FOTO Emphasis on Outcomes

Date: Saturday, October 1, 2016
Time: 2:45 PM - 5:55 PM
Session ID & Location: 7A: MtgRm2
CEU Eligibility: 0.30

Presented by: Nikki Rasmussen, PT, Cert. MDT

Session Description: Implementing a new product can be daunting. Getting staff and organization buy-in, informing your community, and sharing the information with your patients, providers, and payers can be uncertain and stressful. This workshop will first discuss ways to focus in and strategize as you undertake an implementation of a product into your practice.

But then, after implementation, now what? Part two will discuss the importance of understanding your data and using that data. Mentoring, learning from the data, and using it in marketing can be key in thriving in practice. Keeping patients satisfied and engaged, navigating paths with other organizations, and showing referral sources how your patients and staff succeed is essential to thriving in the current healthcare environment. Your outcomes tool is a goldmine of information in growth and development.

1. Understand the importance of an outcomes tool in your practice.
2. Recognize the need for risk adjustment in the use of outcomes tools
3. Learn ways to strategize and prepare for a great launch of the outcomes assessment tool
4. Identify several methods to use data in marketing, engagement, and education of the community and providers

Presenter Bio(s): Nikki Rasmussen, PT, Cert. MDT graduated from Marquette University in Milwaukee in 1995 with a BS in physical therapy and has worked in urban, suburban, and rural private and hospital practices. In her 21 years in the clinic, she has enjoyed treating patients with a wide array of diagnoses, primarily orthopedic, with advanced training in spine and pelvic floor. Her interest in spine drew her to the McKenzie Method, which in turn evolved into a love for outcomes. Nikki has presented on national, regional, and local levels on outcomes and has presented regionally and locally on pelvic floor topics.
“FOTO EMPHASIS ON OUTCOMES: OUTCOMES ARE YOUR FRIEND. NO, REALLY.”

– Nikki Rasmussen, P.T., Cert. MDT

Pre/Post-Test Questions

1. What is a Legacy Tool assessment?

2. Risk adjustment helps you make an “apples to apples” comparison of patients. Name five of the ten risk adjustment categories in FOTO.
   a. 
   b. 
   c. 
   d. 
   e. 

3. True or False: The manner in which an outcomes assessment tool is introduced and instructed, and shared with the patient can have an impact on the relationship between the patient and the clinic/provider, and the patient’s overall satisfaction with the experience.

4. Give some specific examples of writing your outcomes data into your eval, daily treatment note, and discharge documentation so that your referral and payer sources can understand the relevance of the information:
   a. 
   b. 
   c. 

5. Name four different groups to whom you can market your outcomes data:
   a. 
   b. 
   c. 
   d.
OUTCOMES ASSESSMENT IS YOUR FRIEND
NO, REALLY!

NIKKI RASMUSSEN, P.T., CERT. MDT
CLINICAL LEAD, PROVIDER RELATIONS, FOTO, INC.
INSIGHT 2016, TPTA AND PTAG
OCTOBER 1, 2016 – CHATTANOOGA, TN

LEARNING OBJECTIVES

• Understand the importance of an outcomes tool in your practice
• Recognize the value of risk adjustment in the use of your outcomes tools
• Learn ways to strategize and prepare for a great launch of the outcomes assessment tool
• Identify several methods to use data in marketing, engagement, and education of the community and providers

WHY? I ALREADY HAVE ENOUGH “FRIENDS.” WHY DO I NEED OR WANT ANOTHER ONE?

• Competitive arena in which we treat
• Payment from insurance or patients themselves
• Employers’ choices: choosing the providers and networks for their employees and families
• Patients’ choices: where they spend their copayment and coinsurance dollars.
• Alphabet soup: CJR, P4P, VBP, ACO, etc.
• Marketing - Show your cards!
PRE-TEST

- Kahoot!
- Game number
- Choose a screen name for yourself
- Record your score at the end

HISTORY OF OUTCOMES ASSESSMENT

- A long, long time ago...

  Back when big hair was starting to flatten out, and Pearl Jam was new, Wayne's World was popular, and everyone wore flannel shirts and hiking boots with shorts to PT class

BACK TO THE FUTURE

- “Health status instruments may be useful in clinical settings to screen for functional problems, monitor disease progression or therapeutic response, improve doctor-patient communications, assess quality of care, or provide case-mix adjustment for comparing other outcomes between patient groups. However, conceptual, practical, and attitudinal barriers have prevented their wider implementation.”

