If you are viewing this course as a recorded course after the live webinar, you can use the scroll bar at the bottom of the player window to pause and navigate the course.

This handout is for reference only. It may not include content identical to the powerpoint. Any links included in the handout are current at the time of the live webinar, but are subject to change and may not be current at a later date.
Learning Objectives

• The participant will be able to describe Bundled Payment for Care Improvement and Comprehensive Care for Joint Replacement.
• The participant will be able to list at least three changes that have occurred in overall patient management for the total joint arthroplasty.
• The participant will be able to list at least three inpatient acute care staffing changes to manage a growing rehab need.
• The participant will be able to list at least three intraoperative interventions driving the advances in rehabilitative gains.
• The participant will be able to identify at least three methods to improve outcomes in the treatment continuum with community partners.
POLL

- State your discipline:
  - 1. Physical Therapist
  - 2. Physical Therapy Assistant
  - 3. Occupational Therapist
  - 4. COTA
  - 5. Nurse
  - 6. Other

Objectives (from previous lecture)

- Describe the components of an effective interprofessional team for a total joint arthroplasty program
- List rehabilitation exercises that facilitate early ROM return and functional mobility
- List the standardized tests that should be used to assess safety and functional mobility in the acute care hip or knee arthroplasty patient.
So what has changed in 3 years...

American Association of Orthopedic Surgeons

2014 Academy of Ortho Surgeons meeting:
• 2.5 Million Americans Living with an Artificial Hip (188 percent increase in hip replacements)
• 4.7 Million with an Artificial Knee (123 percent increase in knee replacements for patients age 45-64)
• Medicare primary payer for majority of procedures
• The proportion of TKR patients discharged with home health care increased from 19.1 percent in 2000 to 40.5 percent in 2009; and the number of THR patients, from 8.9 percent in 2000 to 40.8 percent in 2009.
Bundled Payments for Care Improvement

• To test innovative payment and service delivery models that have the potential to reduce Medicare, Medicaid, or Children’s Health Insurance Program (CHIP) expenditures while preserving or enhancing the quality of care for beneficiaries.

• https://innovation.cms.gov/initiatives/bundled-payments/

4 Models of Care

• Model 1 - the inpatient stay in the acute care hospital (MDs paid per the Fee Schedule)
• Model 2 – the inpatient stay in an acute care hospital plus the post-acute care and all related services up to 90 days after hospital discharge
• Model 3 – the episode of care is triggered by an acute care hospital stay but begins at initiation of post-acute care services with a skilled nursing facility, inpatient rehabilitation facility, long-term care hospital or home health agency. Under these retrospective payment models, Medicare continues to make fee-for-service (FFS) payments; the total expenditures for the episode is later reconciled against a bundled payment amount (the target price) determined by CMS
• Model 4 – a single, prospectively determined bundled payment to the hospital that encompasses all services furnished by the hospital, physicians, and other practitioners during the episode of care, which lasts the entire inpatient stay
4 Models of Care

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Comprehensive Center for Joint Replacement

- mandates participation of acute care hospitals in the 67 metropolitan service areas (MSAs) - (starting Jan 2016)
- Providers who spend BELOW the target price AND meet quality performance thresholds will be entitled to a reconciliation payment from Medicare, which will be capped at a specific amount. Conversely, providers who exceed the target price will be responsible for repaying the difference to Medicare, up to a specified amount.
Comprehensive Center for Joint Replacement

- The final rule aligns the caps for stop-loss and stop-gain payments, with the exception of year 1.
- Year 1: No repayment risk for hospitals, stop-gains capped at 5% of target price (ended April 2017)
- Year 2: Stop-loss and stop-gains capped at 5% of target price
- Year 3: Stop-loss and stop-gains capped at 10% of target price
- Year 4 and 5: Stop-loss and stop-gains capped at 20% of target price
The Cost of Surgery

- Surgery costs range in price from $16,500 to $33,000
- There is no correlation between the cost of total arthroplasty surgery and geographic location

http://www.modernhealthcare.com/article/20160326/MAGAZINE/30326996

Why does this impact the day to day care?

