Nursing and Therapy Interaction: Improving QM and CMI

Presented by Terry Raser and Kay Hashagen, Senior Consultants

About the Presenters

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Senior Consultant for over 3 years with LW. Physical therapist with extensive LTC experience. Certification in MDS assessments. thashagen@lw-consult.com

Objectives

- Define resources and reports within the nursing realm to enhance QM and CMI
- Review tracking and communications systems that optimize performance
- Identify important items that need to be documented
- Discuss opportunities for therapy to collaborate with nursing
- Learn to identify issues related to quality long term care programming
Importance of QM and CMI Focus

- Increased customer awareness of quality care through social media sites and articles
  - https://www.medicare.gov/nursinghomecompare
- Pressures of reduced reimbursement
  - Regulations related to Bundled Payments
  - Impact of penalties
    - Section GG
    - PBJ
    - Completion of QM
    - Decreased census and restrictions on referrals

It pays to be prepared!

MDS Accuracy
Resident Assessment Instrument Manual (RAI) v1.14

MDS Coordinators Bible
- Guidelines for MDS assessment types
- Guidelines for Accurate MDS item completion
- Guidelines for Care Area Assessments (CAAs)
- Guidelines for Care Planning
- Guidelines for Completion Timelines
- Guidelines for MDS Submission
- Guidelines for MDS Corrections/Inactivation's

Accuracy of Assessment F278 (§483.20(g))
- The assessment must accurately reflect the resident's status.
- Interpretive Guideline:
  - Appropriate qualified health professional
  - Correct documentation of problems
  - Identification of resident strengths
  - The initial comprehensive assessment provides baseline data for the ongoing assessment of resident progress.

Accuracy of Assessment F278 (§483.20(g) and (h))
- Probe (§483.20(g))
  - Based on your total review of the resident, is each portion of the assessment accurate?
- §483.20(h) Coordination
  - A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.
Accuracy of Assessment
F278 (§483.20(i))

- Penalty for Falsification
  - $1,000 per assessment
  - $5,000 per assessment

- Interpretive Guidelines §483.20(j)
  - MDS information as it is reported impacts a nursing home’s payment rate and standing in terms of the quality monitoring process.
  - A pattern within a nursing home of clinical documentation or of MDS assessment or reporting practices that result in:
    * higher RUG scores,
    * untriggering CAA(s), or
    * unflagging QI(s), where the information does not accurately reflect the resident’s status, may be indicative of payment fraud or avoidance of the quality monitoring process.

MDS Accuracy

- Top Cited Deficiency
- Is your MDS nurse(s) knowledgeable?
- Are MDS(s) coded according to documentation?
- Does documentation support the care provided to the resident?
- Are nurses knowledgeable to items on the MDS that supports reimbursement and quality measures?

MDS Accuracy

- Are CNAs aware that their ADL documentation is approximately 30% of the revenue?
- What process is in place for ADL education?
- How is significant change in status identified?
  - CASPER Quality Measures Report
  - B02
  - Internal Software
  - Morning Report/Rounds
  - Staff Referrals
How MDS Accuracy Effects CMI

- If the MDS isn’t accurate, the resident could fall into a lower paying category
- Some Examples:
  - If there is a coding error on diagnosis, you might default to the next lower paying RUG
  - If the ADLs are not coded correctly, the ADL score may drop
- If you have a system that pulls previous assessment information forward and the resident previously had therapy, the RUG payment could be higher than deserved.

ADL Coding Payment Difference

- Bed Mobility 4
- Transfer 4
- Toilet Use 2
- Eating 0
- Total Score 10

<table>
<thead>
<tr>
<th>Low Rehabilitation</th>
<th>Short Stay</th>
<th>Not Used</th>
<th>RLB</th>
<th>RLA</th>
</tr>
</thead>
<tbody>
<tr>
<td>45 minutes/week minimum AND 3 days any combination of 3 rehabilitation disciplines AND Nursing rehabilitation 6 days/week, 2 services (see Reduced Physical Function below for nursing rehab services count)</td>
<td>11-16</td>
<td>11-16</td>
<td>423.51</td>
<td>263.67</td>
</tr>
<tr>
<td>6-10</td>
<td>6-10</td>
<td>Not Used</td>
<td>Not Used</td>
<td>263.67</td>
</tr>
</tbody>
</table>

This 30 day assessment pays for 30 days.

