# Acute Care Productivity Measurement, "What about the Patient?" The Time has Come to Shift to a Value Based Measurement System


CSM 2016 Anaheim, CA.
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## Outline

- Section Activities to Date
- Propose new definitions for productivity, efficiency, quality and value
- Make the case for a value driven measurement approach
- Share the findings of the acute care section survey
- Present a template of a new measurement tool
- Explore possible clinical and practice management uses for the new tool

## Section History

- The Acute Care Section has long recognized the issue for practitioners that the measurement of productivity brings
- The section created its first task force a number of years ago to look into the issue.
  - Survey data
  - Current state analysis

## Section History

– In its 2011 Final report:
- The widely utilized "75% productivity standard may not appropriate due to hospital intrinsic and extrinsic factors"
- Calls for PT managers to critically examine the productivity measures for PTs and PTAs
- There is a huge variability in measures (units, time, visits, RVUs etc) definitions, sources of measures – difficulty in making comparisons or determining what is a useful measure or productivity much less our value
- There is a huge variety of the application of Medicare Part B rules
- Productivity must include quality measures – patient satisfaction and quality outcomes
- Healthcare is a business

## From Initial Task Force Report

**Productivity Grid**

| Facility Information | Methods | Expectations | Evaluation Weight |
|---|---|---|---|
| Mid-Atlantic Medical Center<br>Non-Teaching<br>Two facilities = 389 beds total | • # worked hours (billable & non-billable staff)/ # visits<br>• Consult=15 min (0$ code for unavailable/ holds) | 55-65% | Eval = 1 visit |
| Mid-Atlantic Medical Center<br>Level 1 Trauma Center<br>400 beds | • # worked hours/ # visits | 10 visits/day | Eval = 1 visit |
| Southwest Community | • 15 minute units | 75%, 24 units | Eval = 3 or 4 |
| Midwestern Teaching Hospital<br>550 acute & 26 IRF beds<br>Data provided is for acute & IRF combined | • 8 minute rule | 68% | Eval based on 15 minute units |
| Mid-Atlantic Hospital<br>Non-trauma center – 440 beds | • 8 minute rule<br>• 15 minute units<br>• Dummy charges | 2 units/hr in 7.5 hr day | Eval = 1 unit |
| Midwestern Level 1 Teaching Hospital<br>493 beds | • 15 minutes/CPT code | 60% | Eval = 15-60 minutes depending on complexity |
| Southwestern Medical Center<br>Teaching/Level 1 Trauma<br>600 beds | • 15 minute units<br>• 8 minute rule | 18 units | Eval = 3 units |
| Southwestern Community Hospital<br>900 beds | • 15 minute units<br>• 8 minute rule<br>• "missed visits" = 0.5 units | 65% (2.6 units/hr or 20.8 units/day) | Eval = based on 15 minute units |
| Midwestern Community Teaching Hospital<br>350 beds, 39 bed IRF | • 15 minute units | 65% | Eval = 3 units |

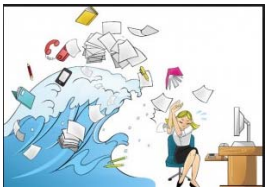
## Take Aways

- No one method to determine productivity
  - Impossible to benchmark
- Measurement is staff time (minutes? % etc) in what is defined by "treatment" in each facility
  - How do we as a profession define interventions in acute care?
- Determining the cost of care
  - No mention of the cost in current measures
  - No standard way to measure cost across acute care physical therapy
- Anecdotal evidence that these "measures and benchmarks" are being brought to facilities and applied to all services by outside consultants
- Many different clinical measures being used, so how do they fit into productivity measurement? Do we need to decide on just one?
- Have we done a good job of being "proactive" in measuring our own business and its value to the patient, the facility and the healthcare system?
- …..***We must be able to do better!***

## Current Status: From Acute Care Survey Feb-March 2015

- Are you using a productivity measurement tool that your admin or an outside consultant requires?

| | |
|---|---|
| Yes | 57.6% |
| No | 42.4% |



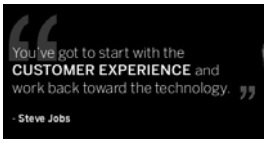
## Section History

- Late 2012
  - New Task Force charged with trying to find a way to help members with the issues related to Productivity, building on the work of the first Task Force
- Task Force Members
  - Jim Dunleavy PT, DPT, MS Chair
  - Allen Lee PT, PhD
  - Gina Surgenor PT
  - Lori Pearlmutter PT
  - Mary Pyfferoen PT
  - Maureen Eaton PT
  - Ed Dobrzykowski PT
  - Daniel Dziadura PT
  - Katesel Strimbeck PT
  - Anita Bemis-Dougherty PT APTA Staff

## What the Profession is talking about…..

- "Anyone have any references for acute care productivity standards? All I could find was a document on the APTA website referencing a "median number of patients seen per week for clinicians spending 76% or more of their time on direct patient care" (30 by the way). This is from 2009. If anyone knows of any other studies regarding acute care productivity (be it #patients/day, # units billed/day or hours/uos), I would be very grateful. Thanks! "

…from acute care listserv




## Current Status: What are We Measuring?

- From Webster's…..
  - **Productivity:** the rate at which goods are produced or work is completed
  - **Efficiency**: the ability to do something or produce something without wasting materials, time, or energy
  - **Quality:** how good or bad something is
  - **Value:** to think that (someone or something) is important or useful

"…***It's the patient who ultimately determines the value."***

## Current Status: What are We Measuring?

- "The PT was very ***productive***….but the patient did not get better"
- "The PT was very ***efficient*** ….but there was no change in the status of the patient"
- "The PT provided high ***quality*** care", but not sure if the patient really needed it
- "The patient saw the positive change after PT, indicating they ***valued*** the care they received"

