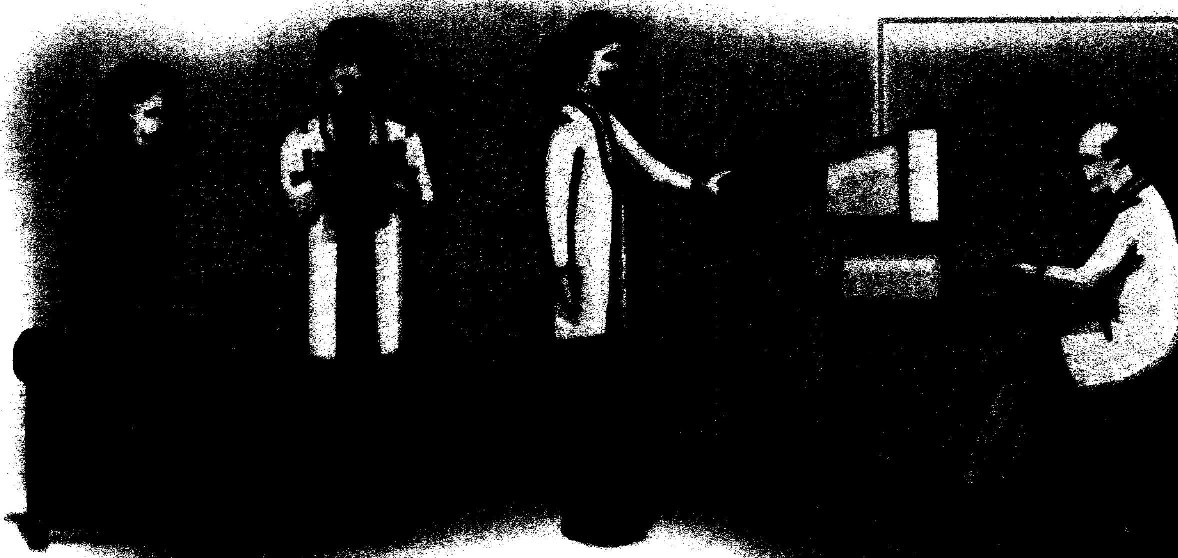


OUTCOMES PROCESS
IN DAILY PRACTICE

by Dennis L Hart, PhD, PT, Adam C Geril, MS, PT, OCS, ATC, and Robert L Pfohl

A crash course for managers on how to integrate an "outcomes process" into practice. Collect the data your practice needs —without jeopardizing productivity.

By now, we all know that outcomes data collection is no longer an option. It's a necessity, as essential to patient management as the examination or the discharge.

Once upon a time, many of us thought that collecting outcomes data would be as simple as "Fill out a form, and you're done." Not so! The work required to produce high-quality outcomes data can be overwhelming. So how do we fit data collection into the daily operations of practices that are already under pressure? After all, the only proclamation we hear more often than "If we don't collect outcomes data, our services won't be reimbursed" is "We need to increase productivity and reduce costs"!

Outcomes data *can* be collected without overburdening staff. To do it right, however, clinicians and managers have to look at their entire practice in a different way—to implement a total "outcomes process" that is standardized within the practice or across clinic sites, a process that becomes part of patient management.

Here's one blueprint for action.

Alex Kim

Start by establishing a practice-wide philosophy. Make it clear that the collection of outcomes data is necessary for survival not only of the practice, but of clinicians' *jobs*.

This is an opportunity for the manager or administrator to really shine. Strong managers tell their staff, "We're going to have an outcomes process because it's the right thing to do. Period. Let's work it through." The time to look for consensus is in establishing the process, not the philosophy. Managers who aren't as assertive or as strong in their convictions may tell their staff, "We can collect outcomes if you *want* to." What message would that give to *you*?

In addition to issues of survival, the manager should emphasize issues of professionalism. *A Guide to Physical Therapist Practice* has established to both the profession and the public that outcomes data collection and analysis are expected of the physical therapy professional,[1] as much a part of today's patient management as examination or evaluation.