$423.51 \times 30 \text{ days} = 12,705.30$

$263.67 \times 30 \text{ days} = 7,910.10$

Difference of $12,705.30 - 7,910.10 = 4,795.20$

How MDS Accuracy Effects QM

- The MDS drives the Quality Measures.
- Dashing items – 2% APU penalty.
- It’s not a pressure ulcer
- Bowel and Bladder CNA coding is not accurate- kiosk speed
- No correlating diagnosis for a catheter
- No pain interview
Important documentation tips for nursing

- Support the need for Medicare Part B therapy.
- Make sure check box documentation correlates to the MDS.
- Skilled nursing documentation should support therapy and reason for skilled service(s).

Important documentation tips for nursing

- ADL clarification
- ADL documentation is not located, therapy documentation may be used. This may decrease your ADL score.
- Restorative nursing- 15 minutes per day, 6 days per week.
- Educate nurses on the MDS and supportive documentation.
- Document behaviors.

Resources within nursing

<table>
<thead>
<tr>
<th>Resource</th>
<th>Link</th>
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</thead>
<tbody>
<tr>
<td>Resident Data Report Manual</td>
<td><a href="https://info.pugetsound.edu/">https://info.pugetsound.edu/</a></td>
</tr>
<tr>
<td>Patient Data Calendar</td>
<td><a href="https://info.pugetsound.edu/">https://info.pugetsound.edu/</a></td>
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<td>Six Spotlight</td>
<td><a href="https://info.pugetsound.edu/">https://info.pugetsound.edu/</a></td>
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<td>Long-term Care Resources for Providers</td>
<td><a href="http://www.dhs.ca.gov/prodvcl/longtermcare/lc_users">http://www.dhs.ca.gov/prodvcl/longtermcare/lc_users</a> информации на сайте</td>
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Resources within nursing

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<tr>
<td>PAHSN</td>
<td><a href="http://www.ansac.org/">http://www.ansac.org/</a></td>
</tr>
<tr>
<td>PA State Phil Coordinator</td>
<td>Karen Landers - <a href="mailto:k.landers@pa.gov">k.landers@pa.gov</a></td>
</tr>
<tr>
<td>NFRP PA Coordinator</td>
<td>Lisa Lockwood - <a href="mailto:l.lockwood@pa.gov">l.lockwood@pa.gov</a></td>
</tr>
</tbody>
</table>

Medicaid Case-Mix (CMI)

[RESIDENT DATA REPORTING MANUAL](https://nfrp.pafhs.submit.com) [https://nfrp.pafhs.submit.com](https://nfrp.pafhs.submit.com)

Nursing Facility Report Portal (NFRP)

The Nursing Facility Report Portal is a secure site for use by Pennsylvania Medical Assistance nursing facilities. The site is supported by Myers and Associates LLC under contract with the Department of Human Services, Office of Long-Term Living.

| NFRP Resources |
|---------------|----------------|
| NFRP Portal  |
| NFRP Report Instructions  |
| MA-11 Resources  |
Managed Long Term Services and Support (MLTSS)

- Phase 1: Southwest Region start date was delayed from January 1, 2017 to July 1, 2017
- Phase 2: Southeast – January 2018
- Phase 3: Northwest, Leigh-Capital and Northeast – January 2019
- Pennsylvania case-mix will eventually cease
- Once MLTSS is started in a region there will be a 6 month transition period for the ACO

Medicaid Case-Mix Index (CMI)

- Do you know your facility MA CMI?
- Did it go up or down? Why?
- Does your CMI represent your acuity/resident population?