***The patient has to be at the center of all our measures of care / practice / finances***

## Current Status: Situational Confusion Abounds!

- "I know there are various schools of thought on the face to face time issue. Long story short, when the "8 minute rule" first came out years ago we did follow it to the tee, and our productivity tanked because of it and threatened to lose FTE's. It ended up going to our legal department at that point, and after they reviewed it, they determined we could go back to traditional "billing" practices. Reality is, very few of our patients are solely part B, and even less of those are appropriate for skilled PT intervention. Also, we have no way of knowing when some patients may become part B after the fact. We are a large institution with many layers of billing and management, thus I imagine for the few patients it does impact, these things may be corrected after the fact (way beyond my PT supervisor level :) ). If it was a big issue we would have heard about it a long time ago. "
- …"I'm with you. I became manager right after we switched to the 8 minute rule and it has been a struggle ever since." …from acute care listserv


## Job Security based on current Methods of Productivity Measurement? Current Status: The Landscape 2001-2013

- Annual admissions fell slightly to 33.6 million from 33.8 million. But because of plummeting lengths of stay, total patient days fell to 182.4 million from 194.1 million, a 6.4% decline.
- Hospital employment, rose 20% over the same period, from 3.99 million to 4.79 million.

http://www.modernhealthcare.com/article/20150711/MAGAZINE/307119984

## Job Security based on current Methods of Productivity Measurement? Current Status: Medicare Part A Rehabilitation Services Interpretive Guidelines

- **Interpretive Guidelines §482.56**
  - This is an ***optional*** hospital service. However, if a hospital provides any degree of rehabilitative services to its patients, the hospital must comply with the requirements of the Condition of Participation.
  - Acceptable standards of practice include **compliance with** any applicable Federal or State laws, regulations or guidelines, as well as **standards and recommendations promoted by nationally recognized professional organizations (e.g., American Physical Therapy Association,** American Speech and Hearing Association, American Occupational Therapy Association, American College of Physicians, American Medical Association, etc.).
- **Interpretive Guidelines §482.56(a)**
  - The hospital must provide the appropriate equipment and types and numbers of qualified personnel necessary to furnish the rehabilitation services offered by the hospital in accordance with acceptable standards of practice.

## Current Status: Volume Driven Measurement

- "I would like to share that looking at my hospital and our sister facilities that the frank number of people in the house is important, but what is really key is how much of that volume we are actually covering. For example, one sister facility runs a census of 140-170 most days and they average 10-20 new evals each day, so essentially 12% of the hospital is supposed to get an eval by PT. At our facility our census is 250-320 and we might have 40-60 new evals each day so that makes it 19%. And that is not counting those patients that we eval, decide they have PT needs and then sign on to follow them. So for our facility we might have active patients in the 75-100 range. Add that to the 60 new evals then we are trying to cover essentially 50% of the hospital. "

...from acute care listserv

***...How many should we see? Who should we treat? Who should we not treat? What intensity of Service? What's the outcome/value to patient-facility-healthcare system?***

## New element of Current Status Bundled Payment

- TJR Bundled payment based on an episode of care
- Rewarded for value
- Many more to come


## Current Status: Measuring/Benchmarking in the Dark....

- We have just been told that we are now going to be compared to other "similar" facilities using xxxxxx, but they have declined to tell us which facilities we are being compared to.

  I would appreciate some truthful and honest feedback about xxxxx.

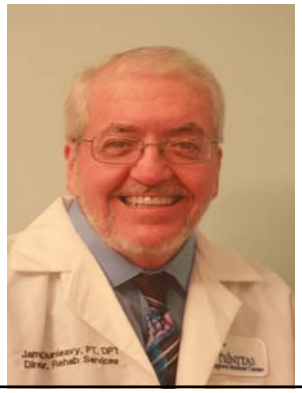
  Do you know what facilities you are matched with?
  Do you feel that the stats accurate reflect your performance and, dare I say, productivity?

  How do you weigh evals? Do you do 15 minute increments weighted as "1", or is a single charge, one time weight of say "4" equivalent to 60 minutes of time? Do your reevals weigh 2 or 3?

  And any additional information you would feel helpful in this conversation would be appreciated.

...from acute care listserv


## "I'm Not Going to Take It Anymore!



## Variables and more Variables

- Measurement tools
- What to Measure? Time? Patient outcome? LOS? Time with patient?
- Benchmarks? Sources?
- Variable definitions?
- Variation in Practice and case mixes?
- What is our value in this setting?
- What is our value to the ***facility*** the ***patient*** the ***healthcare system***?
- Should we even be here?

"*We can't solve problems by using the same kind of thinking we used when we created them.*" – Albert Einstein


## Task Force Initial Activity – Trying to get our arms around it

- Establish Assumptions
- Establish Goals
- Create a Position Statement
- Change current language/definitions and create consistency around physical therapy productivity/value
  - Understandable by many stakeholders
- Develop a model to measure the value of acute care physical therapy that is valid, reliable and usable by all
- ***Can be used with multiple outcome measures***

## Establish Assumptions

- Physical Therapy has ***value*** to the patient, the hospital and the healthcare system in the acute care practice setting
  - Areas of Practice identified as having value:
    - Early determination of appropriate next level of care
    - Validity and timeliness of discharge recommendations
    - Decrease cost of ICU Stays
    - Impact on LOS
    - Decreased variation of practice
    - Patient / Family / Caregiver / staff education
    - Consultation services
    - Identification of at risk for readmission cases based on current versus previous level of function
    - Avoid unnecessary admissions/readmissions in ER

## Establish Assumptions

- In acute care our value is not driven solely by revenue but rather the value we bring to:
  - The patient:
    - cost effective, timely, clinical outcomes
  - The healthcare facility:
    - early determination of next level of care
    - identifying potential readmissions before they leave the first time
    - managing the cost of our interventions
      - Severity of patient condition
      - Intensity of our intervention
  - The healthcare system as a whole:
    - by providing care at the level of value that meets the patient goals and that the patient proceeds seamlessly to other levels of care
    - Right care-right patient-right time (Berwick)
    - Effective transition of care decision making