Deyo, RA, and Carter, WB. Med Care. 1992 May;30(5 Suppl):MS176-86; discussion MS196-209
NOTHING NEW HERE…

“The emphasis is no longer on unbridled growth nor on blind cost containment, but on a balance between assessment of gains achieved for certain costs and an accountability for those costs incurred.”


HISTORY 101

- Patient reported outcomes became more familiar and more widespread in the 90’s
- A few outcomes gathering databases started to evolve, using paper assessment forms and data entry
- Tools evolved into electronic with sophisticated measurement ability and functions in the turn 90’s and 2000’s
- Current tools continue to grow and show potential for incredible amounts of information moving into 2020’s and beyond…

GUIDE TO PT PRACTICE
LOTS OF OUTCOME ASSESSMENT OPTIONS

- Morbidity and mortality
- Chronic illness management
- Re-admission rates
- Infection rates
- Results of treatment (pain, effective movement, imaging studies) - measured by objective tests
- Patient reported outcomes

PATIENT REPORTED OUTCOMES

- Questionnaires asking the patients to report how they feel they are doing or what they can do
- Asks the patient to answer with regard to the current time and their current function
- Is not the same as objective testing done in clinic. Not enough anymore.
- Patient’s perception may be different from the clinician’s perception
- We can not make assumptions

PATIENT REPORTED OUTCOMES

- QOL: Quality of Life
- Function
- Symptoms
- General Health Perceptions
PATIENT REPORTED OUTCOMES

- Are they valid?
  Does it measure what it says it measures?
  Are there floor/ceiling effects?
- Are they reliable?
  - Are the results the same when repeated under the same conditions?
    (e.g., test-retest, internal consistency)

VALIDITY & RELIABILITY:

- Good to excellent validity and reliability established for numerous PRO measures of function/disability

Sullivan MM et al. Phys Ther 2000;
Simmonds MJ et al. Spine 1998;
Teixeira et al. Phys Ther 2011

PATIENT REPORTED OUTCOMES

- Strong and well established psychometric properties of numerous measures
- Mandated by some payers
- CMS Functional Limitation Reporting
- Endorsement by policymakers (US Dept Health & Human Services, National Quality Measures Clearinghouse, Institute of Medicine, NIH and many more)
BUT WE ALREADY DO SOME QUESTIONNAIRES, ISN’T THAT DOING OUTCOMES?

• Yes! and you could have more information, too!
• Collecting a score on that patient in the beginning and end of the series.
• Then what?
• Buried in the abyss of old documentation?
• Is someone collecting and analyzing scores from your Oswestry or LEFS or DASH?

ONE OR THE OTHER?

LEGACY TOOLS

• Easy, inexpensive, low tech
• Must answer every question to achieve score
• Familiar
• No ability to compare or analyze to others

CONTEMPORARY TOOLS

• Some cost, higher-tech, may require use of web or software on tablet or computer
• CAT – reduced number of questions
• Require some education of users
• Robust comparative data for benchmarking

ONE OR THE OTHER?

LEGACY TOOLS

• Oswestry
• LEFS
• DASH
• NDI

CONTEMPORARY TOOLS

• AMPAC
• FOTO
• CARE CONNECTIONS
• ROMS
CHECKLIST OF NEEDS AND WANTS FROM AN OUTCOMES ASSESSMENT TOOL

1. Assess your patient's functional level at intake, at specific intervals, and at discharge from care.
2. Assess patient's level of satisfaction at specific intervals and discharge.
3. Assess your outcomes for your organization, clinic, and individual therapists.
4. Benchmark yourselves against others' outcomes scores.
5. Measure like patients with like patients.
6. Streamlined, easy process to complete – with little math involved by the staff.
7. Support network in place to help and answer questions.

WHICH ONE SHOWS THE BEST OUTCOME?