After you've made the outcomes philosophy clear, focus your staff not only on survival in hard times but on success. There is no need for doom and gloom. Outcomes data collection should be an ongoing, never-ending process as necessary as any continuous quality improvement process or business development plan. If your practice does not make that commitment, from top management to clinicians to support staff, the outcomes process will not be successful.

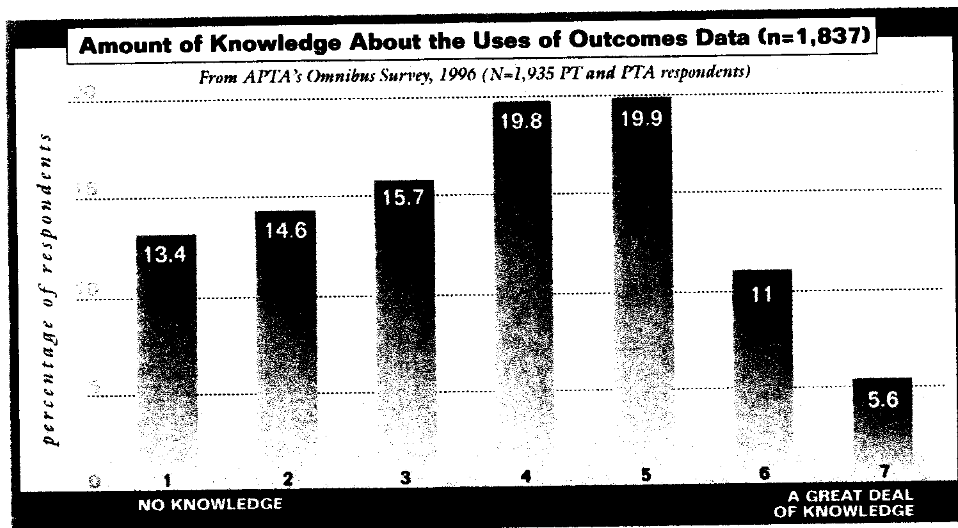
Once your practice has made the commitment, you next have to determine whether the practice will conduct data collection on its own or join a national outcomes database company. Many of the pros and cons of aligning with a national outcomes database company or building an internal database were discussed in *PT*'s outcomes series (October 1996 and March 1997.)[2,3]

Ultimately, your decision may depend on how you weigh the answers to two "business" questions: "Can we afford to purchase the services of an outcomes company?" and "How much do we need external benchmarking?" (with ***benchmarking*** defined as the ability to compare your clinic to an acceptable industry-wide standard or to make comparisons from clinic to clinic or from clinician to clinician within your organization.)

Of course, outcomes companies will tell you that you cannot afford *not* to join their databases. They might be right, if you are losing business because you can't relate your outcomes to those of other clinics when your competition can. With accrediting agencies starting to "strongly encourage" the collection of outcomes (eg, Joint Commission on Accreditation of Health Care Organizations),[4] the lack of external review of your outcomes and the lack of external benchmarking for comparison may become more and more of a liability. And developing an internal database incurs its own costs—costs that include valuable staff time arranging for statistical support and computer programming. Variables such as cost per case and percentage of goals achieved are relatively easy to capture. Ability to perform activities of daily living and to return to work require more time when it comes to choosing measurement instruments.

Clinicians on staff should be able to communicate with *each other* before the practice tries to describe outcomes to people outside the clinic.

No doubt you've heard a lot about "operationalization" and "standardiza-



tion." Regardless of whether you choose an internal database or an external database, one of the key aspects of the outcomes process involves "standardizing" your practice. For outcomes data to be meaningful to all who want to use them, data collection must be standardized. From the operational definitions will evolve the data that you and your staff feel are important for assessing outcomes from the clinician's perspective.

