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Mary Beth Clewell, Dubuque, Iowa.
When I was in graduate school back in the early 90’s, I published a research paper on the perception–price dichotomy in nursing. A new hospital payment program using diagnosis-related groups, or DRGs, had been introduced in 1983, which radically changed the way hospitals were reimbursed for services, and I was curious about what nurses thought about needing to focus on costs while providing patient care.

Historically, hospital financials resembled other businesses. Charges were set based on the cost to provide the service plus some amount for overhead. Insurance companies or patients paid the bills, and the excess of revenue (minus charity care) over expenses was reinvested into the organization to fund new equipment, facility upgrades, new programs, and the like.

The Centers for Medicare and Medicaid Services (CMS) adopted diagnosis-related groups as the basis for hospital reimbursement because the amount they were paying for healthcare for enrollees was consuming more and more of the federal budget and was projected to grow out of control without reform. DRG is a patient classification system comprised of groupings based on clinical diagnoses, procedures, age, sex, discharge status, complications, and co-morbid conditions. In oversimplified terms, a standardized DRG payment covers all services associated with a hospital inpatient stay, from the time of admission through discharge. This reimbursement model encourages cost reduction because the payment to the hospital is the same regardless of the number of days the patient is in the hospital, how many nurses are needed to provide the care, the types of medications prescribed, or the supplies consumed. The system theoretically promotes optimization of resources because, generally speaking, no matter how many resources are used, the reimbursement is the same.

There were 467 groups in the original DRG classification system. Today, there are just under 1,000, and those incorporate thousands and thousands of modifiers and codes that must be supported in clinical documentation in the patient’s medical record and meet rigid submission requirements for claims to be paid.

The hospital payment system has been through many, many iterations since the DRG came on the scene. It is exponentially more complicated and in recent years, with the passage of the Affordable Care Act, is moving from traditional volume to value based, with incentives or penalties for performance on quality metrics like readmission rates, infection rates, and patient satisfaction scores. Accountable care organizations, Medicare shared savings and bundled payment programs impose risk sharing formulas related to the cost of care, so with emerging payment systems, hospitals and providers are financially rewarded for keeping patients well.

For those of us who have been around for a while, we actually take the ever challenging paradigm twists and turns of the health care payment system for granted. While we have to effectively manage costs and continually transform ourselves to stay strong, our number one priority will always be to provide the highest standards of care and service. There isn’t a perception–price dichotomy, rather cost and quality co-exist and serve as a practical reality in advancing health care at Mercy and across the country.
Spot a Stroke **FAST**

A stroke occurs when a blood vessel that carries oxygen and nutrients to the brain is either blocked by a clot or bursts. When that happens, part of the brain cannot get the blood and oxygen it needs, which can lead to permanent damage.

Each year, nearly **800,000** people in the United States have a stroke.

Remember this acronym to spot a stroke **FAST**:

- **F**ACE DROOPING
- **A**RM WEAKNESS
- **S**PEECH DIFFICULTY
- **T**IME TO CALL 911

Stroke is a leading cause of long-term disability and the leading **preventable** cause of disability.

**You can reduce your stroke risk by living a healthy lifestyle, including:**

- controlling high blood pressure
- not smoking
- eating a healthy diet low in saturated and trans fats
- being physically active
- maintaining a healthy body weight
- managing diabetes
- drinking alcohol moderately or not at all

Mercy Dubuque holds **Advanced Certification as a Primary Stroke Center from The Joint Commission**.

Learn more at [mercydubuque.com/stroke](http://mercydubuque.com/stroke).

SOURCE: AMERICAN STROKE ASSOCIATION
Mary Beth Clewell doesn’t recall everything that happened on August 13, 2016. She remembers her son having a couple friends over and videotaping them as they went down the Slip ‘N Slide. She remembers being in the basement with the kids and dropping to the floor. She vaguely remembers the EMTs coming into the house.

Her husband, Steve, fills in the blanks.

The kids had rushed to get Steve. “I came downstairs and told them to call 911 and instantly did the FAST acronym,” he said. “I could tell that she was probably having a stroke. I could see her face was drooping. I asked her to raise her arm, and she couldn’t. I asked her to talk to me, and it sounded like she was trying to say ‘stroke.’”