<table>
<thead>
<tr>
<th>Picture Date</th>
<th>Average Total Facility CMI</th>
<th>Average MA CMI</th>
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</thead>
<tbody>
<tr>
<td>08/01/2016</td>
<td>1.09</td>
<td></td>
</tr>
<tr>
<td>02/01/2016</td>
<td>1.11</td>
<td>1.08</td>
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Resident Data Reporting Manual

- Pennsylvania Medicaid Case-Mix Reimbursement System
- MDS Section S- PA State Specific
- MA for MA Case-Mix
- Data Submission Process and Deadlines
- MA RUG Classification- RUG III, Version 5.12
  44-Group Classification Worksheet
- Picture Date Calendar
Resident Data Reporting Manual

- CMI Reports - Preliminary and Final
- CMI Rates
- Documentation Guidelines
  - Does Include
  - Do Not Include

Case-Mix Index

How therapy can assist nursing with case-mix
Opportunities for therapy to collaborate with nursing

- Screens
- Evaluations to Therapy
- Capturing appropriate rehab minutes within assessment windows
- Restorative programs
- Nursing education and training

Communicate to therapy

- Routines
- Reminders
- Reinforcements
- Review

Screens

- System to communicate list of residents who are coming up for MDS assessments
- Make it a priority to complete timely
- Skill set of who does screens
- Outcome of screens
Function Based Screen Form

- Trouble ambulating or maintaining self-balance
- Trouble with mobility
- Trouble with balance while ambulating
- Trouble with balance while transferring
- Trouble with transferring
- Trouble with weight shifting
- Trouble with maintaining sitting posture
- Trouble with standing
- Trouble with getting in and out of bed
- Trouble with transferring to and from wheelchair
- Trouble with self-care
- Trouble with eating
- Trouble with self-care activities
- Trouble with dressing
- Trouble with hygiene
- Trouble with bowel or bladder management
- Trouble with grooming
- Trouble with personal care
- Trouble with self-care activities
- Trouble with communication
- Trouble with cognitive function
- Trouble with self-care activities
- Trouble with socialization
- Trouble with family activities
- Trouble with independent living

Screen to Evaluation Ratio

- Record all screens done each month and how many converted to an evaluation
- Assess ratio for acceptable percentage
- Identify root cause if not acceptable
  - Not completed
  - "Status Quo"
- Rectify situation
  - Accountability
  - Education
  - Enhanced LTC programming

Basic LTC Programming

- PT: Mobility
- PT: Balance and Falls
- PT/OT: Seating and Positioning
- OT: ADL Re-training
- OT: ROM and Contracture Management
- OT/ST: Communication and Cognitive Re-training
- ST: Dysphagia Management
Enhanced LTC Programming

- PT: Wound Care
- PT/OT: Pain Management
- PT/OT: Continence Management
- OT: Low Vision
- OT/ST: Dementia Staging

Issues related to LTC programming

- Some programs require additional equipment
  - Continence management: patterned electrical stimulation (PENS)
  - Wound management: electrotherapy modalities (electrical stimulation, short wave diathermy, ultrasound)
  - Pain management: electrotherapy modalities (electrical stimulation, short wave diathermy, ultrasound)
  - Low Vision: low vision tools (vision magnifier devices)
- Costs associated with procurement and training

Issues related to LTC programming

- Education of therapy staff
  - PT qualified to collaborate with nursing for wound care using electrotherapy modalities
  - OT/PT with skill set to evaluate and address continence management
  - OT/ST with skill set to evaluate and address Dementia Staging
- Education of nursing caregivers
  - Program protocols are updated
  - Caregivers understand how to follow through with programs
  - Restorative Nursing Programs
Capturing appropriate rehab minutes within assessment windows

Obtaining a Rehab RUG supports the CMI

Typical issues identified during CMI audits:

- Therapy picks patient up whenever
  - No communication to MDS
- MDS has ARD set after therapy discharges the patient
  - Inflexible with changing ARD to capture minutes
- Not all planned minutes are actually delivered for Part B resident
  - RUG requirement is not met

Solutions to ensure capturing appropriate rehab minutes include...

- Outline a system of communication
- Hold everyone accountable
- Educate all parties that are involved
- Discuss ARD and minute counts as for Part A
- Review outcome of increased focus with the team

Example of CMI related to Rehab RUG

Resident was receiving PT for decreased ambulatory ability due to Parkinson’s. The ARD was set for 02/17/17 with projection to meet medium rehab RUG with CMI 1.39. The previous CMI was CC1 1.01 due to need for oxygen. The resident no longer requires oxygen.