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Operationalization is an ongoing process; however, within 3 months, you should be able to 1) develop a basic set of definitions regarding outcomes of choice for your patients and 2) describe the components of each initial evaluation, interim status note, and discharge note. Settle on a patient classification system that makes sense clinically. Describe what clinical measures will be tracked, and come to consensus on the meaning of each measure. Test yourselves to find out whether you can be consistent and reliable. Obviously, not every clinic can conduct its own reliability studies; however, every clinic can have group discussions about whether the operational definitions are "holding up" in real practice. Do patients understand what's being said to them? Is there any trouble with the examination procedures?

As you engage in operationalization, refer to APTA's *A Guide to Physical Therapist Practice*.[1] The Guide describes the elements of patient/client management provided by physical therapists—examination, evaluation, prognosis, diagnosis, intervention, and outcome—and the preferred practice patterns that constitute the boundaries within which therapists may choose a variety of tests, measures, and interventions for specific patient/client diagnostic groups.

Next, determine the perspective from which your outcomes will be assessed—patient, clinician, administrator, payer? The best process, of course includes all of those perspectives Those of you who have experience with a computerized documentation system already appreciate the difficulties encountered in developing a consensus of opinion about what data to include from initial evaluations, progress notes and discharge notes—and especially about how to report the relationship between the patient's perspective of quality of health and the clinician's perspective of clinical improvement.

No matter how much we migh like to think otherwise, there often is large discrepancy between those last tw perspectives, primarily because some of u still are setting goals for patients withou patients' buy in. What does this mean fc standardization of data collection? W need to find a more sophisticated way t sort our data, so that from the momer the therapist begins taking a history, he c she is investigating the problems of mear ing for the patient. Every clinical actio will have an impact on the goal of th patient, and the patient's perception c function during the treatment process wi be optimized, not to mention patient sa isfaction.

Consider the philosophy underlyin the use of the SF-12,[5] a health-relate quality-of-life instrument that quantifi the patient's perception of his or her fun tion in a standard manner. A patient migl believe, for instance, that he or she is lin ited in the kind of work or activities pe formed over the past week. To identi that the patient believes there is a prol lem, the therapist must ask the patier and interventions addressing the proble should be evaluated at each visit. Buildir the SF-12 into examination, evaluatio and reexamination—and into the ou comes process—means that the patie may be more likely to perceive improv ment in these areas and that the outcom are more likely to improve.

From the clinician's perspectiv forced-choice responses in documentati allow decisions to be quantified, tracke

and analyzed. Free text has little value in the outcomes process because it doesn't allow anyone to follow the thought process of a given clinician. Anyone who has provided expert testimony knows that clinicians tend to use inflammatory, nondefensible language in their daily notewriting. Reducing the variability of the written word in the medical record should therefore be an important goal of standardized, forced-choice responses in health care documentation and outcomes reporting.

Consensus building can be a challenge, but physical therapists are creative people. In our experience, we've found that the most successful clinics business-wise are those that have developed a means of fostering consensus building. These clinics typically have a strong leader who encourages creativity and effective communication. In these clinics, the roles of personnel are well defined and clearly identified to others within the practice. Staff are held accountable and know how important their roles are to the success of the entire process. They are kept well informed concerning the success of the process and the overall clinic outcome—not just their own "personal" outcomes.

Even the best outcomes process occasionally has difficulty, however. That's why an internal data-integrity process must be developed to monitor data quality and catch any errors before entry. (More on that later.) A cleaner data set produces more accurate analyses, which are then used to provide timely feedback. With data-integrity checks, consensus building is a continuous quality improvement loop. For more on dealing with consensus building in the outcomes process, refer to Shields et al[6] and Russek et al.[7]

Identifying who's *responsible* for a task is just as important as identifying the tasks themselves.

One of the most important tasks for the manager: identifying the procedures to be followed in the outcomes process—and identifying the staff (and patients) who will have to follow them.

