Title: Getting Serious about Quality, Value, and Effectiveness of Care

Session Description:

Real-time learning for continuous improvement in the quality, safety, and effectiveness of care is critical for increasing clinical decision making that is supported by accurate, timely, and up-to-date clinical information. This session describes a company-wide quality charter that directs performance improvement initiatives focused on improving the value of rehabilitation services in the post-acute environment. The presenters will describe how they adopted the Model for Improvement as their scientific foundation for real-time learning and how they used multiple Plan-Do-Study-Act (PDSA) cycles to complete each step. The Model for Improvement is promoted by the Institute for Healthcare Improvement and described as a means for “dynamic learning” which capitalizes on processes and knowledge growth. The presenters will also illustrate the use of the Knowledge to Action cycle which guides the “Do” component of PDSA and their efforts with knowledge translation. The session will include results of their efforts to implement a core set of clinical outcome measures for all patients in over 180 skilled nursing facilities, their standardization of the assessment process through use of the language associated with the International Classification of Functioning, Disability and Health (ICF), development and implementation of a treatment taxonomy needed to study their clinical practice, and demonstration projects related to implementing evidence-based interventions.

Session Learning Objectives:

Participants will be able to:

Describe how the Model for Improvement and PDSA cycles support real-time learning and continuous performance improvement.

Compare and contrast performance improvement and knowledge translation.

Describe the potential impact of a formal quality charter and associated activities on corporate culture, vision, and resource utilization.

Develop a process for implementing an evidence-based best practice in their work place.

Outline:

1. Introduction – 15 minutes
   a. Environmental scan: Why should we get serious about performance improvement?
      i. Health and Medicine Division (formerly Institute of Medicine) landmark publications
         1. America’s Health in Transition (1994)
         2. To Err is Human (1999)
         3. Crossing the Quality Chasm (2001)
         5. Best Care at Lower Cost (2013)
ii. Legislation: Value-Based Purchasing Timeline
   4.  Independence at Home Act (2012)

iii. Post-Acute Care Reform
   1.  Deficit Reduction Act (DRA) (2005)
   3.  Bundled Payments for Care Improvement (BPCI) (2014)
   4.  Improving Medicare Post-Acute Care Transformation (IMPACT) Act (2014)

b. Organizational Evaluation: Needs identified
   i.  Need for increased reliability due to too much variation in practice
   ii. Need for standardized approaches in outcomes measurement and interventions
   iii. Need to prepare workforce for unprecedented levels of change

c. Strategies
   i.  Review available evidence-based improvement models (i.e., Lean, Six Sigma, etc)
      1.  Model for Improvement (Langley et al.)
      ii. Leading Change (Kotter)

2. The Model for Improvement and the Science of Improvement – 25 minutes
   a.  What are we trying to accomplish?
   b.  How will we know that a change is an improvement?
   c.  What change can we make that will result in improvement?
   d.  Improvement Charter
      i.  The Aim for Improvement – What Are We Trying to Accomplish?
      ii. The Problem
      iii. Reason for the Effort
   e.  Infinity Rehab Quality Charter
      i.  What Are We Trying to Accomplish?
         1.  Ensure that patients reach critical thresholds on outcome measures of health status, activity limitation, and impairment that reduce their risk for falls, ADL or mobility decline, aspiration, re-hospitalization, or other adverse events including mortality.
         2.  Determine the most cost effective strategies for ensuring that patients reach these critical thresholds on outcome measures. Build these strategies into a model for care delivery.
ii. The Problem
   1. Traditional Medicare current reimbursement for post-acute care
      incentivizes more rehabilitation for all patients.
   2. Managed Medicare plans reduce cost by reducing inpatient lengths of
      stay.
   3. Both are one-size-fits-all approaches.
      a. Critical Missing Elements
         i. Linking the amount of rehabilitation provided with the
            patient’s likelihood of responding.
         ii. Considering the type of rehabilitation provided
   iii. Reason for Effort
      1. Different patients need different amounts and types of rehabilitation.
      2. Matching patient factors with the rehabilitation they receive will lead to
         improved value for rehabilitation.
      3. Linking rehabilitation to improved outcomes in not only activity
         limitation, but also health status demonstrates the unique niche of
         rehabilitation in contributing to overall population health.
      4. Literature Themes:
         a. Rehabilitation needs to be specific in nature, consistently
            challenging, and delivered at sufficient dosage.
         b. General mobility and activity play an important part in
            promoting overall health and well-being.
   f. Drivers for Achieving Results
      i. Laying out your theory of how things might be better
         1. Based on knowledge gained from research, observation, and experience
ii. **Infinity Rehab Drivers**