On 2/17/17 the therapist informed the MDS nurse that they did not meet the criteria for medium rehab of 150 minutes of therapy. The projected medium rehab RUG with a 1.39 CMI was lost and the resident’s CMI dropped to the Reduced Physical Function classification with a RUG and CMI of PE1 0.79.

The resident met the criteria of a RNP program and was receiving 2 RNP’s. Which would increase the CMI from PD1 0.79 to PD2 0.81, however, the RNP’s were provided 5 days per week during the 7 day look back which does not meet the 6 days per week criteria to meet the RNP end split for case-mix.
Restorative Nursing Programs

Next to a Rehab RUG level, a Restorative Program adds a valued opportunity for CMI.

When to start a RNP

- Not a candidate for skilled therapy
- Change in condition
- In conjunction with therapy
- Transition from physical, occupational, or speech rehabilitation therapy
Restorative Nursing Program Criteria

- Nursing staff are responsible for overall coordination and supervision of restorative nursing programs.
- Ratio 4:1
- Measurable objective and interventions must be documented in the care plan and in the medical record.
  - If care plan is being revised, reassess the program
  - Document the reassessment results in the medical record.

Restorative Nursing Program Criteria

- Periodic evaluation by the licensed nurse must be present in the resident’s medical record.
- Progress note written by the restorative aide can be countersigned by a licensed nurse after the purpose and objectives of treatment have been established.
- Nursing assistants/aides must be trained in the techniques of the activity.

Restorative Nursing Program Criteria

- A registered nurse or a licensed practical (vocational) nurse must supervise the restorative nursing program.
- Restorative nursing does not require a physician’s order.
- Nursing homes may elect to have licensed therapist perform repetitive exercises and other maintenance treatments or to supervise aides performing these maintenance services.
Restorative Nursing Program Coding

- 7-day look-back period
- Enter the number of days the program was performed for at least 15 minutes during the 24-hour period.
- Perform 6 days per week, 2 RNPs

Restorative Program Affects Reimbursement

<table>
<thead>
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<th>CPT Code</th>
<th>Unit</th>
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<td>97100</td>
<td>Day</td>
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Restorative Program Affects Reimbursement

### Restorative Program Tips

- **Residents with Dementia** learn from repetition, multiple times a day.
- Routine dressing does not count as part of a formal restorative nursing program.
- For inclusion, active or passive range of motion must be a component of an individualized program that is:
  - planned,
  - monitored,
  - evaluated, and
  - documented in the resident’s medical record. Range of motion should be delivered by staff who are trained in the procedures.

### Restorative Program Tips

- For splint or brace assistance: assess the resident’s skin and circulation under the device, and reposition the limb in correct alignment.
- The use of continuous passive motion (CPM) devices in a restorative nursing program is coded when the following criteria are met:
  - (1) ordered by a physician,
  - (2) nursing staff have been trained in technique, and
  - (3) monitoring of the device. Nursing staff should document the application of the device and the effects on the resident.
  - Include only the actual time staff were engaged in applying and monitoring the device.
**Restorative Program Tips**

- Identify a way to track residents on restorative programs.
- Calculate restorative nursing minutes per resident on programs and compare to restorative staffing hours provided.
- To capture appropriate reimbursement through the restorative program:
  - 15 minutes a day
  - 6 days per week
  - 2 Restorative Nursing Programs

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**Restorative success factors**

- Prevent decline.
- Improve mobility, movement, self-esteem, and independence.
- Obtain and maintain the highest level of function.
- Enhance reimbursement.
Percent of Residents Who Self-Report Moderate to Severe Pain (Short Stay)

Numerator
- Must meet either or both Conditions:
  - Condition #1: resident reports daily pain
    - Both of the following must be met:
      - Almost constant or frequent pain and
      - At least one episode of moderate to severe pain
  - Condition #2: resident reports very severe/horrible pain of any frequency

Exclusions:
- Pain Interview not completed
- Pain presence was not completed
- The pain frequency item was not completed
- Neither of the pain intensity items was completed
- The numeric pain intensity item indicates no pain