A Review of Practical Matters

- **The marketing of your outcomes process should begin proactively with staff *prior* to implementation.** The clinic owner or management must be 100% behind the project and convey that commitment to the staff. If not, don't start!
- **At each participating clinic, appoint an "outcomes champion."** This individual should be given full responsibility for managing the process at that location. Management should make it clear that this individual has their full support and is charged with the responsibility for a successful process and staff participation.
- **If you select an external outcomes system, ensure that all staff, both clerical and clinical, read all training materials**—and ensure that the company provides an easy way to interpret those materials. Suppose, for instance, that the attention-to-detail thought process has been overlooked, ignored, or written in a way that could be misinterpreted. The company may have meant to instill an understanding of the need to visually inspect all data before they are entered into the system, but the company may not have emphasized it. If you use an internal process, provide your staff with detailed training manuals describing each step of the process. In either case, the materials should be read and understood by each member of your staff who will participate in the process. If an outside vendor is selected, insist that there is easy access to technical support.
- **Ensure that the process you design or select has the capability to provide routine activity reports.** These reports should indicate the number of patients and the number of data forms submitted and discharge forms completed. Routine activity reports will provide an ongoing mechanism to monitor compliance with the process and will assist in the identification of any internal bottlenecks that need attention.
- **Successful outcomes data reporting relies on accurate and complete data collection.** Establish a mechanism in your process that quickly reviews all data forms for completeness and accuracy. A few seconds of careful review by a designated clinician prior to data form submission will enhance the success of the process and the accuracy of the data report. Consider one common problem: confusion about dates of service. People have been known to enter birth dates for dates of discharge, which results in poor quality of data entered and leads to time-consuming edits of data or to inaccurate data and analyses.
- **Share outcomes data with your staff.** The ability of your staff to appreciate the value of their efforts and the process is proportional to the feedback they receive from the outcomes data reports. Use the information to enhance performance at the clinic level. When outcomes information is understandable to all participants in the process, staff also will be more likely to effectively market the practice to community and referral and payer sources.
- **A successful outcomes process is a team effort.** This is true whether you choose an internal database or a relationship with a national outcomes company. The process should not be viewed as a penalty or a punishment of more paperwork for either patients or staff. It should be viewed as a cooperative effort designed to enhance the quality of care and to substantiate to the community and the payer the value of your services. The outcomes process is an ongoing continuous quality improvement and marketing process—not just a fad! Administrators who focus only on productivity at the expense of other factors will not survive managed care. They will miss the "value" boat and will not be able to compete in the next phase of managed care, when the focus will be on improved health status of the managed care member groups.

What kinds of tasks are involved in the outcomes process? Here's a basic list:

- Introduce the outcomes process to the patient (one of the most important responsibilities, because it sets the tone for how fully the patient buys into his or her role in the outcomes process).
- Answer all patient questions prior to data collection.
- Complete patient data forms during treatment and at discharge.
- Check data on initial evaluation forms.
- Complete clinician data forms at initial evaluation and discharge.
- Check data forms before data entry into an internal system, before submission of data to an outcomes company, or both.
- Match patient scheduling records to outcomes data to ensure highest participation possible.
- Perform or arrange for (eg, through a university or an outcomes data company) analyses of data.
- Review outcomes reports after analyses.
- Disseminate pertinent analyses of outcomes reports to all parties involved in process, for feedback.
- Analyze the results of the outcomes process to determine how the data could assist the clinic's continuous quality improvement process.
- Analyze the results to determine which, if any, special statistical analyses could be helpful to the understanding of practice patterns.
- Analyze the results of the outcomes process to determine the need for individualized continuing education.