OUTCOMES

- Medicare is willing to reexamine 20 years of treatment history and reimbursement for better utilization of the healthcare dollar
- Rewards to care of total joint patients is finally shifting to OUTCOMES BASED care
- What does Rehab care about?

continued
### Factors impacting Discharge

<table>
<thead>
<tr>
<th>Preoperative</th>
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<tbody>
<tr>
<td>Patient education and expectation setting</td>
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<tr>
<td>Preoperative nutritional assessment and optimization</td>
</tr>
<tr>
<td>Carbohydrate loading</td>
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<tr>
<td>Minimal preoperative fasting</td>
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<tr>
<td>Anemia detection and optimization</td>
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<tr>
<td>Preemptive pain management</td>
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### Factors impacting Surgery

<table>
<thead>
<tr>
<th>Intraoperative</th>
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<tbody>
<tr>
<td>Minimally invasive surgery</td>
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<tr>
<td>Multimodal analgesia</td>
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<tr>
<td>Goal directed fluid management</td>
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<tr>
<td>Nausea vomiting prophylaxis</td>
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<tr>
<td>Active warming</td>
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<tr>
<td>Blood loss prevention</td>
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Factors impacting Recovery

<table>
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<tr>
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<tr>
<td>Early return to oral diet</td>
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<tr>
<td>Physiotherapy and early mobilization</td>
</tr>
<tr>
<td>Early discharge</td>
</tr>
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Key Articles in Arthroplasty Rehab
4 Current Articles

• Falvey JR, Burke RE, Malone D, Ridgeway KJ, McManus BM, Stevens-Lapsley JE. Role of Physical Therapists in Reducing Hospital Readmissions: Optimizing Outcomes for Older Adults During Care Transitions from Hospital to Community. Phys Ther. 2016; 96(8): 1125-34.

• Emphasizes the importance of PT to the interprofessional team in total joint arthroplasty

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Falvey – Team Rounds

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• Collaboration with community providers to discuss discharge plan prior to leaving hospital  
• Integration of patient, family, and caregiver input into discharge plans | • Development of care pathways that include routine, synchronous communication between physical therapists in different care settings about an older adult’s discharge plan prior to hospital discharge |
| Complete communication of information             | • Ensure hospital discharge summaries include complete information about a patient’s hospital stay and condition at discharge  
• Include information about response to treatments while hospitalized in all discharge summaries | • Increase involvement in development and optimization of documentation methods that automatically populate critical functional information into discharge information sets  
• Development of a standardized template for communicating information about function between disciplines during care transitions |
| Availability, timelines, clarity, and organization of information | • Make discharge summaries available in a timely manner after hospital discharge  
• Ensure information is presented in a standardized way that facilitates apt identification of critical information | |

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| Educating patients to promote self-management    | • Educate patients and caregivers on medical management and follow-up care required  
• Provide information about warning signs (eg, >1.36-kg [3-lb] weight gain in 24 h in patients with heart failure) that necessitate follow-up | • Routinely educate patients and caregivers about the risks associated with functional decline (eg, decreasing ability to rise from a chair)  
• Provide patients and caregivers with information on how to seek physical therapy in the event that functional decline develops after hospitalization |
| Enlisting help of home and community supports     | • Assess the need for formal and informal caregiving at time of hospital discharge  
• Enlist skilled and nonskilled services to meet at-home needs of older adults | • Ensure caregivers are trained to meet ADL deficiencies before discharge  
• Work with discharge planners to ensure older adults have adequate caregiving resources to manage ADL disability during transitional periods |
| Advance care planning                             | • Discuss goals of ongoing care after hospital discharge  
• Refer to palliative care or hospice services, as appropriate | • Advocate for routine functional evaluation referred for hospice/palliative care services  
• Provide maintenance physical therapy to patients using hospice/palliative care to reduce functional decline |

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| Coordinating care among team members             | • Establish open lines of communication among all providers  
• Maintain continuity of providers as much as possible | • Help develop standardized care handoffs to optimize management of functional deficits  
• Develop standards for physical therapy provider continuity after hospitalization |
| Monitoring and managing symptoms after discharge  | • Monitoring for declines in medical status  
• Monitor for inability to self-manage condition adequately | • Implement routine monitoring of key physical function parameters after hospitalization  
• Educate community physicians on key self-reported functional deficits representing increased risk of hospitalization |
| Outpatient follow-up                             | • Ensure safe transition of care  
• Utilize multidisciplinary teams  
• Follow-up with medical providers most aligned with care needs | • Assist in development of a functional assessment battery for use during posthospitalization physician follow-up visits  
• Increase participation in interprofessional models of care for posthospitalized older adults, such as the patient-centered medical home model |

continued
4 Current Articles


• The benefits of Physical Therapy staffing shifts to later to accommodate later rehab start and facilitate shorter length of stay

Pelt – Physical Therapy Staffing

• Previous staffing of 3-6 full-time physical therapists and physical therapy assistants (PTAs) with a work schedule of 8 AM-5 PM was modified to a new schedule to provide 3-4 full-time physical therapists and PTAs during the regular daytime shift and adding a swing shift from 11 AM to 8 PM with 1-2 physical therapists and PTAs.
4 Current Articles