The ambulance rushed Mary Beth to Mercy’s emergency department, where they confirmed that she was indeed having a stroke. She was airlifted by AirCare 3 to the University of Iowa Hospital and Clinics.

Mary Beth had experienced a significant brain bleed, and her entire right side and speech were affected. She stayed at the University of Iowa for nine days before
Mary Beth’s recovery is the perfect example of the team effort required for stroke recovery. With speech therapy, she worked to improve skills of verbal expression, attention, and processing. The strength she regained working with physical therapy allowed her to progress with functional mobility."

— Mary Lohberg, MSOT, OTR/L

Mary Beth returns to Dubuque and being admitted to Mercy’s rehabilitation unit for intense therapy. Every day, even weekends, Mary Beth participated in speech therapy, occupational therapy, and morning and afternoon physical therapy, along with mandatory rest.

“Mary Beth’s recovery is the perfect example of the team effort required for stroke recovery,” said Mercy occupational therapist Mary Lohberg, MSOT, OTR/L. “With speech therapy, she worked to improve skills of verbal expression, attention, and processing. The strength she regained working with physical therapy allowed her to progress with functional mobility.”

Her occupational therapy helped with developing the skills needed for daily living.

“Often during the inpatient rehabilitation phase, we start with the most basic aspects of daily living routines, such as regaining the skills to perform tasks of self-care,” Mary explained. “For Mary Beth, this meant addressing areas such as dressing, showering, grooming, and all areas of her daily routine that were affected by her stroke.”

Mary Beth admits that the work was frustrating at times.

“I had to learn how to walk again. How to cook again. Speech was a big one. Everything, really.”

She spent six weeks on the rehabilitation unit. Before being discharged, her therapists performed a home safety assessment where they tested Mary Beth on skills in her home setting. They checked such tasks as negotiating stairs, or getting in and out of bed or the shower. The team decided to extend her discharge after the first assessment to further strengthen and improve her mobility. After more work, Mary Beth successfully demonstrated her skills in her home and also during a community outing.

Following discharge from the inpatient unit, Mary Beth continued physical, occupational, and speech therapy at Mercy’s outpatient rehabilitation clinic.

“When Mary Beth started she needed 24-hour supervision at home for safety,” explained Mercy physical therapist Annemarie Day, PT. “Her husband was helping her with bathing and dressing. She required assistance to walk with her cane outdoors. Her goal was to regain as much independence as she could.”

Mary Beth went through several months of outpatient therapy and regained much of her independence. She began cooking again, going out with friends, participating in her favorite hobbies such as knitting, and she’s even able to drive now—certainly a monumental achievement toward independence.

When Mary Beth was discharged from outpatient rehabilitation, she was given a home exercise program to continue working on her strength, endurance, and balance. So for two hours, four days every week, Mary Beth exercises with a variety of weight and cardio machines.

“She’s come a long way, 360 degrees,” said her husband. “Every day, every week she gets a little stronger. To see her progress, it’s pretty amazing. She continues to grow both physically strong and linguistically strong.”

“I feel good with what I’ve accomplished, but my goal is to keep getting better, to keep gaining strength on my right side,” Mary Beth said with absolute determination. “It’s part of my life, and I have to work on it every single day. You can’t let it sit and do it tomorrow, because things don’t get better on their own.”

“Some days I would think, ‘Why does it have to be me?’ But you’re given what you can handle. And I can handle it.”
Q: My child walks on his toes. Should I be concerned?

A: “Toe walking” is when a child consistently walks on the balls of his or her feet without the heels touching the floor. It can be considered normal if your child has just started walking or only toe walks on occasion.

However, if he or she is displaying the following, it’s a good idea to be evaluated:

- Your child has been consistently toe walking for more than a few weeks
- You notice tightness in your child’s legs when trying to place their foot flat or stretch their legs
- Your child does not like their feet touched
- Your child cannot walk with feet flat on the ground if asked

There are many components that can play into toe walking, including balance, muscular tightness, vision, and sensory issues. Physical therapy can help with developing a stretching program, improving balance, and determining if other intervention is necessary. Your first step should be to schedule an evaluation with a physical therapist who can help determine the cause of your child’s toe walking and develop a therapy program if needed.