To ensure high productivity as you collect outcomes data, make certain that staff expectations are clear regarding when tasks must be completed—and assign staff to tasks that are commensurate with their professional skills and with the costs involved. For example:

- The receptionist or other support staff responsible for meeting and greeting patients should introduce the outcomes process to the patient, ensure that information on pretreatment health-related quality-of-life is collected prior to treatment, and ensure that the patient provides the necessary post-treatment health-related quality-of-life and patient satisfaction information.
- If the outcomes process is to include the patient's perception of functional level, the patient must complete the data collection forms. This means that the patient has a part to play in the outcomes process, too, and should be considered a member of the team.
- The collection of information during examination, evaluation, intervention, reexamination, discharge, and follow-up should be part of the job description of the therapist primarily responsible for managing the patient. This places the responsibility of data collection at the correct level of staff. After all, the primary therapist will reap the rewards if the outcome is good—and should be responsible if the outcome is not good. Clinicians also should be empowered as the ones to explain the need for the outcomes process and answer any questions that the patient may have.
- Both the secretary or receptionist and the therapist should be responsible for ensuring that all follow-up forms (status and discharge) are completed in a timely manner.
- The administrator or administrative staff should provide billing and any other financial information that needs to be included with the outcomes data.
- The responsibility for making certain that the entire outcomes process is completed correctly (through data-integrity checks) and completed on time, should rest with the clinical chief, supervisor, or department director, who also has the responsibility of communicating the importance of the process to all of the staff. Communication is essential because more than one staff member is involved in collecting the data, from therapists to secretaries to physical therapist assistants and other support staff.
- The administrator or physical therapy director should make sure that all data are analyzed properly and that pertinent results are disseminated to the appropriate people.

Remember that no one process will fi all practices. Visualize the outcomes process, from collecting data before the patien arrives to analyzing the data to providing feedback to the contributing clinicians based on your individual clinic or clinics. In a small clinic—for instance, one with tw therapists, an aide, and a secretary or recep tionist—one therapist might serve as th "supervisor" responsible for checking dat integrity and ensuring that the outcom process for each patient is complete. In a large practice, the receptionist may be th most logical one to explain the need for th outcomes process to the patient.

As you can see, the process of collectin outcomes data provides a great opportunit to assess the administrative infrastructur support structures, and procedures for th entire management of the practice. The prac tice team must work in a coordinated man ner for the collection process to yield a com plete set of data—just as they must wor together to ensure good patient outcome: It's all part of the same animal.

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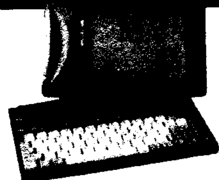

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Investigate your communication process, chain of command, and ability to work as a team. Repair the weak links in the chain, or you will never reach the level of excellence you and your patients expect.

> A primary goal of the outcomes process is to reduce mistakes. Communication about data collection and submission is critical.

If just one person does not understand his or her position in the outcomes process, the process may break down. The overworked receptionist in a large practice, for instance—who may not have an enthusiastic attitude when presenting why the clinic is participating in an outcomes process—could have a negative influence both on patients' outcomes and on patients' willingness to fulfill their role in the outcomes process.

A weekly check-in should be made with staff regarding the steps described in the outcomes process. Any issues related to the collection process and quality of the outcome data should be aired. Updates on the pertinent variable information, such as proper ICD-9 codes or other demographic identifiers, should be made weekly. The shorter the time interval, the lower the risk of error.

One source of errors that cannot be overlooked is the patient. That's why we emphasize communicating with patients about their participation—and the value and importance of that participation—periodically throughout the episode of care. One source of errors that cannot be overlooked is the patient. That's why we emphasize communicating with patients about their participation—and the value and importance of that participation—periodically throughout the episode of care. Every time patients fill out a form in the outcomes process, explain the purpose of what they're doing. Otherwise, they may fill out the form based on the fact that they don't like what the physician just told them or based on a problem they're having with Workers' Compensation coverage—and that may negatively influence the outcomes. Have the therapist treating the patient check the data form right after the patient has filled it out to ensure that the patient is focusing on the care that he or she is receiving in physical therapy. And, as another safeguard, designate a therapist to check all of the patient data forms at the end of every day to identify these kinds of problems.