## Establish Assumptions

- **Value:**

  Value should always be defined around the customer, and in a well-functioning health care system, the creation of value for patients should determine the rewards for all other actors in the system. Since value depends on results, not inputs, value in health care is measured by the outcomes achieved, not the volume of services delivered, and shifting focus from volume to value is a central challenge. Nor is value measured by the process of care used; process measurement and improvement are important tactics but are no substitutes for measuring outcomes and costs.*


***Porter ME, What is Value in Healthcare, NEJM Perspective, December 23, 2010**

## Task Force Goals

- Utilizing our assumptions that helped to define a new paradigm of acute care ***value*** (formerly known as "productivity") measurement
  - Create a position Statement on Value/Productivity Measurement in Acute Care Practice that can be used by practitioners in dealing with non clinical professionals and colleagues alike
  - Standardize definitions to create a common language – one that is understood by:
    - Hospital administrations – esp. Finance
    - Other healthcare professionals
    - Our colleagues
  - Create a measurement process that can be used in all acute care settings that links the cost of care provided to a value measure that demonstrates:
    - Or value to achieving the patient's outcome
    - Our value to the Hospital
    - Our value to the healthcare system

## Task Force Goals

Develop and test a model, the result of which blends cost, severity and intensity of physical therapy care with the patient's outcome that produces a measure that it understood by Practitioners, Administrators and Financial professionals as a true measure of the value of acute care physical therapy services

**Position Statement**

**Productivity Measurement in Acute Care Physical Therapy**

**The measurement of productivity in Acute Care Physical Therapy practice requires a unique system which captures the value of our care to the patient, as well as our value to the facility and the healthcare system.**

**The value for acute care physical therapy services must take into account the patient's needs that drive the goals of treatment and the intensity/cost of those services required to meet those goals which can only be achieved by our unique interventions.**

**Productivity, measured solely as a percentage of daily staff time engaged in direct clinical activity holds little value for the true stakeholders of our care.**

**A blended measurement system that encompasses the patient's severity, patient defined outcomes, as well as the cost of the care that meets those outcomes is the best way to determine the value of acute care physical therapy services to the patient, the facility and the healthcare system.**

http://www.acutept.org/

## Shifting Language and Debunking the Myths

- **CPT Codes:**
  - While Hospitals will continue to run on CPT code structures for cost reporting etc.
    - CPT codes/definitions/rules are best suited to the outpatient environment and do not serve as a good productivity statistical tool
  - Current definitions/codes not sensitive to patient severity
  - Current definitions and codes not sensitive to costs of the interventions we provide
  - Current definitions and codes not sensitive to intensity of the interventions we provide
- **Educate other care givers: We generate no revenue (except Part B)**
- **The terms "billable" and "charges are inaccurate**
  - We are actually capturing "costs" in an antiquated way (***charge master***)
  - Our "cost capture inputs" are contributions to cost reporting
- **Adopt PTCPS language for severity and intervention**


## The Basis for Financial Life in Acute Care….Whoaa?

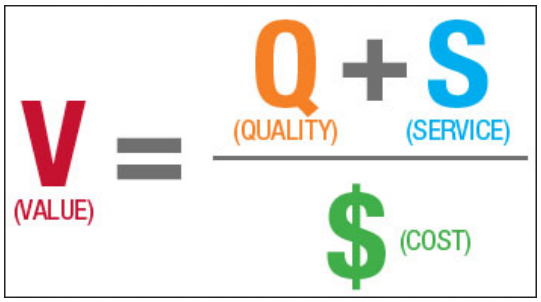
- "Asked by a wall street journal reporter to explain how U.S. hospitals price their services, William McGowan, chief financial officer of the University of California, Davis, Health System and thirty-year veteran of hospital financing, responded: "There is no method to this madness. As we went through the years, we had these cockamamie formulas. We multiplied our costs to set our charges."[1]

The Pricing of U.S. Hospital Services: Chaos Behind A Veil of Secrecy Uwe E. Reinhardt Health Affairs. 2006;25(1):57-69

## Shifting Language and Debunking the Myths

- **The value of Acute care physical therapy is measured by comparing its cost in a way that is sensitive to**
  - patient severity
  - service Intensity
  - Patient progress towards goals
- Goals set in acute care should be for the acute care stay and measured by a valid/reliable tool
- The value of our care should include the cost of providing services in all professional activities ie: rounding, clinical meetings, education etc.
- Measurement of value should be done sensitive to specific patient populations (ie Ortho, Neuro etc)
- Classifying patients by their defined "severity" and our treatment defined by the "intensity" of the intervention

## "Value Math"




The Journey to Value; Lee V. MD 2/10/15 healthsciences.utah.edu

## Decrease Variation in Practice – Working Definitions

- **Goals:**
  - Statements representing the expectation of the condition of the patient at the time of discharge from acute care
- **Prognosis:**
  - The determination of the next level of care as defined in part by the severity of the case and the intensity of the service needed to produce meaningful change in the patient's condition
- **Severity**
  - "Lets not reinvent the wheel"
    - APTA Severity classification system: www.apta.org/PTCPS/

## Working Definitions
Severity:
defined by patient condition and professional judgment

- Patient safety
- Age
- Time since Onset
- Clinical Presentation
- Mechanism of injury/illness
- Current condition
- Pre-morbid functional level
- Intervention
- Current functional level
- Co morbidity impact on function
- Cognition
- Goals – time to achieve
- Home environment
- Psychosocial support
- Prognosis
- Patient motivation
- Progression
- Probable outcome