Krista Laufenberg, PT, DPT

For more information or to schedule an appointment with a physical therapist, call Mercy Rehabilitation Services at 563-589-9035.

MERCY CANCER CENTER

Mercy is committed to making a $25 million dollar investment in the development of a regional cancer center to create a better experience for our patients.

Learn more about the project and the compelling reasons why it’s so critical at mercydubuque.com/cancer-center.

MERCY HOME MEDICAL EQUIPMENT STORE – WE’VE MOVED

Now with over 1,500 square feet of showroom space and private consultation rooms, the Mercy Home Medical Equipment Store is in its new location in the hospital, on first floor, next to Mercy Family Pharmacy and the Mercy Gift Shop. Enjoy convenient parking and equipment pickup or drop-off at our retail entrance on the north side of the building.

Visit the new location Monday – Friday, 8 a.m. – 5 p.m., or call 563-589-8118 to speak with expert staff.

MERCY GIFT SHOP

Shop gifts and home decor at the Mercy Gift Shop. All proceeds support programs and services for children in Mercy’s care. As always, there is no sales tax.

Monday, Thursday, and Friday: 10 a.m. – 5 p.m.
Tuesday and Wednesday: 10 a.m. – 7 p.m.
Saturday: 10 a.m. – 3 p.m.
MERCY BIRTH CENTER Offers New Birthing Tool

A new birthing tool at Mercy, called a peanut ball, can reduce the incidence of emergency Cesarean sections. Mercy Birth Center is the first in Iowa to have a peanut ball birthing tool ambassador available to laboring mothers.

A peanut ball is a therapy ball that is shaped like a peanut: oblong shaped, larger on each end, and slightly narrower in the middle. Peanut balls can be used for a variety of strength training or physical therapy needs, as well as by laboring women.

Mercy Birth Center nurse Katie Wiederholt, MSN, RN, is the first and only certified ambassador for the peanut ball program in Iowa. Katie and a group of labor and delivery nurses at Mercy conducted research on the effectiveness of the birthing tool.

“We completed a nursing study and found that during the six months following initiation of peanut balls for positioning, we decreased our C-section rate for first-time mothers by 8.8 percent,” said Katie. “The peanut ball has become a great addition to our birth center, and we’re receiving great feedback from laboring moms.”

For more information about services available at Mercy Birth Center, visit mercydubuque.com/birth-center.

LEMON BASIL QUINOA SALAD

MAKES APPROXIMATELY 8 SERVINGS (¾ cup)

INGREDIENTS
3 cups cooked quinoa, cooled to room temperature
1 cup blueberries, fresh or frozen
1 cup frozen cubed mango, thawed
1 cup cucumbers, cubed
½ cup dried cranberries
12 large basil leaves, divided and julienned
4 tablespoons lemon juice
4 tablespoons olive oil
2 tablespoons honey
¼ teaspoon salt
¼ teaspoon pepper

INSTRUCTIONS
1 - Prepare quinoa according to package directions.
2 - Season cooled quinoa with salt and pepper.
3 - Cut mango and cucumber into small cubes and combine with blueberries and dried cranberries.
4 - Just before serving, whisk together the lemon juice, olive oil, honey, and eight julienned basil leaves.
5 - Toss quinoa with fruits and lemon vinaigrette, garnish with remaining julienned basil leaves.
6 - Serve immediately.
HEALTHY VARIETY

Created and approved by Mercy dietitians, Healthy Variety frozen meals are heart healthy, low in sodium, diabetic friendly — and delicious. Try all 12 varieties!

PICK YOUR MEALS UP TODAY!

Healthy Variety meals are available for purchase in the Mercy cafeteria and at the Mercy Family Pharmacy Elm Street location.

» mercyhealthyvariety.com

LEMON BASIL QUINOA SALAD

This recipe was inspired by a creation from our executive chef, Patrick Hanniford. Quinoa (pronounced KEEN-wah) is a gluten-free grain product that can typically be found in three different varieties: red, white, and black. Quinoa is an excellent source of protein and contains all essential amino acids, making it a complete protein source. Other sources of complete protein include meat, fish, eggs, and dairy products.”

— Stacy Huss, RD, LD

NUTRITIONAL INFORMATION:
206 calories, 1g saturated fat, 31g carbohydrates, 78mg sodium, 3g fiber, 3.5g protein