As part of your data-integrity process, establish checks and balances. For example, the total number of initial evaluation records should match the number of discharge records; however, as clinicians and administrators know, it's often difficult to obtain a discharge summary for each initial evaluation because some patients do not return for the discharge visit. To improve the record's integrity, check each month. While you are checking, a quick scan of the number of visits, duration of the episode of care, and charges for each patient will catch most errors at a time when errors can still be easily corrected. Beyond a month, the number of errors that can be easily corrected drops.

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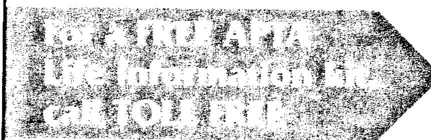

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a medical record software program that is user friendly and allows export of data, export your documentation records and merge them with the outcomes data. The more sophisticated software packages also allow the merging of selected financial and billing information. From such a system, the user can collect automated information leading to analysis of the unit of functional improvement per dollar charged per dollar of cost and to analysis of the relationship between patient and clinician perceptions of treatment.

Those practices that provide no feec back find that their staff have no reason t be enthusiastic about the outcomes prc cess. Other practices disseminate tl entire data set to all staff, giving those n immediately involved more informatic than they want or can understand.

This is another time when administr tors and managers can show their leade ship. When they share quarterly repo with staff, relating the outcomes data to tl individual patients of individual physi

What Are the Progressive Practices Doing?

Improving administrative and clinical efficiency: Progressive administrators have begun to merge their financial profit-and-loss spreadsheets with the outcomes data collection process for the purpose of managing their businesses more effectively. The financial statements allow analyses of the important business necessities, such as charges, costs, and profit, whereas the outcomes data provide analyses of the clinical "product." Did the outcomes improve? Which therapists or clinics produced better outcomes at the lowest utilization rates? Which therapists need specific continuing education efforts? Managers and clinicians alike are finding that this process of "outcomes utilization" reduces the guesswork in assessing clinical skills and improves resource management.

Preparing for a shift from value to quality of health: One 1996 report[1] explained the early use of price reductions, fee schedules, per diem rates, and discounted fees to entice providers to participate in managed care systems. Price has always been and always will be important in any negotiation regarding products and providers, but the next managed care phase currently is driving the selection of providers or managed care networks based on the value of their products. *Value* can be defined as "quality divided by cost." Outcomes can be said to equal "quality." The National Committee for Quality Assurance (NCQA), through its Health Plan Employer Data and Information Set (HEDIS),[2] has begun to emphasize the need to collect outcomes on a standardized, national basis. One important reason: to provide managed care members with data from which to select networks and providers.

If this stimulates feelings of anxiety among providers, Cigich and Mischler[1] predict that the next phase of managed care will be the phasing out of purchasing decisions based on value in favor of purchasing decisions based on improved health status of the managed care group members. The members will not forget about value of services; they will just be adding to their demand for value the new demand of "improved health." If physical therapy practices do not understand their outcomes, they will be positioned poorly to assess the overall health status of the managed care members.

Determining efficiency: Before understanding outcome data, it's important to understand efficiency data. Managed car organizations expect to know the average number of visits, dur tion of the episode of care, and charge for a typical episode c care for a diagnostic group. As the managed care syste evolves, these numbers will become information for internal us only as providers go "at risk" with their ability to predict and ma age their patients. Without efficiency numbers, providers cann be competitive with proposals to managed care networks.