1. **Primary**
   a. Gait speed training
   b. Strength training at intensities between 70-80% 1 RM
   c. Balance training at “very hard” level of intensity (challenge)
   d. Limited rest during therapy sessions (< 2 min at a time)
   e. More locomotor training than transfer and bed mobility training
   f. Task Training
   g. Patients engaged in activity and mobility outside of therapy
   h. Patient engagement/participation in rehabilitation using Enhanced Medical Rehabilitation strategies

Provost L, Bennett B. Quality Progress. 2015; Jul:36-43.
2. **Secondary**
   a. **Outcomes reporting**
   b. **Ability to document specific interventions**
   c. **Development of clinical protocols, clinical support tools, and training of clinicians**
      i. Gait speed trials
      ii. Intensity campaign
      iii. Total joint protocols associated with BPI
      iv. Locomotor training
      v. Task training
      vi. Development of “outside of therapy” protocols
      vii. Highest Level of Mobility Scale
      viii. Adherence to clinical protocols

g. **Tools for Improvement**
   i. **Plan-Do-Study-Act – Testing a Change**

   ![Plan-Do-Study-Act Cycle Diagram]

1. **Plan** the test or observation, including a plan for collecting data.
   a. Predict what might happen and why
   c. Measurement
2. **Do**
   a. Small scale trial
   b. Identify problems and unexpected barriers
3. **Study**
   a. Analyze data and study results
   b. Compare the data to predictions
c. Reflect on what was learned.

4. Act
   a. Refine
   b. Prepare for the next test

ii. Knowledge-to-Action Cycle (for Knowledge Translation efforts)

3. Implementing a Core Set of Outcome Measures – 25 minutes
   a. Clinician Readiness Survey
   b. Selecting Measures with Discipline-Specific Peer Groups
   c. Training
   d. Activation in EMR
   e. Measuring and Reporting Adherence
   f. Enthusiasm Campaign
      i. Patient Examples
      ii. Clinician Testimonials
      iii. Friendly Competition and Prizes
      iv. “Happy” Video
      v. Site Visits
      vi. Communication, over and over again

g. **Sustainability**
   i. Adherence Reporting and Scorecard
   ii. Best Practices
   iii. New Employee Orientation
   iv. Using the Outcome Data
      1. Individual patient examples
      2. Customer meetings
   v. Outcomes Reporting
   vi. Outcomes Analysis

4. **Learning Labs and Pilot Projects – 25 minutes**
   a. **Gait Speed Trials – a simple treatment**
      i. Cycle 1 – broad approach
      ii. Cycle 2 – focused approach with enthusiastic clinicians
      iii. Cycle 3 – focused approach with less enthusiastic clinicians
      iv. Cycle 4 – standard of care
   b. **High Intensity Stepping – a complex treatment**
      i. Need for Modeling
      ii. Preliminary Testing
      iii. Cycle 1 – Focused Application
         1. Development of Clinical Support Tools
            a. Streamlining Clinical Decision Making
            b. Documentation Support
         2. Training and Skill Development
         3. Strategies for Scaling Training

5. **Future Plans – 15 minutes**
   a. **Systematic Clinical Decision Making Support**
      i. Standardizing the “A” Section
         1. Using the ICF to build a patient profile
         2. Consideration of prognosis for remediation
         3. Linking hypotheses to treatment planning
   b. **Treatment Taxonomy**
      i. Capturing critical elements of care

6. **Discussion – 15 minutes**
Selected References:


