easterseals
Capital Region & Eastern Connecticut

Medical Rehabilitation: Program Measurement & Management Report
Reporting Period: July 1, 2020 – June 30, 2021

Program Effectiveness Summary & Analysis

Process

Service effectiveness is evaluated through a four-part assessment of functional capacity, tailored from the widely recognized Functional Assessment Measurement (FAM) system. Following an admission for medical rehabilitation services, the primary therapist compiles an assessment of a patient's functional capacity on up to 44 different dimensions of functional capacity that are expressly being addressed through treatment. Initial and projected FAM scores are generated during the initial evaluation. These measures have been selected on the basis of relevance to the types of patients served and therapeutic services provided by our therapists. Major areas and items are summarized in Table 1 below.

Table 1
Functional Capacity Measures

Major Area	Functional Capacities Measured	
1 Self-Care	A. Eating B. Grooming C. Dressing Upper Body	D. Dressing Lower Body E. Toileting F. Swallowing
2 Mobility/Transfers	A. Bed/Chair/Wheelchair B. Toilet	C. Tub or Shower D. Car
3 Mobility/Locomotion	A. Wheelchair B. Walking	C. Stairs D. Community
4 Communication	A. Comprehension/Auditory B. Comprehension/Visual C. Expression/Non-Verbal D. Expression/Verbal	E. Reading F. Writing G. Speech Intelligibility
5 Cognitive Function	A. Problem Solving B. Memory C. Orientation	D. Attention E. Safety Judgment
6 Orthopedic	A. Range of Motion B. Strength C. Pain	D. Edema E. Gait
7 Community Re-Entry	A. Community Ambulation B. W/C Community Mobility C. Communication	D. Executive Function E. Food Preparation F. Medical Management

Ratings are made on a seven-point ordinal rating scale, based on the classification schema presented in Table 2 below. New therapists are oriented to the system prior to application through the discipline specific training/mentoring process and the Director of Rehabilitation Services reviews initial ratings to ensure inter-rater reliability. Review sessions on the assessment protocol are provided episodically to promote consistency and to identify changes to the protocol that may be indicated to sustain relevance to the practice and current patient base.

Table 2
Functional Capacity Rating Schema

Rating	Interpretative Considerations
1 Dependent	Does <25% of task
2 Maximum Assistance	Does 25-49% of task
3 Moderate Assistance	Does 50-74% of task
4 Minimal Assistance	Does >75% of task
5 Supervision	Requires some help, possibly including safety issues
6 Modified Independent	Can do the task, but requires extra time, or a device
7 Complete Independent	Can perform the task on a timely basis, safely, consistently, and with endurance

Following an initial period of assessment and observation, individualized treatment planning is performed and, as part of that process, goals are set for the functional capacities that will be addressed through therapy services. These same functional capacities are measured at discharge and follow up.

Data are aggregated into the eight major functional areas to understand the impact of treatment. In addition to outcome data, statistics are collected on units of treatment provided, service intensity, and costs. While number of visits is externally controlled by third party payors, a new measure has been added to examine treatment efficiency. As an assessment of comparative efficiency, a measure has been established for units of functional capacity gain per ten (10) visits of direct treatment. The intent of this measure is to have a proximate measure of gain which is independent of how much treatment may be authorized by a third-party payor.

Analysis

As the measurement domain program effectiveness relates to the plan, the objectives are: individuals independence level increased, and individual successfully completed treatment. To determine if the individual's independence level increased, two indicators were reviewed – change in self-care, as well as locomotion from admission to discharge. The target for self-care is an increase of at least 1.0 unit. During this reporting period, only mobility-locomotion and orthopedic were assessed as patients did not report difficulties in the functional measure of self-care. The main functional deficit for patients seen was pain or assistance in getting DME ordered. These patients were not assessed on self-care due to their needs focusing on pain relief and difficulty with getting around. With additional therapy providers joining the team, self-care will be assessed during the 2021-2022 reporting period.

