initiatives to achieve this goal.

The Role of Patient- and Family-Centered Care at Memorial Rehabilitation Institute

By Becky Boyle, OTR, Director of Rehabilitation, Memorial Rehabilitation Institute

Patient- and family-centered care is a not only a healthcare philosophy but an integral part of our mission at Memorial Rehabilitation Institute. Just as the words indicate, patient- and family-centered care allows patients and their families to be at the center of the care we provide, which is at the heart of everything we do.

The Patient Family Advisory Council was created to ensure that the voices of our patients and families are heard. This allows hospital leadership to consider patients' concerns when making decisions regarding program development, process improvement and new construction at the hospital.

Our Patient Family Advisory Council consists of patients, patients' family members, current and retired staff members and individuals from the community who have a vested interest in helping our hospital provide the best possible patient care. Our group of advisors also volunteer their time to stay current with Memorial Rehabilitation Institute and its operations.

There are a number of ways our Patient Family Advisory Council gets the information it needs to make informed decisions. One way is through a monthly advisors' meeting where staff members share information regarding existing programs, program development ideas and educational materials for input from the Council. Secondly, advisors participate in meetings where program development and hospital quality outcomes are discussed. Thirdly, one or more of our advisors partner with nursing leaders to perform patient experience rounds with current patients. Through participation in these varied meetings, our advisors are able to provide timely feedback from the patient and family perspective. Lastly, the members of the Patient and Family Advisory Council are asked for their opinion on any decisions that will directly or indirectly impact patient care.

At Memorial Rehabilitation Institute, the Patient Family Advisory Council also assists with the development of programs that are important to patients and their families by simply listening to their needs. For instance, in the past patients and families shared their desire for allowing patients to stay in the already familiar hospital setting for outpatient therapy since patients with neurological diagnoses often have difficulty transitioning to new environments. Months later, an outpatient therapy program was developed on site to meet that need. An outpatient day treatment program for patients with brain injury, known as Community Re-Entry at Memorial, was also developed to address the specific cognitive and behavioral training that is required after a brain injury.

Another focus of the Patient Family Advisory Council is how to promote an optimal healing environment within our physical space. Our solarium, located on the first floor of Memorial Regional Hospital South, is one such example. This air-conditioned greenhouse welcomes patients, families, staff and visitors alike to enjoy the beautiful plants and warm Florida sun, all while staying indoors within the air conditioning and safety of the hospital setting. What's more, the solarium has helped many patients and families within Memorial Rehabilitation Institute's inpatient wing by providing a sense of normalcy and warmth during longer-than-expected hospital stays.

Other innovative council-sponsored ideas focus on connecting with patients while they are in the hospital. A "patient connection" form, which is completed in conjunction with the patient, helps to identify patient preferences and interests so staff can design a safe and supportive environment for optimal patient recovery. A discharge song was even created to provide a heartfelt sendoff to patients as they leave us for their next level of care. The song makes every patient and loved one feel special and a part of our Memorial family.

Patient- and family-centered care is not just a catch phrase; it's a true philosophy in practice at Memorial Rehabilitation Institute. Through the Patient Family Advisory Council, we have strengthened the relationships between our patients, families and caregivers, which has been key to providing a true healing environment for our patients' mind, body and soul.

Memorial Rehabilitation Institute

INPATIENT REHABILITATION

Memorial Regional Hospital South
3600 Washington, Hollywood, FL 33021
Main Hospital: 954-966-4500
Rehab Admissions: 954-518-5725

Joe DiMaggio Children's Hospital
1005 Joe DiMaggio Drive, Hollywood, FL 33021
954-518-5725

OUTPATIENT REHABILITATION

Memorial Regional Hospital South
Joe DiMaggio Children's Hospital
300 Hollywood Way, Hollywood, FL 33021
954-265-5453

Joe DiMaggio Children's Hospital, Coral Springs
5830 Coral Ridge Drive, Suite 207, Coral Springs, FL 33076
954-575-8962

Memorial Hospital West
703 North Flamingo Road, Pembroke Pines, FL 33028
954-844-7180

Memorial Hospital Miramar
1951 Southwest 172 Avenue, Suite 109, Miramar, FL 33029
954-538-4760

SKILLED NURSING

Memorial Manor
777 South Douglas Road, Pembroke Pines, FL 33025
954-276-6200

HOME HEALTHCARE

Memorial Home Health Services
7369 Sheridan Street, Suite 101, Hollywood, FL 33021
954-265-5974 | FL license #HHA20712096

ADULT SERVCES PEDIATRIC SERVICES

Memorial Rehabilitation Institute
Post-Acute Care Network

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Fall 2019

MHS.net/Rehab

By the Numbers • 2nd Quarter: April – June 2019

Adults

550
TOTAL ADMISSIONS

DISCHARGE TO COMMUNITY
85%
National average = 81%

TOP 3 DIAGNOSES
- Stroke: 21%
- Medically Complex: 20%
- Orthopedic: 19%

Source: USDmrPro

Pediatrics

LENGTH OF STAY (DAYS)
13.3
National average = 24.1

TOP 3 DIAGNOSES
- Brain Dysfunction: 42%
- Stroke: 16%
- Neuro: 10.5%
- Ortho: 10.5%

DISCHARGE TO COMMUNITY
100%
National average = 91%

IMPROVEMENT RATING INCREASE PER DAY
2.04
National average = 1.44

Source: UDSPRO

Certifications

- **Joint Commission accredited**
- **CARF-accredited** (Commission on Accreditation for Rehabilitation Facilities)
- **Department of Health Brain and Spinal Cord Injury Program**