Improving patient management: Despite the abo administrative eventualities, we cannot forget the primary pu pose of outcomes—the improvement of care. In a rece Editor's Note, Rothstein[3] encouraged us to "understand th nuances of practice" and then progress toward eliminating th interventions that have not been shown to be successf Rather than using our data to "selectively shine a penlight c our most attractive features," we should use them to illuminat

Ensuring continuous quality improvemen Outcomes data can be a powerful tool for continuous quali improvement. Consider a practice that has been collecting da for a substantial time and has a large number of patients in i database. If the practice wants to improve its understanding outcomes and ultimately improve them, a continuing educati meeting could be used not only for presenting various metho of intervention, but for discussing characteristics of patie who did not obtain good outcomes with specific interventio and who were treated for extended periods of time. Cause a effect cannot be established through outcomes effectivene data; however, having those data available to analyze practi patterns would place any practice at the top of continuous qu ity improvement. These data improve competitiveness on t most valuable clinical product—improved patient outcomes.

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therapists, the barriers break down. *That's* when a practice can start tracking improvement. Today, the more experienced practices distribute complete timely reports to managers only and distribute only those outcomes data that are directly related to the management of patients to clinicians and staff. Quarterly meetings to discuss outcome processes and results are helpful and answer questions such as: Can this process be streamlined? How can we deliver therapy to patients in a particular diagnostic group to ensure a good outcome without compromising productivity? How do we increase the ratio of patients who are discharged to patients who are evaluated? What ICD-9 code should we use for our patients with anterior cruciate ligament repairs? Monthly meetings are even better to keep the clinic, the clinicians, and the support staff on track and informed.

During the process of dissemination, make sure you discuss, in nonstatistical terminology, both positive and negative results. Each time the results are discussed, take the time to elucidate the variables, such as age, sex, diagnosis, and interventions performed. Repetition helps everyone understand the outcomes process and its results. Always seek to describe the relation between a person's actions in the clinic and the outcomes of the patients.

At this time in our history, we should consider the process of outcomes data collection as one that involves descriptive and correlational statistics that can be used to generate testable hypotheses. Unless your practice has a great deal of data and has controlled for extraneous variables, your outcomes process cannot determine cause and effect. That is, your outcomes data can tell you what outcomes were achieved, but they cannot tell you whether specific interventions were effective in reaching those outcomes. *Use the outcomes process to understand practice patterns from administrative and clinical perspectives.*

To further encourage staff participation in the process, use outcomes to identify clinical and administrative "stars" in your practice. How? Publicize their success both internally and externally. Staff constantly hear, "If we don't collect outcomes data on our patients, soon we won't get paid for our services!" and "We need higher productivity!" Imagine how a clinician would feel if he or she walked into the waiting room and saw "Clinic ABC Beats the National Average for Value for Patients With Neck Syndromes!" posted on the wall. Start reporting the positives to your staff before you market externally.

A potential added bonus: The outcomes process can supply you with another means to assess clinician performance.

If your clinic is using a health-related quality-of-life measurement tool, such as the SF-12, another source of external review is introduced: the opinion of the patients whom the clinician treated. Such a process adds to the performance review process and can go beyond cooperativeness and procedural compliance to the heart of what physical therapists do: manage patients.

Using these data for this purpose can pose special problems. Just as outcomes data can't prove cause and effect, they can't prove that because patients of a certain therapist had poorer outcomes than those of another therapist, the therapist's skills are the cause of those poor outcomes. There are many variables, such as patient characteristics and case mix. When outcomes data are being used in performance appraisal, there also might be a temptation to submit data in a way that could skew the reports.

As outcomes data collection and analysis are refined, their use in performance appraisal will be studied. In the meantime, outcomes data may be useful in providing information about therapist performance to complement or confirm the results of other, more traditional measures of therapist performance, such as supervisor observations.

If you decide to introduce outcomes data to the performance review process, do so in steps. We all learn from our mistakes. Assess the results of the outcomes process, identify errors, correct the process, and start again! Steps might include:

- Check the percentage of each specifi therapist's patients who are actuall entered into the outcomes database.
- Set as a goal that 95% of all appropriat patients will be entered into the dat set, and monitor quarterly as part o the quick staff review.
- Analyze the outcomes of each thera pist, comparing across therapists in th practice and comparing to nation aggregate data, if available.
- In conjunction with other methods performance appraisal, identify clinic or administrative strengths and weak nesses of specific clinicians, publicizin the strengths and correcting the weak nesses through individualized contin ing education.
- Track trends over time, and set goa with the clinician.