Covariates:
- None

Percent of Residents Who Self-Report Moderate to Severe Pain (Long Stay)

Numerator
- Must meet either or both Conditions:
  - Condition #1: resident report almost constant or frequent moderate to severe pain in the last 5 days
    - Both of the following must be met:
      - Almost constant or frequent pain and
      - At least one episode of moderate to severe pain
  - Condition #2: resident reports very severe/horrible pain of any frequency
**Percent of Residents Who Self-Report Moderate to Severe Pain (Long Stay)**

**Exclusions:**
- Target Assessment is admission or 5 day PPS.
- Resident did not meet the numerator AND any of the following:
  - Pain Interview not completed
  - Pain presence was not completed
  - The pain frequency item was not completed
  - Neither of the pain intensity items was completed
  - The numeric pain intensity item indicates no pain

**Covariates** - C1000 = 0, 1 or C 0500 is 13-15

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**Pain Documentation Review**

- Are pain interviews being conducted?
- How and when are they being conducted?
- Are cue cards used for pain scale?
- If the resident has pain, what is the follow up process?
- What commonalities are identified?
  - Residents triggered have no scheduled pain medication order.
  - Residents have the same pain level throughout their stay as well as discharge.

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**Therapy- Pain Management**

- Acute pain may occur after a fall or other physical incident
- Chronic pain may be related to diagnosis
  - Arthritis
  - Other degenerative disorder
- Therapy can utilize modalities and activity to support a medication regime to minimize pain and promote healing.
Percent of Residents With Pressure Ulcers That Are New or Worsened (Short Stay)

Numerator
- Short-stay residents for which look-back scan indicates one or more
  - new or worsening Stage 2-4 pressure ulcers

Exclusions:
- The resident doesn’t have a new or worsening Stage 2-4 pressure ulcer

Percent of Residents With Pressure Ulcers That Are New or Worsened (Short Stay)

Covariates
- Requiring limited or more assistance in bed mobility self-performance on the initial assessment:
- Indicator of bowel incontinence
- Diabetes or peripheral vascular disease on initial assessment
- Low BMI of 12-19
- All covariates are missing if no initial assessment is available.

Pressure Ulcer Documentation Review
- Identified and documented on admission
- Correct ulcer type identified
- History of ulcer- Resident, representative, physician
- Correct staging of ulcer(s)
- Conflicting location(s)
- Conflicting Stage(s)
- Correct coding of the MDS
- Correct coding of healed ulcers
Therapy- Pressure Ulcer Management

- Physical therapists can use electrotherapy modalities for wound healing as part of their training
  - Any sharps debridement requires specialized certification
- Electrical stimulation, Short wave diathermy and ultrasound have indications for wound healing
  - The choice depends on the stage and the goal
- Therapist should participate in Wound Rounds
- Therapist should know Medicare requirements for when skilled modalities are allowed to be performed

Therapy- Pressure Ulcer Management

- Nursing and Therapy would work together on dressing changes since dressing changes are not considered “skilled” minutes for therapy
- Therapy should also focus on pressure management techniques
  - PT or OT could work on positioning in bed and wheelchair
  - PT or OT could work on a therapeutic exercise program to improve/maintain ROM

Percent of Residents Experiencing One or More Falls with Major Injury (Long Stay)

Numerator

- One or more falls that resulted in major injury

Exclusions: One of the following is true for all of the look-back scan assessments.

- The occurrence of falls was not assessed
- The assessment indicates that a fall occurred and the number of falls with major injury was not assessed.

Covariates

- None
Falls Documentation Review

- What is a fall?
- Coding of falls
- Look back period for falls
- Three injury types
  - No injury, includes no pain
  - Injury (except major), includes pain
  - Major injury
- Symptoms after the fall

Therapy - Falls Management

- A member of the therapy team should be part of the Falls Team
- All falls should be screened by therapy to review cause and possible interventions
- “Frequent fallers” need even more critical review of possible root causes and interventions
  - Root causes: pain from being in one position too long, needing to go to the bathroom, boredom, anxiety are all things that therapy could address

Common Fall Interventions

- Keep environment free of clutter
- Review toileting schedule
- Review medication
- Take postural BP
- Assess for dizziness
- Assess balance and strategies: sight, sensation
- Look for repairs
- Provide adaptive equipment
- Assess cognition and implement strategies for communication
- Improve activity level
- Evaluate least restrictive device
Percent of Residents Whose Need for Help with Activities of Daily Living Has Increased (Long Stay)

Numerator
- Late Loss ADLs (Bed Mobility, Transfer, Eating, Toilet)
- Self-Performance Only
- Comparison of target assessment to prior assessment resulting in increased need for assistance.
- Increase in two or more coding points in one late-loss ADL
  \(\text{OR}\)
- One point increase in coding points in two or more late-loss ADL items

Percent of Residents Whose Need for Help with Activities of Daily Living Has Increased (Long Stay)

Exclusions:
- All four of the late-loss ADL items indicate total dependence on the prior assessment, (4, 7, 8)
- Three of the late-loss ADLs indicate total dependence on the prior assessment, as in #1 AND the fourth late-loss ADL indicates extensive assistance (value 3) on the prior assessment.
- Comatose
- Life expectancy less than 6 months, Hospice
- ADLs are dashed (-)
- Covariates: None

ADL Documentation Review
- Accurate ADL documentation
  \(\rightarrow\) Resident representation
- Consistent education
- ADL review for decline
- ADL spot education
- ADL clarification documentation
Therapy- ADL Management

- OT should perform an evaluation on anyone with a reported decline in ADL
  - Family report, C.N.A. report, patient report
  - Make sure there is documentation
  - Onset date is the date of the report

- Outcome of the evaluation
  - No decline substantiated
  - RNP development and training
  - Skilled OT intervention is required

Percent of Low Risk Residents Who Lose Control of Their Bowel or Bladder (Long Stay)

Numerator
- Frequently or always incontinence of the bladder

Exclusions
- Target assessment is an admission assessment or a PPS 5-day assessment
- Urinary and bowel Continence is dashed (-)
- Residents who have any of the following high risk conditions:
  - Severe cognitive impairment on the target assessment
  - Totally dependent in self-performance bed mobility, transfer, locomotion on unit (4, 7, 8).
- Resident does not qualify as high risk (see above) and both of the following two conditions are true for the target assessment:
  - BIMS Score ≥ 99 or dashed and Short Term Memory is dashed or decision making is dashed.

Exclusions continued
- Comatose or comatose status is dashed
- Resident has an indwelling catheter or indwelling catheter status is dashed.
- Resident has an ostomy or ostomy status is dashed

Covariates
- None
Incontinence Documentation Review

- Accurate coding of continence
- Understanding the continence coding definitions
- Documentation of incontinence episodes
- Process to identify first incontinence
- Toileting programs
  - Restorative Program
  - Skilled Therapy Program

Therapy Continence Management

- Skilled OT and/or PT is appropriate for both Stress Incontinence, Urge Incontinence or Mixed
- Physician must be involved to identify diagnosis
- Stress Incontinence = muscle weakness
- Urge Incontinence = hypersensitivity of the detrusor muscle in the bladder causes urge to urinate
- 24 Voiding Tracking Record helps to identify the origin of incontinence and support a diagnosis

Plan for Therapy Continence Program

- Pelvic Floor Strengthening Exercises “Kegel Exercise”
  - Medicare requires documentation of 30 days of program prior to use of any electrical stimulation
  - Skilled PT/OT can train resident, C.N.A., Activities Department or Restorative Aide to perform
  - Repeat 24 Hour Voiding Tracking to see change
- Use of electrical stimulation (PENS)
  - Most common for Urge Incontinence (> 8 incontinence episodes in 24 hours)
Benefits from Improved Continence

- Improved patient dignity; can go to events
- Decreased cost for products (facility or family)
- Decreased laundry costs (wet linens/clothes)
- Decreased risk of skin breakdown
- Decreased C.N.A. involvement for transfers to toilet
- Decreased risk of falls (due to attempting to get to the bathroom or wet floors)

Biggest Bang for the Buck!

THANK YOU

Submit questions to:

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