Appendix A - Criteria to Determine Severity of a Condition as These Criteria Affect Duration and Cost of an Episode of Care

| Criteria | Lower Severity | | Higher Severity |
|---|---|---|---|
| Patient Safety | Safe/adequate safety to meet patient's needs | ⟷ | not safe/no insight/not safe to meet patient's needs |
| Age | no concerns related to age/irrelevant to condition | ⟷ | age likely to impact outcome/highly relevant |
| Time since onset | Intervention well timed to need | ⟷ | timing likely to impact care |
| Clinical presentation | Straightforward/well circumscribed | ⟷ | clinical presentation evolving |
| Mechanism of injury/illness | Well defined | ⟷ | uncertain |
| Current condition | stable | ⟷ | unstable/fluctuating/recurrent |
| Premorbid functional level | high/stable/sufficient to patient's needs | ⟷ | low/significant change to current/less-matched to patient's needs |
| Current functional level | high/stable/sufficient to patient's needs | ⟷ | low/ significant change to premorbid/ mismatched to patient's needs |
| Comorbidity impact on function | low impact on function | ⟷ | high impact on function |
| Cognition | intact/no impact/sufficient to patient's needs | ⟷ | impaired/significant impact/insufficient to patient's needs |
| Physical environment | no concerns/appropriately matched to current and future needs | ⟷ | Uncertain/significant barrier |
| Psychosocial support | no concerns/ appropriately matched to current and future needs | ⟷ | Uncertain/significant concerns needs |
| Goals | directly related to therapist control | ⟷ | outside of therapist control |
| Goal agreement | high agreement between patient/PT | ⟷ | low agreement between patient/PT |
| Time to achieve goals | certain/short | ⟷ | uncertain/long/highly variable |
| Prognosis | good/certain | ⟷ | uncertain/highly variable |
| Patient mood/motivation | unrelated to goal achievement/motivated | ⟷ | essential to goal/not motivated |
| Intervention | known/effective | ⟷ | uncertain/questionable |
| Risk of procedure | low | ⟷ | high |
| Progression | fast/consistent/predictable | ⟷ | slow/variable/unpredictable |
| Probable outcome | certain/predictable | ⟷ | uncertain/variable |

## A Comment from a P.T. on "Intervention"

"It is my opinion that direct patient care is definition of interventional care. However, these meetings with physicians, social workers, families, patients, discharge planning, and rounds are a vital part of optimal patient care and these things are necessary. But most times because these meetings are not billable time these meetings count against "productivity" time. So in efforts to increase "productive" time, therapy staff are taken out of these meetings and a portion of the patient's complete picture is eliminated; in turn, making patient's picture more like a puzzle missing a piece--useless."

...from acute care listserv

**Task Force Response: ..... 100% agreement**

## Intervention – "So how much is that bill?"

- "I'm wondering how you can bill for documentation and conference time. I know in acute care we don't actually "bill" typically and I would love to be able to capture all the time we do spend on the care of these patients. However, we do have some part b patients, and some that that after D/C end up being part b, such as when they have used up all their part A benefits. Because there is a chance that they could be billed, we follow Medicare 8 minute rule, and all other "face to face" rules of Medicare. Is that not a concern of yours? "

...from acute care listserv

## Working Definitions: Expanding "Intervention"

- **Intervention** :
  - The amount of time, which is spent in direct contact with the patient:
    - Input into Hospital charge system:
      - Direct treatment (CPT)

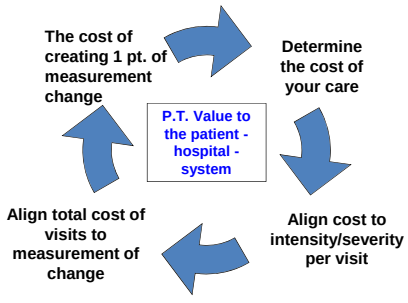
*And…*

  - Documentation of care
  - Education of patient/family
  - Time spent in care planning
    - Rounding, clinical team meetings etc

## Development of a new measure Blending cost, intensity, severity and patient outcome

- From Position Statement:
  - "The value for physical therapy care must take into consideration the patient's needs that drive the clinical outcomes, and the intensity/cost of those services required to meet those outcomes that can only be achieved by our unique interventions."
- We need to use valid, reliable clinical measures that can be aligned with the cost of providing care

## Task Force Proposal - Measured Value



## Determining Your Practice Cost

- Time Driven Activity Based Costing (TDABC) Approach*
  - Relatively easy to do
  - Can be adjusted as situations change
  - Allows for variations of cost capture in different facilities
  - Can be utilized in all acute care settings
  - A language Admin/Finance will understand

*Kaplan R., Porter ME, How to solve the Cost Crisis in Healthcare, Harvard Business Review, September 2011

## Elements of Practice Cost

- Pd hrs/day
- Pd Hrs/year
- Hourly pay rate
- Benefit Percentage
- Supervisory Salary
- # staff Supervised
- Support staff Salary
- Operating budget
- Vacation/benefit time
- Breaks/lunchtime per day
- Sched. Time for notes
- Square feet?????

## Determining Cost

| | | | |
|---|---|---|---|
| | | **Work Sheet** | |
| Pd hours/day | | 7.5 | |
| # Pd Days per Year | | 260 | |
| #hrs pd per year | | 1950 | |
| Compensation Hourly rate: | $ | 35.00 | |
| Benefit Percentage | | 20% | |
| Supervisory Salary | $ | 80,000 | |
| # staff supervised | | 8 | |
| Support staff Salary | $ | 20,000 | |
| Acute care expense budget | $ | 1,500 | |
| Vacation/sick/holidays | | 28 | |
| Breaks/Lunch time per day | | 1.00 | hrs |
| Est time/day sched. Paperwork | | 0.30 | hrs |

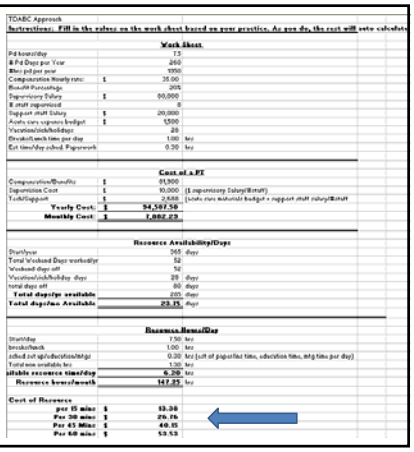
## Determining Cost

| | | | |
|---|---|---|---|
| | | **Cost of a PT** | |
| Compensation/Benefits | $ | 81,300 | |
| Supervision Cost | $ | 10,000 | ($ supervisory Salary/#staff) |
| Tech/Support | $ | 2,688 | (acute care materials budget + support staff salary/#staff |
| **Yearly Cost:** | **$** | **94,587.50** | |
| **Monthly Cost:** | **$** | **7,882.29** | |