Some accreditation systems that a planning to require outcomes as part of t accreditation process are using an approa that is similar to the one outlined above.[8]

In some practices, the percentage patients with initial evaluations who al have discharge information entered in the database is being increased by linki financial bonuses to outcomes data ent or outcomes results. Should your practi use outcomes as part of the financ bonus structure? That depends on seve variables. When there is a financial ince tive, there tends to be higher complian Is that always good? Maybe not. Each s uation must be examined individually.

This is accomplishable now! If y have all of the pieces, figure out how merge them. Make the process seaml and invisible to the clinician, and make manager responsible for management the system.

Because there are several vend developing computerized systems and s eral companies that have spent great su

of money on the development of such systems without realizing the benefit of a finished system, take the time to make sure that the system you purchase or develop is developed by a clinician first and computer programmer second. Develop forced-choice responses that are based on a practical, clinical decision-making process. Link the documentation to the outcomes process. Use the outcomes data to generate patient goals and monitor functional progress of the patient. Build flexibility into the patient management process, but adhere to a strict philosophy for the outcomes measurements.

In such a system, the clinician should be able to expand evaluation and patient management philosophies consistent with current literature. The computerized documentation will force standardization on your practice, so make sure the system provides avenues for modification, such as elimination of interventions that have poor outcomes or enhancement of interventions that have good outcomes. Software packages should allow for development of these features; if not, don't buy them!

It's best to to view the outcomes process as a never-ending project that provides a structure in which you and your staff can strive for clinical excellence. Go for it! PT

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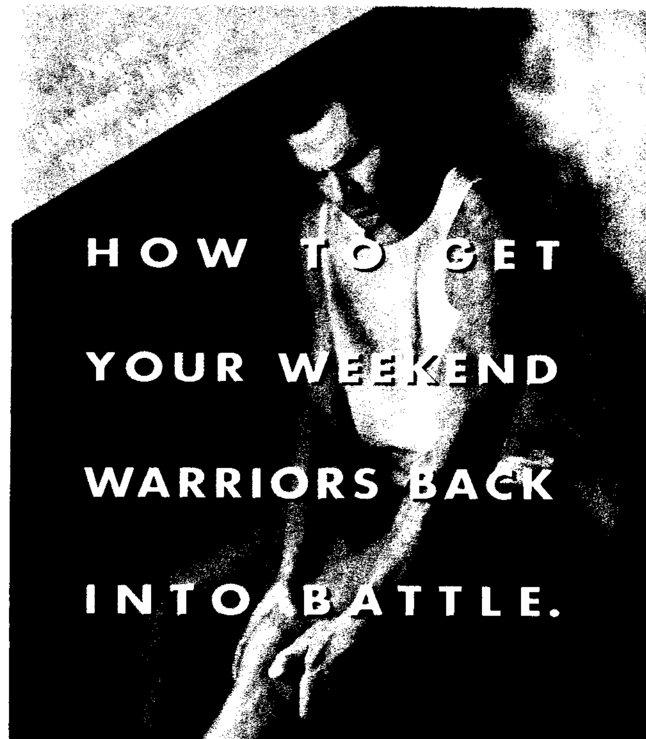

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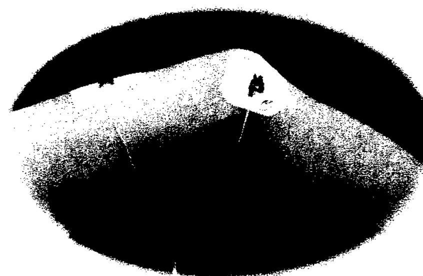
1. Pellecchia, G.L. et al.1994. J. Sport Rehab. 3:135-145.



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