Quantifying the IMPACT of Clinical Interventions with the CARE Item Set

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OVERVIEW

IMPACT Act, Purpose and CARE Item Set
WHAT IS THE BIG DEAL?

Value

Dollars

EMBRACE CHANGE

Now

• Payments based on volume
• Care delivered in silos of care settings
• Unable to compare quality across care settings
• No information exchange between settings; unable to share data.
• Care planning and discharge planning within care settings

IMPACT

• Payments based on value
• Care transitions and coordinated care essential
• Common/standardized patient assessment data elements
• Information exchange mandates across PAC settings (databases)
• Person-centered/goal driven care planning and discharge planning
KEY LEGISLATION

**Patient Protection & Affordable Care Act (PPACA)**
- Legislated “Initiatives to Accelerate the Development and Testing of New Payment and Service Delivery Models”; e.g. VBP

**Protecting Access to Medicare Act (PAMA) of 2014**
- Delayed cuts to PFS
- Value Based Purchasing

**KEY LEGISLATION**

**IMPACT: Improving Medicare Post-Acute Care Transformation Act of 2014**

“Post Acute Care”: LTCH, IRF, SNF, HH

1. Mandated standardized data at time of admission and discharge across PAC providers
2. Develop and publicly report QMs across settings
3. Hospitals and PAC providers will be required to provide QMs to consumers when transitioning to another PAC provider
4. HHS and MedPAC are required to conduct studies to link payment to quality
5. $11m in funding for payroll data in SNF
GOAL OF THE IMPACT ACT

Achieve Uniformity to Facilitate Effective Communication for Better Care of Individuals and Communities

How?

- Standardized patient assessment data across post-acute care (PAC) settings

Categories

- Function
- Cognitive Function
- Special services
- Medical conditions
- Impairments

Domains

- Functional, Cognitive & Changes
- Skin Integrity & Changes
- Medication Reconciliation
- Incidence of major falls
- Communicate & Transfer HL & preferences
DATA ELEMENTS: STANDARDIZATION

STANDARDIZED ASSESSMENT DATA ELEMENTS
Information Follows the Person

IMPACT TIMELINE

<table>
<thead>
<tr>
<th>FY 2017</th>
<th>FY 2018</th>
<th>FY 2019</th>
<th>FY 2022</th>
</tr>
</thead>
<tbody>
<tr>
<td>Standardized resource use measure and some quality reporting begins.</td>
<td>Confidential feedback provided on previous year’s reports.</td>
<td>Standardized assessment data required. Public quality data available. Penalties take effect for those not reporting.</td>
<td>CMS &amp; MedPAC reports on PAC prospective payment. Study on hospital assessment data.</td>
</tr>
<tr>
<td>10/1/16</td>
<td>10/1/17</td>
<td>10/1/18</td>
<td>10/1/21</td>
</tr>
</tbody>
</table>

www.ahcancal.org
Why Function?

FUNCTION AND HEALTH

National Committee on Vital & Health Statistics,
Subcommittee on Health

Subcommittee on Health National Committee on Vital and Health Statistics, "Classifying and Reporting Functional Status" (2001)

“Information on functional status is becoming increasingly essential for fostering healthy people and a healthy population. Achieving optimal health and well-being for Americans requires an understanding across the life span of the effects of people’s health conditions on their ability to do basic activities and participate in life situations, that is, their functional status.”
GG: PRIOR FUNCTIONING

<table>
<thead>
<tr>
<th>Self-Care Comparison</th>
<th>LTCH</th>
<th>SNF</th>
<th>IRF</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self-Care</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Indoor Mobility (Ambulation)</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Stairs</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Functional Cognition</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Prior Device Use</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Manual WC, Motorized WC, Mechanical lift,</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Walker, Orthotics/Prosthetics, None of</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>above</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
</tbody>
</table>

✓ = New GG items 10/1/2018
### GG: SELF-CARE ITEMS

<table>
<thead>
<tr>
<th>Self-Care Comparison</th>
<th>LTCH</th>
<th>SNF</th>
<th>IRF</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prior Level of Function: Cognition</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Eating</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Oral Hygiene</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Toileting Hygiene</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Wash Upper Body</td>
<td>✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Shower / Bathe Self</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Upper body dressing</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Lower body dressing</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Putting on/taking off footwear</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
</tbody>
</table>