• Comprehensive look at all of the adjustments to the overall treatment protocol to allow patient mobilization, effective pain management and decreasing length of stay

Robertson et al (2011)

• Education / DVD
• Scheduling and prep
• Blood management protocol
• Medical mgmt. including post op mgmt.
• Identifying social support
• Setting rehab expectations
• Pain protocols including analgesia, NSAIDs, HTN control

• Mobility by RN (OOB) and PT DOS
• Anticipatory pain mgmt.
• GI management
• POD 1-2 DC
4 Current Articles


- The shift of care is moving this procedure towards becoming an outpatient service. This is the potential beginning of removing Physical Therapy from part of the continuum of recovery.

Warren – Outpatient Total Joint

- At discharge from the hospital, the proportion of participants who met the ROM goals (0° knee extension and 90° of knee flexion; Cook et al., 2008) did not differ ($p = .61$ and $p = .07$ for knee extension and flexion ROM, respectively). Therefore, the two groups were statistically similar with respect to knee ROM at hospital discharge.

- At the first outpatient PT visit, there were no differences in knee extension ROM between groups (6.4°± 5.4° in HH and 4.7°± 4.6° in OP; $p = .14$). Knee flexion ROM was greater for HH than for OP (101.0°± 9.8° and 91.8°± 8.3° for HH and OP, respectively; $p < .0001$). One patient in HH was excluded from this analysis, as manipulation under anesthesia was required because of very low knee flexion ROM at the first outpatient PT visit (28°).

- There were no significant differences in the proportion of OP and HH patients who achieved knee extension (0°) and flexion (110°) ROM at the time of discharge from outpatient PT (see Table 2).
Acute Care Inpatient Changes

Inpatient Acute Care Physical Therapy

- Supports increasing treatments in number and frequency of visits for this population to decrease LOS
Inpatient Acute Care Physical Therapy

- The mean LOS - QD group 2.7 days, 2.0 days for the BID group.
- Mean FIM score was greater for the BID group.
- QD greater ROM than patients in the BID group.
- Mean pain reported by the BID group was greater.
- When decreasing LOS and improving FIM scores are the objectives, BID treatment appears to be beneficial.
- QD treatment may be more effective in decreasing pain and improving ROM.
- The physical therapist should determine which frequency is appropriate on a case by case basis.

Swing Shift Staffing

- Pelt (2016)
Swing Shift Staffing

• Both groups did not differ significantly in the 90-day readmission rate.
• Early ambulation was associated with higher odds of achieving at least 90 degrees of knee flexion (adjusted odds ratio, 1.33; P < 0.01) and requiring a walking aid with a smaller base of support.

Swing Shift Staffing

• Early intervention leading to shorter LOS without compromising patients satisfaction.
Joint Commission

• Disease Specific Certification for Total Hip and Total Knee Arthroplasty
  • Core certification
  • Advanced certification

Joint Commission

• Advocating for the early mobilization of TJA in their key concepts for process improvement in hospitals and ambulatory surgical centers performing total hip and total knee replacements:

• THKR-1 Neuraxial Anesthesia
• THKR-2 Postoperative Mobilization on Day of Surgery
• THKR-3 Discharged to Home
• THKR-4 Preoperative Functional/Health Status Assessment

PPE has not been shown to affect post-operative outcomes – except for a significant reduction in preoperative anxiety.
Education – No Effect


- Study claimed it was not an effective method of helping patients to achieve an earlier hospital discharge

Education – Positive Impact


- The mean length of stay was significantly reduced from 7 days in the Conventional group to 5 days in the Education group (P < 0.01). In addition, 20% more patients were discharged early (within 1–4 days) in the Education group compared to the Conventional group (P < 0.01).
Education – Positive Impact

- understand patient expectations, decrease dissatisfaction, improve commonality between patient and physician’s expectations

Patient Expectations

- Managing patient expectations helps to manage outcomes
- The discrepancy between predicted expectations related to outcomes of treatment and ideal expectations related to outcomes may factor into continued health care use by patients with chronic pain and subsequent increased health care costs
Physical Therapy Intensity


- Encourages aggressive PT after first 3 weeks of recovery

Shift to Outpatient Arthroplasty
Outpatient Total Joint


- He is one of the leaders in outpatient total joint arthroplasty, discharging these patients from the hospital same day

Outpatient Total Joint


- No difference in outcomes between hospital based or home based rehab programs
Outpatient Total Joint


- “Insufficient evidence exists to establish the effectiveness of physiotherapy exercise following primary hip replacement for osteoarthritis. Further well designed trials are required to determine the value of post discharge exercise following this increasingly common surgical procedure.”