MEASUREMENT

- An inch is an inch regardless of where it starts on the ruler.
- Does one meter equal one yard?
- “A mole is a mole is a mole.” Lloyd Haville
RISK ADJUSTMENT

- Actuarial term and methodology that considers the aspects of an individual’s health that can be a factor in their health and well-being
- Allows for comparison of a broad population who are not completely similar
- In Outcomes: allows for apples-to-apples comparisons by making adjustments to a measurement to help accurately represent a patient’s health status – adding or subtracting values which have been studied to be valid and reliable to enable a more equal comparison
- Comparison of patients who are younger, healthier, non-surgical, lower fear; and those who are older, sicker, surgical, more fear. Eliminates “my patients are worse than yours”

- In Insurance – can impact payment/premium costs, and payment to providers (look at population of retirement community in Florida vs. suburbs of major city)
- In Insurance– insuring 16 year old new male drivers vs. his 42 year old mother who has been driving for 26 years
- Some employers offer a rebate or discounted premiums to their tobacco-free employees, or those who participate in a risk-assessment test
- In education – weighted classes or GPA

TWO STEP PROCESS

- RISK ASSESSMENT: method used to determine the relative health risk of an individual
- RISK ADJUSTMENT: method used to adjust the measurement to the known risks or variables
TERMINOLOGY CAN BE CONFUSING, MISUSED, AND MISUNDERSTOOD

- Retrospective or concurrent RA: uses claims data from a particular time period for assessment of same time period – preferred for accuracy
- Prospective RA: uses data from the past to help gauge the future risk
- Risk stratification
- Case-mix adjustment

RISK STRATIFICATION

- Different than risk adjustment
- Used to sort patients into categories of high, moderate, or low risk for reporting and quality improvement: “sorting hat” or “buckets”
- It does not compare a single patient to the aggregate to determine comparability of the patient to others in their peer group.
- Has goals of identifying risk, prioritizing care, and reducing negatives (costs, further disability, etc.)
- Also called segmentation

CASE MIX ADJUSTMENT

- An adjustment to a measure for population differences beyond health status
- Consider: a hospital that performs transplants and one that does not. It may appear that one has a substantially higher infection rate, and so it could appear to be a lesser quality facility, when in fact, it is due to the larger volume of higher-risk cases they treat and the greater inherent risk in caring for that population of patient. When case mix adjustment is accounted for, the faculties may appear on a more level playing field.
TEN RISK ADJUSTMENT CATEGORIES IN FOTO

- Age
- Gender
- Payer source
- Duration of symptoms
- Body area
- Care type
- Surgery status
- Comorbidities
- Severity
- Fear

RISK ADJUSTMENT: A COMPARISON

- 18: No comorbidities
  - Male
  - Very severe
  - Preferred provider: Elevated fear
  - 15-21 days
  - Shoulder
  - Orthopedic
  - No surgeries

- 67: 3+ comorbidities
  - Female
  - Slight severity
  - Medicare B
  - Greater than 6 months
  - Shoulder
  - Orthopedic
  - No surgeries

RISK ADJUSTMENT: A COMPARISON

- Each pretend patient answered the questions exactly the same:
  - Some difficulty combing hair
  - Much difficulty pulling something from back pocket
  - Some difficulty reaching shelf at shoulder height
  - Some difficulty carrying 5-10 pound object in crook of arm
  - No difficulty getting a scarf or necktie over head and around neck using both hands
  - Little difficulty reaching across to the middle of the table to get salt shaker while sitting
RISK ADJUSTMENT: A COMPARISON

- FOTO INTAKE SCORE 54
- RISK ADJUSTED STATISTICAL FOTO SCORE 58
- PREDICTED POINTS OF CHANGE 23
- DASH CROSSWALK: 34.2 (HIGHER SCORE EQUALS GREATER DISABILITY)

18 YEAR OLD MALE

- FOTO INTAKE SCORE 54
- RISK ADJUSTED STATISTICAL FOTO SCORE 55
- PREDICTED POINTS OF CHANGE 13
- DASH CROSSWALK: 34.2 (HIGHER SCORE EQUALS GREATER DISABILITY)

67 YEAR OLD FEMALE

TIME OUT

SCORE:
- Badgers – Wolverines
- Vols - Dawgs

IMPLEMENTING AN OUTCOMES ASSESSMENT TOOL

Lots of questions to ask yourselves and consider
- Time investment in clinic every day with every patient
- Training of staff
- Costs
- Value
- ROI
- What questionnaires or surveys to use
- Best way to introduce the tools to the patient, providers, and community
IMPLEMENTING AN OUTCOMES ASSESSMENT TOOL: ASK YOURSELF…

• What do I want to do with the data I collect?
• Who will score the questionnaires?
• How important is it for the patient to know the answers to their surveys and do they really care?
• But I have the toughest patients, and the most critical staff. They don’t want to do this. How do I get them interested in participating? Or at least not hate it?
• What processes will we follow? What are the best practices?