 ✓ = New GG items 10/1/2018

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### Mobility - Comparison

<table>
<thead>
<tr>
<th>Mobility - Comparison</th>
<th>LTCH</th>
<th>SNF</th>
<th>IRF</th>
</tr>
</thead>
<tbody>
<tr>
<td>Roll Lt &amp; Right</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Sit to Lying</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Lying to sitting on side of bed</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Sit to Stand</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Chair/bed to chair transfer</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Toilet transfer</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Car Transfer</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
</tbody>
</table>

 ✓ = New GG items 10/1/2018

---

<table>
<thead>
<tr>
<th>Mobility - Comparison</th>
<th>LTCH</th>
<th>SNF</th>
<th>IRF</th>
</tr>
</thead>
<tbody>
<tr>
<td>Does the patient walk?</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Walk 10 feet</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Walk 50 feet with 2 turns</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Walk 150 feet</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Walking 10 feet on uneven surfaces</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>1 step / 4 steps / 12 steps</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Picking up object</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Does the patient use WC or scooter?</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Wheel 50 feet with 2 turns &amp; type of WC</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Wheel 150 feet &amp; type of WC</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
</tbody>
</table>
APPLICATION OF MEASURES IN PAC

<table>
<thead>
<tr>
<th>Measure</th>
<th>IMPACT Domain</th>
<th>Method</th>
<th>SNF</th>
<th>LTCH</th>
<th>IRF</th>
<th>HH</th>
</tr>
</thead>
<tbody>
<tr>
<td>Functional Status</td>
<td>Functional, Cognitive Status &amp; Changes</td>
<td>Facility Assessment</td>
<td>10/1/16</td>
<td>10/1/18</td>
<td>10/1/16</td>
<td>1/1/19</td>
</tr>
</tbody>
</table>

1. Percent of Patients with Admission and Discharge Functional Assessment & Care Plan that Addresses Function – SNF, LTCH, IRF 10/1/2016
2. Change in Mobility Among LTCH Patients Requiring Ventilator Support – LTCH 10/1/2016

The following 4 are currently used in the IRF setting, and finalized for SNF effective 10/1/18
1. Application of IRF Functional Outcome Measure: Change in Self-Care Score for Medical Rehabilitation Patients
2. Application of IRF Functional Outcome Measure: Change in Mobility Score for Medical Rehabilitation Patients
3. Application of IRF Functional Outcome Measure: Discharge Self-Care Score for Medical Rehabilitation Patients
4. Application of IRF Functional Outcome Measure: Discharge Mobility Score for Medical Rehabilitation Patients

PLACING A VALUE ON OUTCOMES

Points given for performance along an “achievement range”

Achievement Threshold
Benchmark
Outcome Analysis of Clinical Improvement using the CARE Item Set

TRAINING IN CARE TOOL UTILIZATION

- Hours of Training: 2
- Exams: 3
- Passing Score: 80%
- Re-Credentialed: 2 Year
DATA COLLECTION IN OPTIMA THERAPY

Score 37.00 / 84.00

Basic Mobility

- Lying or Sitting on Side of Bed: I [S] [C] [U] (Sep T. P) [Mod] [S] [N] [A] [P]
- Stroking: I [S] [C] [U] (Sep T. P) [Mod] [S] [N] [A] [P]
- Feeding Left & Right: I [S] [C] [U] (Sep T. P) [Mod] [S] [N] [A] [P]
- Stroking Head: I [S] [C] [U] (Sep T. P) [Mod] [S] [N] [A] [P]
- Chair or Bed to Chair Transfer: I [S] [C] [U] (Sep T. P) [Mod] [S] [N] [A] [P]
- Toilet Transfer: I [S] [C] [U] (Sep T. P) [Mod] [S] [N] [A] [P]

Sitting/Walking

- Sitting Distance (ft.): 10 - 15 feet
- Sitting Level of Assistance: I [S] [C] [U] (Sep T. P) [Mod] [S] [N] [A] [P]

Walking/Wheeling

- Walking Distance (ft.): 10 - 50 feet
- Walking Level of Assistance: I [S] [C] [U] (Sep T. P) [Mod] [S] [N] [A] [P]
- Wheeling Distance (ft.): 10 - 50 feet
- Wheeling Level of Assistance: I [S] [C] [U] (Sep T. P) [Mod] [S] [N] [A] [P]

Additional mobility

- Picking Up Objects: I [S] [C] [U] (Sep T. P) [Mod] [S] [N] [A] [P]
- Car Transfer: I [S] [C] [U] (Sep T. P) [Mod] [S] [N] [A] [P]