## Determining Cost

| | | | |
|---|---|---|---|
| | | **Resource Availability/Days** | |
| Start/year | | 365 | days |
| Total Weekend Days worked/yr | | 52 | |
| Weekend days off | | 52 | |
| Vacation/sick/holiday days | | 28 | days |
| total days off | | 80 | days |
| **Total days/yr available** | | 285 | days |
| **Total days/mo Available** | | **23.75** | days |
| | | | |
| | | **Resource Hours/Day** | |
| Start/day | | 7.50 | hrs |
| breaks/lunch | | 1.00 | hrs |
| sched set up/education/mtgs | | 0.30 | hrs (est of paperline time, education time, mtg time per day) |
| Total non available hrs | | 1.30 | hrs |
| **ailable resource time/day** | | **6.20** | hrs |
| **Resource hours/month** | | **147.25** | hrs |
| | | | |
| **Cost of Resource** | | | |
| **per 15 mins** | **$** | **13.38** | |
| **Per 30 mins** | **$** | **26.76** | |
| **Per 45 Mins** | **$** | **40.15** | |
| **Per 60 mins** | **$** | **53.53** | |

This is an administrative function by the Director of your Service. To be done yearly or as factors change



## Were we off the Mark?

- We wanted to see if our approach, definitions and potential outcome tool elements were understood and generally accepted by practitioners most likely to use it
- Survey of membership in Feb-March 2015
- 591 respondents
  - 98% PT 2% PTA
    - 52.4% Staff PT
    - 9.8% Supervisor
    - 31.5% Manager/Director
    - 53 respondents labeled themselves under 30+ other job titles
  - 77% had 5-20+ years experience in acute care

## Acute Care Survey Feb-March 2015

- What is your opinion of the measurement of cost item (previous slides)

| | |
|---|---|
| A. The list of items is generally complete | 77.5% |
| B. The list of items is incomplete, and requires additional items | 11.9% |
| C. The list of items is too comprehensive, and certain items can be dropped | 9.3% |
| D. Measurement of the calculation of cost of acute care physical therapy is unnecessary | 1.2% |
| If you selected B or C, please tell us what items should be added or removed (124 suggestions) | |

B&C: many mentioned sq. ft., student teaching, orientation and training costs, Staff Educ $,

## Cost by Severity APTA PTCPS

| Eval: Chart Review - Tests and Measures | | |
|---|---|---|
| | Mins* | Cost** |
| Low Complexity Evaluation | 15 | $ 13.38 |
| Moderate Severity Evaluation | 30 | $ 26.76 |
| High Complexity Evaluation | 45 | $ 40.15 |
| | | |
| Interventions incl: charting/Clinical Mtgs) | UP to mins | |
| low severity - limited intervention | 30 | $ 26.76 |
| moderate severity - limited intervention | 30 | $ 26.76 |
| High Severity - Limited intervention | 30 | $ 26.76 |
| low severity - moderate intervention | 31-45 | $ 40.15 |
| moderate severity - moderate intervention | 31-45 | $ 40.15 |
| High Severity - moderate intervention | 31-45 | $ 40.15 |
| low severity - significant intervention | 46-60 | $ 53.53 |
| moderate severity - Significant intervention | 46-60 | $ 53.53 |
| High Severity - Significant intervention | 46-60 | $ 53.53 |
| | | |
| | | |
| * taken from APTA definitions | | |
| ** From Acute care resource tab | | |

| Criteria | Lower Severity | | Higher Severity |
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| Mechanism of injury/illness | Well defined | ⟷ | uncertain |
| Current condition | stable | ⟷ | unstable/fluctuating/recurrent |
| Premorbid functional level | high/stable/sufficient to patient's needs | ⟷ | low/significant change to current/mis-matched to patient's needs |
| Current functional level | high/stable/sufficient to patient's needs | ⟷ | low/ significant change to premorbid/ mismatched to patient's needs |
| Comorbidity impact on function | low impact on function | ⟷ | high impact on function |
| Cognition | intact/no impact/sufficient to patient's needs | ⟷ | impaired/significant impact/insufficient to patient's needs |
| Physical environment | no concerns/appropriately matched to current and future needs | ⟷ | Uncertain/significant barrier |
| Psychosocial support | no concerns/ appropriately matched to current and future needs | ⟷ | Uncertain/significant concerns needs |
| Goals | directly related to therapist control | ⟷ | outside of therapist control |
| Goal agreement | high agreement between patient/PT | ⟷ | low agreement between patient/PT |
| Time to achieve goals | certain/short | ⟷ | uncertain/long/highly variable |
| Prognosis | good/certain | ⟷ | uncertain/highly variable |
| Patient mood/motivation | unrelated to goal achievement/motivated | ⟷ | essential to goal/not motivated |
| Intervention | known/effective | ⟷ | uncertain/questionable |
| Risk of procedure | low | ⟷ | high |
| Progression | fast/consistent/predictable | ⟷ | slow/variable/unpredictable |
| Probable outcome | certain/predictable | ⟷ | uncertain/variable |

## Acute Care Survey Feb-March 2015

- Question asking whether the severity chart meets the needs in acute care PT

| | |
|---|---|
| A. Applies well to determining a severity level for acute care patients as is | 74.5% |
| B. Applies well to determining a severity level for acute care patients with revisions | 18.1% |
| C. Would not apply well to determining a severity level for acute care patients | 7.2% |
| * If you answered A or B, please answer question 10, otherwise proceed to question 11 | 0.2% |