Threats To Our Practice


- Challenges the need for Physical Therapy post operatively and minimizes skilled intervention
Importance of PT Intervention


- There is consensus that a complete and specific rehabilitation post-operative program is effective in reducing the length of hospitalization and the incidence of early complications.

Anesthesia
Regional Anesthesia


- Regional anesthesia produces less side effects and improved pain management.

Exparel

Tranexamic Acid


- A product for decreasing blood clotting, TXA helps to decrease pain caused by pressure in the joint space. This assists with improved post operative management.

Paracetamol (IV Tylenol)


- The results showed a decrease in length of stay and rate of discharge to skilled nursing facilities with the implementation of a novel multimodal pain protocol. Furthermore, there was no change in patient satisfaction before and after the execution of the new protocol.
Paracetamol (IV Tylenol)


- Oral multimodal analgesia incorporating a combination of opioid and nonopioid analgesics, selective and nonselective anti-inflammatory drugs, acetaminophen, and gabapentinoids are recommended as a part of a pre-emptive approach to pain management in patients undergoing hip or knee arthroplasty.
Successful Program Changes

- Becker’s Hospital Review
  - Looking at how hospitals and health systems updated their total joint replacement programs


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Successful Program Changes

- Treatment team redesign
- Physician engagement
- Post acute care partnerships
- Analytics tools
- Telehealth
- Education and a coordinated patient experience
- Identifying best medications through genetic testing
- Participation with American Joint Replacement Registry
- Increasing Rehab intervention and ambulation, including group classes
- Use of technology for surgery
Enhanced Recovery After Surgery

Francesco Carli MD

Enhanced Recovery After Surgery


- The ERAS group fell short of achieving satisfactory compliance in three of the perioperative care components (Joint Camp attendance, indwelling catheter removal Day 1 and IV tranexamic acid (TXA) use). Initially, Joint Camp was optional and was only established in the later stages of the implementation period. With experience, it was realized that this was an important component of the programme and it was made ‘compulsory’.
**Enhanced Recovery After Surgery**

- Early mobilization (<24 h) was achieved in 81% of patients in the ERAS group. Eight-two percent of those patients mobilizing early were successfully discharged within 4 days or less. This is in contrast to the control group, which demonstrated only 48% of patients mobilizing within 24 h of their operation.

**Acute Care Post Op Exercise**

- **Shabbir M et. al.** Comparison of functional training and strength training in improving knee extension lag after first four weeks of total knee replacement. *Biomedical Research 2017; 28 (12): 5623-5627.*

- Functional training exercises resulted in significant reduction in post-operative knee pain compare to resistance training.
- Significant improvement was found in the secondary outcome i.e. pain for the participants in interventional group. This supports the use of functional activities over strengthening exercises.
Acute Care Post Op Exercise


- “The optimal technique of rehabilitation needs evaluation, since present data even with immediate strength training have been disappointing and where all data have documented a reduction of muscle function for several weeks postoperatively”

Perceptions for Success

- Westby MD and Backman CL. Patient and health professional views on rehabilitation practices and outcomes following total hip and knee arthroplasty for osteoarthritis:a focus group study. BMC Health Serv Res. 2010; 10: 119.

- Physio-pedia.com
Perceptions for Success

Patient Reported Outcomes

• Integrating this voluntary data submission initiative into the CJR model will provide an opportunity to collect data from the patient’s perspective, data that are necessary to finalize and test the specifications of a hospital-level performance measure(s) of patient-reported outcomes following elective primary total hip and/or total knee arthroplasty (THA/TKA PRO-PM).
Patient Reported Outcomes

- Submission of PRO and risk variable data is not required for reconciliation payment eligibility. However, CJR participant hospitals that successfully submit PRO data may increase their financial opportunity under the model, since CJR participant hospitals that successfully submit PRO and risk variable data can receive two points toward their composite quality score.

- 4 Tests
  - the Veterans RAND 12 Item Health Survey (VR-12) or Patient-Reported Outcomes Measurement Information System (PROMIS) Global-10 generic PRO survey; and
  - the Hip disability and Osteoarthritis Outcome Score (HOOS)/Knee injury and Osteoarthritis Outcome Score (KOOS) Jr. or HOOS/KOOS subscales PRO survey for patients undergoing eligible elective primary THA/TKA procedures.