So What?
IMPROVEMENT RANKING

LEVERS | CHARACTERISTICS

Clinical Program Integration Scores

Documentation Audit Scores

Turnover

Full Time: PRN ratio

Readmissions
Outcome Analysis of Clinical Improvement with Biophysical Agents
Measuring Value in Rehab Settings

The ACP Outcomes Study by The Moran Company

STUDY OBJECTIVE

To conduct an analysis of patient experience and outcomes related to the delivery of physical and occupational therapy in skilled nursing facilities with a focus on specific biophysical agents supported by Accelerated Care Plus (ACP) programs

The aim of the study was to examine the outcomes associated with the use of ACP clinical programs for selected modalities used to address underlying impairments that restrict patient function and functional recovery
DATA COLLECTION

Analysis performed on 25,363 Medicare Part A stays during a 17-month period (4/1/2014 through 9/1/2015) provided in 81 SNFs affiliated with Consonus Healthcare Rehab Services.

Outcomes data for this sample was assessed via the CARE Tool Item Set Assessments for Self-Care and Mobility domains at admission and discharge to the SNF.

THE STUDY POPULATION

Approximately 58% of Medicare Part A patient stays in the study were fee-for-service (FFS) beneficiaries with the remainder enrolled in Medicare Advantage (MA).

Average Medicare Part A SNF length of stay was about 22 days
- Patients on FFS Medicare had longer lengths of stay (LOS) than MA patients on average (24 days vs 19 days), about 25% less
- This relative difference between payers exists for all therapy patients

On average, Medicare Part A patients had 18 days of therapy or a little over 33 hours per stay.
Approximately 43% of patients utilized one or more of the study modalities.

Study modalities are frequently used in conjunction with each other:
- Overall about 50% of patients that received diathermy also received electrical stimulation.
- Of the patients that received ultrasound, about 44% also received diathermy and 48% also received electrical stimulation.

Of the patients that utilized one or more of the study modalities over the course of their stay, study modality services were delivered on about 8.2 days, or about 37% of the days during their stay.

Delivery of physical agent modalities to patients during SNF Medicare Part A stays yielded significantly greater outcomes in self-care and mobility functional improvement than therapy services provided without modality intervention.

The use of PAMS was effective to produce significant outcome improvements across levels of independence, from the most dependent to the least dependent.

The use of PAMS provided efficient outcome improvements during SNF Med A stays.
### Superior Functional Improvement

<table>
<thead>
<tr>
<th>Selected Modalities Overall</th>
<th>No Modalities Overall</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Avg. Starting Score</strong></td>
<td><strong>Avg. Ending Score</strong></td>
</tr>
<tr>
<td>Total Self-Care Score</td>
<td>52.8</td>
</tr>
<tr>
<td>Total Mobility Score</td>
<td>40.7</td>
</tr>
</tbody>
</table>

Total Self-Care and Total Mobility Score Performance for Medicare A Patients, Comparing Functional Outcomes for those who Received Selected Modalities Versus those who did not

### Effective Outcomes Across All Levels of Independence

<table>
<thead>
<tr>
<th>Level of Assistance</th>
<th>Self Care</th>
<th>Mobility</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Any Modality</td>
<td>No Modality</td>
</tr>
<tr>
<td>Substantially Dependent</td>
<td>17.9</td>
<td>11.1</td>
</tr>
<tr>
<td>Moderate Assistance</td>
<td>22.1</td>
<td>17.0</td>
</tr>
<tr>
<td>Minimal Assistance</td>
<td>19.6</td>
<td>15.6</td>
</tr>
<tr>
<td>Largely Independent</td>
<td>6.9</td>
<td>4.5</td>
</tr>
</tbody>
</table>

Average Improvement in Overall Self Care and Mobility Functional Assessment Scores by Level of Assistance at Admission Category for Medicare Part A Patients
TREATMENT EFFICIENCY

The number of minutes per treatment per day were just 4 minutes higher for patients receiving modalities (116 minutes/treatment day) than for patients receiving therapy services overall (112 minutes/treatment day).

Study modality services were delivered on about 37% of the treatment days during their stay.

TURNING DATA INTO KNOWLEDGE

The use of biophysical agents, when clinically indicated, can yield efficient, effective treatment outcomes across levels of independence that are superior to therapy services rendered without biophysical agents.

Why?

Effectively addresses underlying impairments
Part of a rehabilitative treatment philosophy that considers the whole patient rather than focusing simply on function.
THOUGHTS FOR FUTURE STUDY

Are results consistent if the variable of LOS is held steady?

Will LOS decrease if the frequency of biophysical agent intervention is increased?