SUCCESSFUL IMPLEMENTATION

For successful implementation of any outcomes process

• Plan or checklist of needs and wants from your outcomes system
• Champions or Superusers selected and a part of the process from day one
• Administration support and corporate culture
• IT considerations and infrastructure in place
• Implementation team in place

PROCESSES FOR COLLECTING OUTCOMES

Legacy Tools

• paper and pen
• well-researched and long-studied
• easy to complete and implement
• familiar to medical community
• staff person scores documented manually into notes
• patient answers every question on survey whether pertinent or not
• separate surveys needed for patient satisfaction and no way to compare
• multiple surveys available for body parts – which ones are best? Over 40 for lumbar!
**processes for collecting outcomes**

Contemporary Tools using Computer Assisted Testing (CAT)

- Questions taken from legacy tools and developed from other research
- Asks a mid-level functional question, then based on answer asks one that involves a higher functional activity or lower functional activity
- Number of questions typically 5-8 to determine a good functional level
- Score is generated on standard 0-100 (100 highest function) scale
- Well-researched and studied (over 90 articles in peer-reviewed journals)
- Can load directly into EMR depending on program integration
- Can roll out satisfaction and optional survey questions

**implementation team**

- Rehab services directors with administrator support as needed
- 1-2 Front line clinicians “SuperUsers or Champions”
- IT department people
- Support staff – front desk
- Select these people before the process begins!
OUTCOMES CHAMPION

- One of your documentation committee people, front line clinician and support staff
- Knows your outcomes procedures inside and out and can communicate with everyone
- Responsible for training and being the “face of outcomes” in your facility
- Works in concert with marketing and PR and administration
- Communicates with hospital board, shareholders, administration, news media, social media...
- Should be a respected, creative, and motivating person who is approachable and interested in bettering the organization

IT CONSIDERATIONS

- Equipment
- Security
- Involve your IT team for maximum effectiveness
  - they know the language

ADMINISTRATION SUPPORT AND CULTURE

- Support of upper management requires basic understanding of the use of the tool, and to be able to demonstrate the importance of it on several levels.
- For staff to be on-board with it, also requires management to display ways in which they find it valuable. Allow clinicians to share the data with the administration team, the community, referral sources, and the patients
- Do not use it in a punitive way. See it as opportunities to improve or get curious, rather than “judge.”
ROLL OUT (THE BARREL)

Determine the following:
1. Which surveys to use
2. Who will score them
3. Standardization of the documentation of scores
4. Frequency of administering surveys
5. Education of staff, patients, providers, and community
6. Introducing the tool (scripting)
7. Using the data once satisfactory volume has been collected

MEET AND GREET

- Invite some current patients, staff, and providers you know well to do some test surveys
- Determine the scripting you want to use to introduce the surveys and have your support staff and clinical staff practice to eliminate the “canned” sound. Make this fun and let your staff be creative and shine.
- Invite your marketing team, social media staff, or local newspaper/radio/TV to do a feature on the new tools you are using to generate interest in the community
- Find some patient “champions” to be a focus of your news features

THE CRAZY TRAIN
GETTING STAFF ON BOARD WITH OUTCOMES

- Incorporate clinicians into the decision making process
- Include them in training of other staff
- Give them ownership of the tool
- Frees up manager for managerial-only tasks
- Do not use punitively
- Use in collaborative manner
- Include all staff in goals (clinicians and support staff may have different goals)
- Have a celebration once fully implemented (pizza, bbq, game, picnic, jeans day, theme day)
COMMON PROBLEMS AND CONCERNS

• “You’re using this to judge me.”
• “Why now? We never had to do it before.”
• “How is this valid?”
• “This does not meet my needs. I want to use other scales like the DGI and the Berg.”
• “Our patients are too old or not tech savvy enough to use the tablets.”
• “People are going to steal our tablets.”
• “There are not enough hours in the day.”

AFTER IMPLEMENTATION, THEN WHAT?