The target for locomotion is an increase of at least 1.0 unit. This target was successfully met. The average discharge was 6.38 and the average admission was 5.38 which results in a change of 1.0 unit.

Records for patients seen during the reporting period were reviewed to determine if an individual successfully completed treatment. For those seen, fifty-two percent were seen for wheelchair and other durable medical equipment evaluations and did not receive treatment. Of the forty-eight percent seen for treatment, approximately sixteen percent were still active in treatment and therefore not included. One indicator for this objective is achieving functioning level goals, with success defined as achieving at least 70% of the goals set at admission. The target is at least 80%. During this reporting period, only 62.5% met at least 70% of the goals set at admission.

The second indicator for this objective is patients terminating treatment prior to goal achievement or medical benefit. The target is to be no more than 10%. This target was not met due to this reporting period yielding 24% of discharged patients terminating treatment prior to goal achievement or maximum medical benefit. Reasons for not achieving target include patients not being invested in their care (i.e. – those needing surgery or additional imaging but patient's doctor or insurance requiring a trial of rehabilitation therapy).

As summarized in Table 3 below, patients made significant gains in areas assessed. Across the right areas, patients were presenting at time of admission in the range of 3.18 to 5.38, reflecting a need for significant physical, organizational, and/or structural assistance. At the time of discharge, however, patients had made gains in all areas, achieving a "Supervision" level for orthopedic and a "Modified Independence" level for mobility-locomotion. Magnitude of increase ranged from a low of 1.00 in the area of mobility-locomotion to a high of 2.63 for orthopedic.

Table 3
Functional Outcomes for Patients

Major Area	Admission	Projected	Discharge	Difference	Follow-Up
1. Self-Care	-	-	-	-	-
2. Mobility - Transfers	-	-	-	-	-
3. Mobility - Locomotion	5.38	6.63	6.38	1.0	6.07
4. Communication	-	-	-	-	
5. Psychosocial-Adjustment	-	-	-	-	
6. Cognitive Function	-	-	-	-	
7. Orthopedic	3.13	5.88	5.75	2.63	5.24
8. Community Re-Entry	-	-	-	-	
Simple Average	4.26	6.26	6.07	1.82	5.66

Area of comparative strength in terms of pre- vs. post-treatment change is the areas assessed – Mobility-Locomotion and Orthopedic. The increase for these functions speaks to an increasing presence as a provider of physical therapy. It is also noteworthy that while significant gains were made (i.e., average increase of 1.82), gains did fall slightly short of projections.

Table 4
Percent of Expected Increase Achieved

Major Area		% Increase Achieved
1.	Self-Care	N/A
2.	Mobility-Transfers	N/A
3.	Mobility-Locomotion	69%
4.	Communication	N/A
5.	Psychosocial-Adjustment	N/A
6.	Cognitive Function	N/A
7.	Orthopedic	95%
8.	Community Re-Entry	N/A

On a related note, it was observed that patients received an average of 11.5 treatment visits. This translates into slightly more than one visit per week over the course of an average 9.34-week length of attachment. Direct care costs for this service totaled $1,298.32 per patient.