What impact does the use of biophysical agents to address underlying impairments have on patient satisfaction?

Are there greater or poorer results within specific diagnostic groups?

Interpreting the Analysis through the Lens of Value
1. CONSIDERATIONS IN COLLECTING INFORMATION

Take time.... think short and long term.... Anticipate future needs

Key variables
Essential vs. “nice to have”
Burden of reporting
Actionable/meaningful

Complete records
Establish a minimum set of elements which must be completed

Contribute to registry/vendor or “stand-alone, home grown”? AM-PAC, UDS, Remedy, VRDC (CMS)

<table>
<thead>
<tr>
<th>Admission Car Transfer</th>
<th>Current Scoring Value</th>
<th>Discharge Car Transfer</th>
<th>Current Functional Change</th>
<th>Frequency of Example</th>
</tr>
</thead>
<tbody>
<tr>
<td>S</td>
<td>1</td>
<td>2</td>
<td>+1</td>
<td>317</td>
</tr>
<tr>
<td>S</td>
<td>1</td>
<td>3</td>
<td>+2</td>
<td>1,344</td>
</tr>
<tr>
<td>S</td>
<td>1</td>
<td>4</td>
<td>+3</td>
<td>3,143</td>
</tr>
<tr>
<td>S</td>
<td>1</td>
<td>5</td>
<td>+4</td>
<td>782</td>
</tr>
<tr>
<td>S</td>
<td>1</td>
<td>6</td>
<td>+5</td>
<td>1,423</td>
</tr>
</tbody>
</table>

Total Count: 7,009

<table>
<thead>
<tr>
<th>Admission Car Transfer</th>
<th>Current Scoring Value</th>
<th>Discharge Car Transfer</th>
<th>Current Functional Change</th>
<th>Frequency of Example</th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
<td>S</td>
<td>1</td>
<td>-1</td>
<td>207</td>
</tr>
<tr>
<td>2</td>
<td>A</td>
<td>1</td>
<td>-1</td>
<td>33</td>
</tr>
<tr>
<td>2</td>
<td>P</td>
<td>1</td>
<td>-1</td>
<td>17</td>
</tr>
</tbody>
</table>

Total Count: 257

Activity Codes
S = Not attempted due to safety concerns
N = Not applicable
A = Task attempted but not completed
P = Patient refused
2. SELECTION OF INFORMATION COLLECTION

Efficiency
- LOS, Therapy min/visits, Overall episode cost
- Time points: admission, discharge, 30-day

Quality
- Own unique information already collecting
- CARE + cognitive elements
- Readmissions

Demands of the hospital/plan partner
- Duplication sometimes will happen

3. TURNING DATA TO INFORMATION

Multiple use reporting/Dashboards
- Operational/Resources/Productivity
- Cost, Quality, Value

Considerations for report development
- Determine intent
- Relationships between variables
- Choices to be made: Averages, SD, risk adjusted, variances
  - Functional gain, rate of improvement, gain per cost
  - Value v. “nice to know”
  - Snapshot v trended

Actionable
- Well defined, easily understood (graphics)
4. TURNING DATA INTO KNOWLEDGE

What is the change in self-care or mobility for?

- Patients admitted with cardiac conditions? Joint replacements?
- Patients who are discharged home versus to an assisted living facility?
- What is gain (change) per day (value) in self-care/mobility?
- How have these values improved/declined over time (trended)?
- Where can you prove “center of excellence”?
- Where are there opportunities for improvement?

ONE STEP FURTHER....

What is the readmission percentage for:

- Joint replacements with discharge score of 75-84 in mobility?
- Patients with a discharge score of 65-74 in mobility?

What is the utilization of ED/ER visits for:

- Patients with a discharge score of 75-84 in mobility?
- Patients with a discharge score of 65-74 in mobility?

What is the incidence of falls for:

- Patients with a discharge score of 75-84 in mobility?
- Patients with a discharge score of 65-74 in mobility?
CHANGING THERAPY CULTURE

Proving value of rehab vs. revenue generator
1. Measure
2. Analyze
3. Plan
4. Change
5. Measure

CLINICAL ACCOUNTABILITY

Recognize key organizational success drivers
Set the level of these drivers / goals
   Through strategic goals
   Through operational benchmarking
Manage the achievement of the goals
Foster accountability through the recognition of the achievement
   Positive consequences based on goals and outcomes
   Negative consequences due to lack of achievement
CLINICAL COMPLIANCE

Achievement → Improvement

Documentation to support these!