About 21 % seem to want additional definition of "moderate" Intensity

## Acute Care Survey Feb-March 2015

- When setting goals for an acute care patient, you are:

| | |
|---|---|
| A. Defining the expected outcome(s) to be achieved at discharge from acute care | 81.5% |
| B. Defining the expected outcome(s) to be achieved upon discharge from a post acute setting (acute, sub acute, Home care) | 13.1% |
| C. Defining the expected outcome(s) to be achieved upon going home without additional services | 2.4% |
| D. Defining the expected outcome(s) to be achieved upon conclusion of all the above plus outpatient physical therapy | 2.9% |

TF Goal Definition:
Statements representing the expectation of the condition of the patient at the time of discharge from acute care

## Acute Care Survey Feb-March 2015

- Do you determine a prognosis for your patient?

| | |
|---|---|
| Yes | 79.3% |
| No | 19.1% |

- When determining the prognosis you are defining:

| | |
|---|---|
| A. The next level of care after acute care discharge | 59.8% |
| B. The functional level of the patient upon discharge from post acute care | 20.2% |
| C. The functional level of the patient upon discharge from all services including outpatient physical therapy | 10.8% |
| D. None of the above | 7.9% |
| • If you selected D please tell us what you do use to define prognosis: | 1.3% |

Task Force Definition: Prognosis: The determination of the next level of care as defined in part by the severity of the case and the intensity of the service provided that produces a change in the patient's condition

## Acute Care Survey Feb-March 2015

TF Def: **Intervention:** The amount of time, which is spent in direct contact with the patient and in addition the time spent in Documentation of care, Education of patient/family, Time spent in care planning, Rounding, clinical team meetings etc

| | |
|---|---|
| Direct care of the patient (CPT defined treatment) | 23.6% |
| Patient rounding | 0.0% |
| Meetings with social service, care coordination, nursing, patient's family, D/C planning | 1.4% |
| All of the above | 71.8% |
| None of the above | 0.0% |
| Other: Please describe | 3.2% |

Other: be sure to inc. documentation, chart review, collab. w/MD-RN, Family, D/C planning,

## ….and more variability

- "My hospital is currently going through an audit on productivity/efficiency for our acute therapy department. We currently use man hour/stat. I want to know what standard you guys use and how many visits and/or patients your therapists see per day in acute care. Any info would be appreciated as we go through this audit."
- "They see 7-9 pts/8 hr day typically. We have had a long-standing target of 19-24 billed units/day, but it has been getting more challenging for staff to hit this target. I noticed that many are counting evals as 1 or 2 units – are people finding that evals are being done in 15-30 min.? It seems to be taking 45-60 min. here. "

…from acute care listserv

## Acute Care Survey Feb-March 2015

- What is your productivity Measure?

| | |
|---|---|
| Visits | 36.1% |
| CPT Code Counts | 18.6% |
| Units of time per visit (15 minutes) | 70.0% |
| Relative value units (RVUs) | 17.0% |
| None of the above | 2.0% |
| All of the above | 2.2% |
| Other: Please describe | 7.0% |

Other: APC Value weights, avg charge, BTU= 1 min., Time efficient: 59.375%, procedures per visit, Rule of "8"s, "stat assigned by outside consultant

## Acute Care Survey Feb-March 2015

- Which of the following Measures are You Using (Select all that Apply)

| | |
|---|---|
| Acute Care Index of Function | 3.0% |
| AMPAC-6clicks | 40.6% |
| Functional independence measure (FIM) | 26.7% |
| Home Grown measure | 5.2% |
| We do not use any clinical measures | 26.3% |
| Other: Please list the measure(s) you are using | 21.4% |

Other: 10 min walk, times up and go, Tinetti, Berg, Barthel, Modified FIM, Elderly Mobility Scale, DGI, "FIMish", FOTO, FSS-ICU, Gait Speed, Kansas,

## Acute Care Survey Feb-March 2015

- What is your value measurement in Acute Care?

| | |
|---|---|
| Functional outcomes of individual patients | 30.3% |
| Functional outcomes of patient populations (Ortho, Neuro, etc.) | 17.9% |
| Acute care P.T. impact on LOS | 28.6% |
| Discharge disposition (home, SNF, IRF, HH, LTAH) | 29.3% |
| We do not use any value measures | 40.8% |
| Other: please describe | 6.9% |

Other: AM-PACS, pt. Satisf., measure ortho only, response time to referral, how to measure PT impact on LOS, G codes on observ. Pts.,

"We do complete outcome tools, yet our management hasn't been collecting the data"

## In your opinion how would you rate the following data elements to help determine value/ productivity in acute care PT?

| Answer Options | Not important at all | Some what Unimp ortant | Neutr al | Some what Import ant | Very Importa nt |
|---|---|---|---|---|---|
| Diagnosis | 8 | 11 | 39 | 261 | 259(5) |
| Severity | 4 | 1 | 12 | 125 | 439 (1) |
| Intensity of treatment measured by the amount of time spent in treatment | 6 | 25 | 66 | 201 | 283 (4) |
| # visits per case to achieve goals | 10 | 33 | 136 | 226 | 175(7) |
| Measurement of functional improvement | 3 | 4 | 54 | 203 | 311(2) |
| * Cost per 1 point change in measurement tool | 29 | 56 | 232 | 181 | 76(11) |
| **Total cost of acute PT care | 12 | 41 | 141 | 219 | 161(8) |
| Date of admission | 63 | 69 | 156 | 192 | 98(10) |
| Date of start of PT | 22 | 37 | 99 | 222 | 199(6) |
| Discharge date | 44 | 41 | 123 | 209 | 153(9) |
| Length of stay | 5 | 13 | 48 | 226 | 288(3) |

## Acute Care Survey Feb-March 2015

- Do you use an EMR in Acute Care?

| | |
|---|---|
| Yes | 95.1% |
| No | 4.9% |

- Which EMR are you Using in Acute Care?

| | |
|---|---|
| eClinicalWorks | 0.2% |
| McKesson | 5.6% |
| Cerner | 20.1% |
| Epic | 34.2% |
| Athena Health | 0.2% |
| Allscripts: Eclipsys-Sunrise Clinical Manager | 7.5% |
| GE Healthcare | 1.6% |
| Other (please list) | 30.6% |