- [https://innovation.cms.gov/Files/x/cjr-qualsup.pdf](https://innovation.cms.gov/Files/x/cjr-qualsup.pdf)
Creating opportunities for community partners

• **Post-acute care providers.** The CCJR model could effectively create "winners" and "losers" among post-acute care providers if they do not proactively plan how to manage care under this program, according to the report. Post-acute care providers will likely aim to develop networks, care pathways and delivery patterns with hospitals.

http://www.beckershospitalreview.com/finance/how-the-ccjr-model-will-impact-8-key-stakeholders.html

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Creating opportunities for community partners

• **Skilled nursing facilities.** Historically, skilled nursing facilities were incentivized to create long lengths of stay for Medicare rehab patients. However, this practice has added significantly to the total cost of the surgical episode. The CCJR model will instead drive hospitals to find SNF partners that can deliver high quality outcomes at the lowest possible costs.

http://www.beckershospitalreview.com/finance/how-the-ccjr-model-will-impact-8-key-stakeholders.html
Creating opportunities for community partners

- **Home health agencies.** Home health agencies will be critical to hospitals' ability to reach bundled savings, according to the report. Because the episode of care lasts 90 days, independent hospitals will need to contract with care managers and other providers within the community to help support patients after they are discharged and have passed through rehab and/or skilled nursing facilities.

http://www.beckershospitalreview.com/finance/how-the-ccjr-model-will-impact-8-key-stakeholders.html

Case Study
Case Study:

• A physical therapy department is tasked with meeting the needs of an expanding orthopedic patient schedule. A new Ortho surgeon is scheduled to perform 8 cases on Monday and Wed and this is a new addition to the current caseload of Tuesday’s 6 cases and Thursday’s 5 cases. The staff are willing to try any changes to insure patients receive BID treatments, including changing their current start times. The therapists currently move all over the hospital to cover patients. The Ortho surgeons have all gotten together and decided they would like all single joint patients to get up the day of surgery with PT. The Medical Director, Charge RN, Head of Anesthesia and the Rehab Coordinator are meeting to come up with a plan.

73

Case Study:

• 8 cases on Monday
• 8 cases on Tuesday
• 8 cases on Wed
• 5 cases on Thursday
• 29 cases for the week

74
Case Study:

• 8 cases on Monday
• 8 cases on Tuesday
• 8 cases on Wed
• 5 cases on Thursday

• The therapists covering the day before cannot also evaluate the cases the next day (need a PM PT)
• BID treatments = twice the treatments each post op day

Case Study:

• 8 cases on Monday
• 8 cases on Tuesday
• 8 cases on Wed
• 5 cases on Thursday

• 16 cases on Tuesday
• 32 cases on Wed including remaining from Monday
• 32+ cases on Thursday including any remaining from Tues and Wed
• 26+ treatments on Friday

• This estimates a two day LOS
Case Study:

- 8 cases on Monday
- 8 cases on Tuesday
- 8 cases on Wednesday
- 5 cases on Thursday

- 16 cases on Tuesday
- 16+ cases on Wednesday including remaining from Monday
- 16+ cases on Thursday including any remaining from Tuesday and Wednesday
- 26+ cases on Friday including any remaining
- This estimates a one day LOS

Case Study:

- 8 cases on Monday
- 8 cases on Tuesday
- 8 cases on Wednesday
- 5 cases on Thursday

- This does not allow for patients who fall outside of the expected outcome
- Relies on coordinated effort to correctly anticipate discharge
Case Study:

- 8 cases on Monday
- 8 cases on Tuesday
- 8 cases on Wednesday
- 5 cases on Thursday

- This does not allow for patients who fall outside of the expected outcome
- Relies on coordinated effort to correctly anticipate DC

Case Study:

- 8 cases on Monday
- 8 cases on Tuesday
- 8 cases on Wednesday
- 5 cases on Thursday

- Integrating the patients with like diagnoses into a group exercise class for therapeutic exercise is a supplement to care, not a substitution for individualized treatments.
Home Discharge


Conclusion

• Definite shift in the expected progress of this patient population
• CCJR is putting the financial pressure on surgeons and the treatment team to “get it right”
• Accountability is critical
• Clinicians need to keep up with the rapidly changing field
• Plenty of opportunity to enact change if we recognize that we are important for success at every level of care
Conclusion

• There is a HUGE deficit in acute care physical therapy research by therapists!
• Studies needed in:
  • Effective immediate post op care
  • Expected norms before DC
  • Therapy protocols

Questions?
Questions?

- Alisa Curry PT DPT GTC GCS
  - Bodyphysics@yahoo.com
- Total Joint Special Interest Group – Acute Care Section
  - https://groups.yahoo.com/neo/groups/totaljointtherapists/info

THANK YOU FOR YOUR TIME!