• Rolling along.
• Rolling along.
• This is cool. We are rolling along. We got this. We so got this.
• Oh shoot. What was that? Blew a tire. Now what do we do?
• Bumps in the road, falls, skids, trips, and slips.

STUFF LEARNED BY 2 X 4 METHOD

• Small group training is better than big group training, which is like herding cats.
• Standardized “scripting” makes a big difference in how the process is understood.
• Getting the right surveys to the patients the first time is critical.
• Reviewing the patient’s surveys with them is imperative for establishing therapeutic alliance.
• You can use your outcomes tool to help determine and write goals.
• It takes a good 12-18 months to really get good at using the tools and how to modify your plan based on your results.
THINGS PEOPLE GET TIRED OF HEARING ME SAY:

• “Take the emotion out of the data.”
  Look at your data objectively. What is it telling you? What is the patient in front of you telling you?
• “You can’t prove it unless you can prove it.”
  You can’t get by on your reputation only anymore, or on the reputation of your predecessors. YOU have to be able to prove what you do. And there is only one way you can do that.
• “You need a bigger N.”
  Larger data sets are a better indicator of your true outcomes.

JUMP AROUND!

Badgers - Wolverines
Vols – Dawgs

NOW THAT WE FOUND DATA, WHAT ARE WE GONNA DO… WITH IT?

• Marketing
• Patient engagement
• Staff training
• Physician engagement
• Satisfaction comparisons
• Professional standardization
MARKETING WITH OUTCOMES

- Direct emails to referral sources with their patients' data
- Community marketing with radio, TV, or newspaper advertising
- Human interest stories
- Website
- Direct mailers to community
- Community fraternal organizations: Rotary, Lions, Young Professionals, Jaycees, Kiwanis, VFW, American Legion, college alumni associations, booster clubs, senior centers
- Community wellness events

OTHER WAYS TO USE OUTCOMES

- Patient engagement
- Staff training
- Physician engagement
- Satisfaction comparisons
BENCHMARKING TOOL

PEOPLE
• Organization
• Clinic
• Therapist

PROBLEMS
• Care type
• Body region
• Condition

STANDARDIZING ACROSS THE PROFESSION

• Very fragmented in schools of thought, treatment principles: us vs. them
• Increasingly competitive market
• Difficulty in generating consensus
• So if we as a profession have difficulty coming to consensus, how can we expect the American society, payers, referral sources to know what we do?

WHAT EXACTLY DO YOU DO ALL DAY?

• General public has little knowledge of what we do, and is often inaccurate.

You know so much, you could be a trainer!
Are you nurses? You girls are so smart!
Am I going to get a massage?
Did you go to school for this?
Are you going to hurt me?
PHONE TIME!

SEARCH "PHYSICAL THERAPIST"
FIRST IMAGE THAT COMES UP

STANDARDIZING ACROSS THE PROFESSION

- Begin using the same tools, accept the same high standards and values
- Acknowledge that we are not a commodity and that different therapists have different skills, but change in health policy requires a way for us to determine competence and skill in being efficient and effective
- A patient reported outcome survey with no way to gather and analyze the data gleaned from it is good for scoring that particular patient. But there is no way to look at effectiveness, efficiency, variability in patient, and no way to compare the raw data to determine the therapist’s percentile ranking.

STANDARDIZING ACROSS THE PROFESSION

- Over 40 lumbar spine outcomes assessments
- Makes for difficult decisions
- No common language
- Inconsistent measurement tools affect how services are rendered, paid, valued
STANDARDIZING ACROSS THE PROFESSION

• If we do not actively involve ourselves in what happens to our profession, and let others make the decisions for us, we will continue to be at the kids’ table at Thanksgiving.

Using outcomes tools will help us graduate to the Adult table.

LONG TERM GOALS

• Everyone uses the same tool for measuring, managing, and marketing.
• Level playing field for all comparisons to be equal and well understood.
• Have a seat at the table with all the other major players. And bring that data. Or pie. Whatever works.
GO BADGERS!

“IN GOD WE TRUST, ALL OTHERS BRING DATA.”
W. EDWARDS DEMING

- START NOW!
- Choose an outcomes system and begin collecting data!
- Not starting is worse than starting small
- Don’t wait for the “perfect time”
- Collectors of outcomes are better positioned moving forward than those who are not
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