## Clinical Measures
## Acute Care Index of function

- Valid / Reliable tool
- Simple to use and program into documentation software
- Used with neurological, cardiopulmonary and lower extremity orthopedic cases*

*VanDillen LR, Roach KE, Reliability and validity of the Acute Care Index of Function for patients with neurologic impairment, Physical Therapy 1988, Jul88(7)

*Roach KE, Ally D, Finerty B etal, The relationship between duration of physical therapy services in the acute care setting and change in functional status in patients with lower-extremity orthopedic problems. Physical therapy 1998 Jan 78(1)

*Sherer SA, Hammerich AS, Outcomes in Cardiopulmonary Physical Therapy: Acute Care Index of Function, Cardiopulmonary Physical Therapy J, September 2008, 19(3)

"Develop a model to measure the value of acute care physical therapy that is valid, reliable and usable by all that ***Can be used with multiple outcome measures"***

## Acute Care Index of Function

| | | | | P.T. |
|---|---|---|---|---|
| Mental Health Status | YES | No | | Score |
| 1. Verbal Commands | 2 | 0 | | 2 |
| 2. Commands | 1 | 0 | | 1 |
| 3. Learning | 2 | 0 | | 2 |
| 4. Safety | 1 | 0 | | 1 |
| Total | 6 | | | **6** |
| Bed Mobility | Unable | Dep | Indep | |
| 5. Rolling supine to ri | 0 | 4 | 10 | 10 |
| 6. Roll Supine to left | 0 | 4 | 10 | 10 |
| 7. Supine to sit | 0 | 4 | 10 | 10 |
| 8. Sit to supine | 0 | 4 | 10 | 10 |
| Total | | | 40 | **40** |
| Transfers | | | | |
| 9. Bed to Chair | 0 | 5 | 10 | 5 |
| 10. Chair to bed | 0 | 5 | 10 | 5 |
| 11. Sit to stand | 0 | 5 | 10 | 5 |
| 12. Stand to sit | 0 | 5 | 10 | 5 |
| 13. Sitting Balance | 0 | 5 | 10 | 5 |
| 14. Standing Balance | 0 | 5 | 10 | 5 |
| Total | | | 60 | **30** |
| Mobility | | | | |
| 15. Gait w/device | 0 | 14 | 20 | 14 |
| 16. Gait w/o device | 0 | 21 | 30 | 21 |
| 17. Ascend stairs | 0 | 7 | 10 | 7 |
| 18. Descend stairs | 0 | 7 | 10 | 7 |
| total | | | | **49** |
| 19. Propel wheelchair | 0 | 14 | 20 | 20 |
| 20. set up wheelchair | 0 | 7 | 10 | 10 |
| Total | | | 100 | **30** |
| | | | 206 | 155 |
| | | | | 75% |

**So… if we have a tool to measure our cost and a tool that measures clinical performance …can they be brought together to give us meaningful data?**

## Measure of Value - ACIF

| | Interventions incl: charting/Clinical Mtgs) | UP to mins | Resource Cost | # Visits | Initial ACIF score | Final ACIF score | chg | Total cost | Cost per 1pt of change Value |
|---|---|---|---|---|---|---|---|---|---|
| 4 | low severity - limited intervention | 30 | $ 33.26 | 5 | 75 | 100 | 25 | $ 166.30 | $ 6.65 |
| 5 | moderate severity - limited intervention | 30 | $ 33.26 | 5 | 50 | 60 | 10 | $ 166.30 | $ 16.63 |
| 6 | High Severity - Limited intervention | 30 | $ 33.26 | 5 | 10 | 100 | 90 | $ 166.30 | $ 1.85 |
| 7 | low severity - moderate intervention | 31-45 | $ 49.89 | 5 | 75 | 100 | 25 | $ 249.45 | $ 9.98 |
| 8 | moderate severity - moderate intervention | 31-45 | $ 49.89 | 5 | 50 | 60 | 10 | $ 249.45 | $ 24.95 |
| 9 | High Severity - moderate intervention | 31-45 | $ 49.89 | 5 | 10 | 100 | 90 | $ 249.45 | $ 2.77 |
| 10 | low severity - significant intervention | 46-60 | $ 66.51 | 5 | 75 | 100 | 25 | $ 332.55 | $ 13.30 |
| 11 | moderate severity - Significant intervention | 46-60 | $ 66.51 | 5 | 50 | 60 | 10 | $ 332.55 | $ 33.26 |
| 12 | High Severity - Significant intervention | 46-60 | $ 66.51 | 5 | 10 | 100 | 90 | $ 332.55 | $ 3.70 |

## Definition
## AM-PAC Boston "6-Clicks"

- Valid – Reliable Tool
- Shorter tool
- Does not include measures for mental status/wheelchair function
  - Will this be a limitation to use with discharge planning?

"Develop a model to measure the value of acute care physical therapy that is valid, reliable and usable by all that ***Can be used with multiple outcome measures"***

PTJ Online First

Validity of the AM-PAC "6-Clicks" Inpatient Daily Activity and Basic Mobility Short Forms
Diane U. Jette, Mary Stilphen, Vinoth K. Ranganathan, Sandra D. Passek, Frederick S. Frost and Alan M. Jette
PHYS THER. Published online November 14, 2013
Originally published online November 14, 2013
doi: 10.2522/ptj.20130199

## AM-PAC Boston "6-Clicks"

**Appendix 1.**
"6-Clicks" Inpatient Basic Mobility Short Form*

| Please check the box that reflects your (the patient's) best answer to each question. | Unable | A Lot | A Little | None |
|---|---|---|---|---|
| **How much difficulty does the patient currently have . . . .** | | | | |
| 1. Turning over in bed (including adjusting bedclothes, sheets, and blankets)? | ☐1 | ☐2 | ☐3 | ☐4 |
| 2. Sitting down on and standing up from a chair with arms (eg, wheelchair, bedside commode)? | ☐1 | ☐2 | ☐3 | ☐4 |
| 3. Moving from lying on back to sitting on the side of the bed? | ☐1 | ☐2 | ☐3 | ☐4 |
| **How much help from another person does the patient currently need . . .** | | | | |
| 4. Moving to and from a bed to a chair (including a wheelchair)? | ☐1 | ☐2 | ☐3 | ☐4 |
| 5. To walk in hospital room? | ☐1 | ☐2 | ☐3 | ☐4 |
| 6. Climbing 3–5 steps with a railing? | ☐1 | ☐2 | ☐3 | ☐4 |

Clinicians may find the following helpful in selecting responses:
1. Total/Unable=Total/Dependent Assist
2. A Lot=Maximum/Moderate Assist
3. A Little=Minimum/Contact Guard Assist/Supervision
4. None=Modified Independence/Independent

PTJ Online First

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## Measure of Value? - AM-PAC Boston "6-Clicks"

| | Interventions incl: charting/Clinical Mtgs) | UP to mins | Resource Cost | # Visits | Initial AM-PAC score | Final AM-PAC score | chg | Total cost | Cost per 1pt of change Value |
|---|---|---|---|---|---|---|---|---|---|
| 4 | low severity - limited intervention | 30 | $ 33.26 | 5 | 20 | 24 | 4 | $ 166.30 | $ 41.58 |
| 5 | moderate severity - limited intervention | 30 | $ 33.26 | 5 | 12 | 20 | 8 | $ 166.30 | $ 20.79 |
| 6 | High Severity - Limited intervention | 30 | $ 33.26 | 5 | 6 | 12 | 6 | $ 166.30 | $ 27.72 |
| 7 | low severity - moderate intervention | 31-45 | $ 49.89 | 5 | 20 | 24 | 4 | $ 249.45 | $ 62.36 |
| 8 | moderate severity - moderate intervention | 31-45 | $ 49.89 | 5 | 12 | 20 | 8 | $ 249.45 | $ 31.18 |
| 9 | High Severity - moderate intervention | 31-45 | $ 49.89 | 5 | 6 | 12 | 6 | $ 249.45 | $ 41.58 |
| 10 | low severity - significant intervention | 46-60 | $ 66.51 | 5 | 20 | 24 | 4 | $ 332.55 | $ 83.14 |
| 11 | moderate severity - Significant intervention | 46-60 | $ 66.51 | 5 | 12 | 20 | 8 | $ 332.55 | $ 41.57 |
| 12 | High Severity - Significant intervention | 46-60 | $ 66.51 | 5 | 6 | 12 | 6 | $ 332.55 | $ 55.43 |

## Issues / Discussion

- Appears comparable between acute care practices using same functional measurement tools
- Will need to establish benchmarks
- Current application platform (excel spreadsheet) cumbersome

## Potential Uses

- Determine value of our service by patient population type
  - Questions it can help answer:
    - What types of cases do we bring the greatest value to?
    - Are there types of patients that gain little to no value from our care?
    - Will it prove our value in all patient populations?
      - Who needs us – Who does not?
    - Will it give us information to change staffing patterns to meet high/low value patient populations?
    - Assist in determining Prognosis of patient function?
    - Assist in determining FTE enhancement – retraction
    - Effect of patient severity on intensity of our services
    - Data to assist in decreasing variability of practice

## Potential Uses

- Can determine if higher or lower intensity results in the same clinical outcome and its effect on cost
- Begin to classify cases by severity and then have data to support studies related to patient discharge and readmission
- Enhance the understanding of our value by admin/finance in staffing discussions
- Appears to be able to utilize existing multiple existing clinical measurement tools

## Imagine if we had the Data…

- "Does your facility/hospital use any criteria for labeling referrals for PT eval inappropriate so that the PT does not have to proceed with the eval?
  Appreciate any input in this matter. '

…from acute care listserv

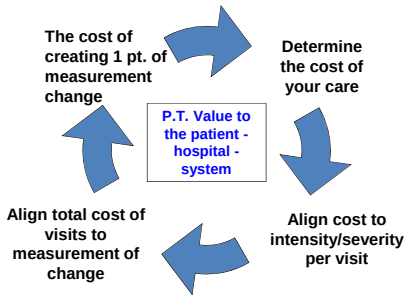
## Summary

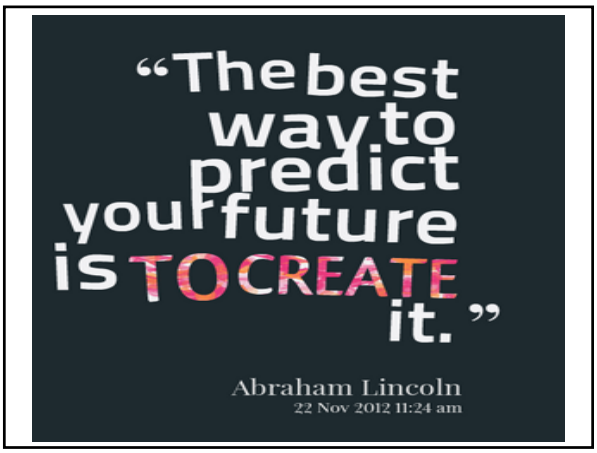
- Physical Therapy, our patients and the facilities where we practice are best served with a blended approach to measurement that focuses on value
- Cost, patient severity, treatment intensity and the patient's outcomes must be part of that blended measure
- We must standardize our terms
- We must identify where we bring and where we do not bring value to the patient, the facility and the healthcare system
- We must measure our value in a way that is understandable to different stake holders
- We must be the catalysts of the change, we cannot wait for others to "do it to us"

## Summary

- Task Force Next Steps:
  - Pilot test different patient populations (now)
  - Pilot test using other outcome measurement tools (now)
- If Pilots are successful:
  - Software Solution
  - Teach utilization of the tool to membership
  - Conferences / Cont. Ed

## Task Force Proposal - Measured Value






Acute Care Section
Value / Productivity Round Table

Saturday February 20, 2016
8-10am
Hilton Anaheim – Mezzanine Room 5

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