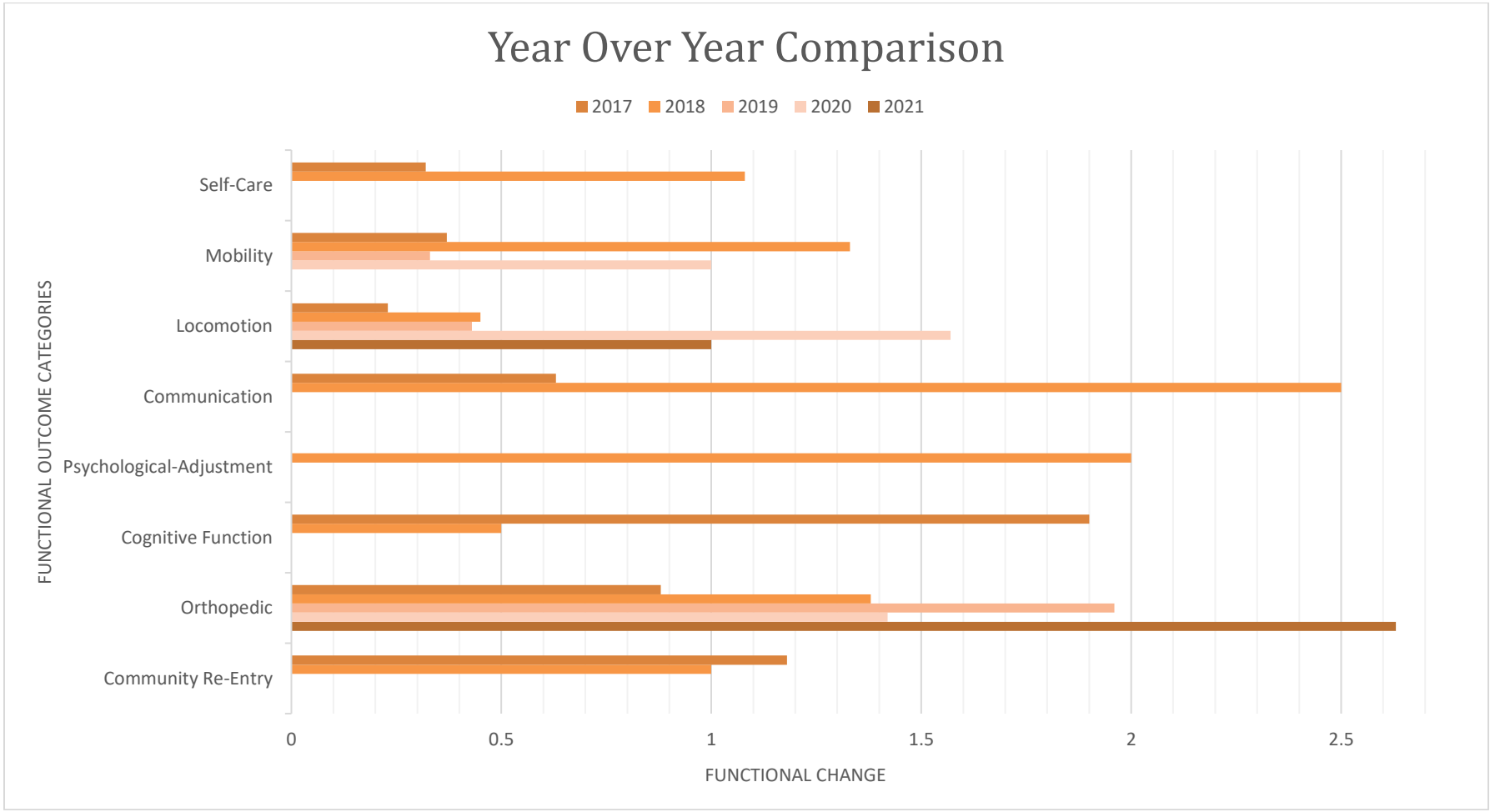
Benchmarking

Below is the data from 2017, 2018, 2019, 2020, and the most recent year for functional outcomes for patients. For 2019 & 2020, only three major areas were assessed, with 2021 only having two major areas assessed. These included: mobility-locomotion and orthopedic. The established target for all functional outcomes is 1.00. The functional outcomes are calculated by subtracting the rating at admission from the rating at discharge. The established target of 1.00 represents the patient making a gain to another functional capacity level that is, ideally, one step closer to independence. In both the major areas assessed, the average shows patients improved by at least one rating level and in the case of orthopedics – two levels. This shows services were effective, shows patients were getting one step closer to independence and are in line with our mission "to provide exceptional services to ensure that all with disabilities and their families have equal opportunities to live, learn, work and play in their communities."

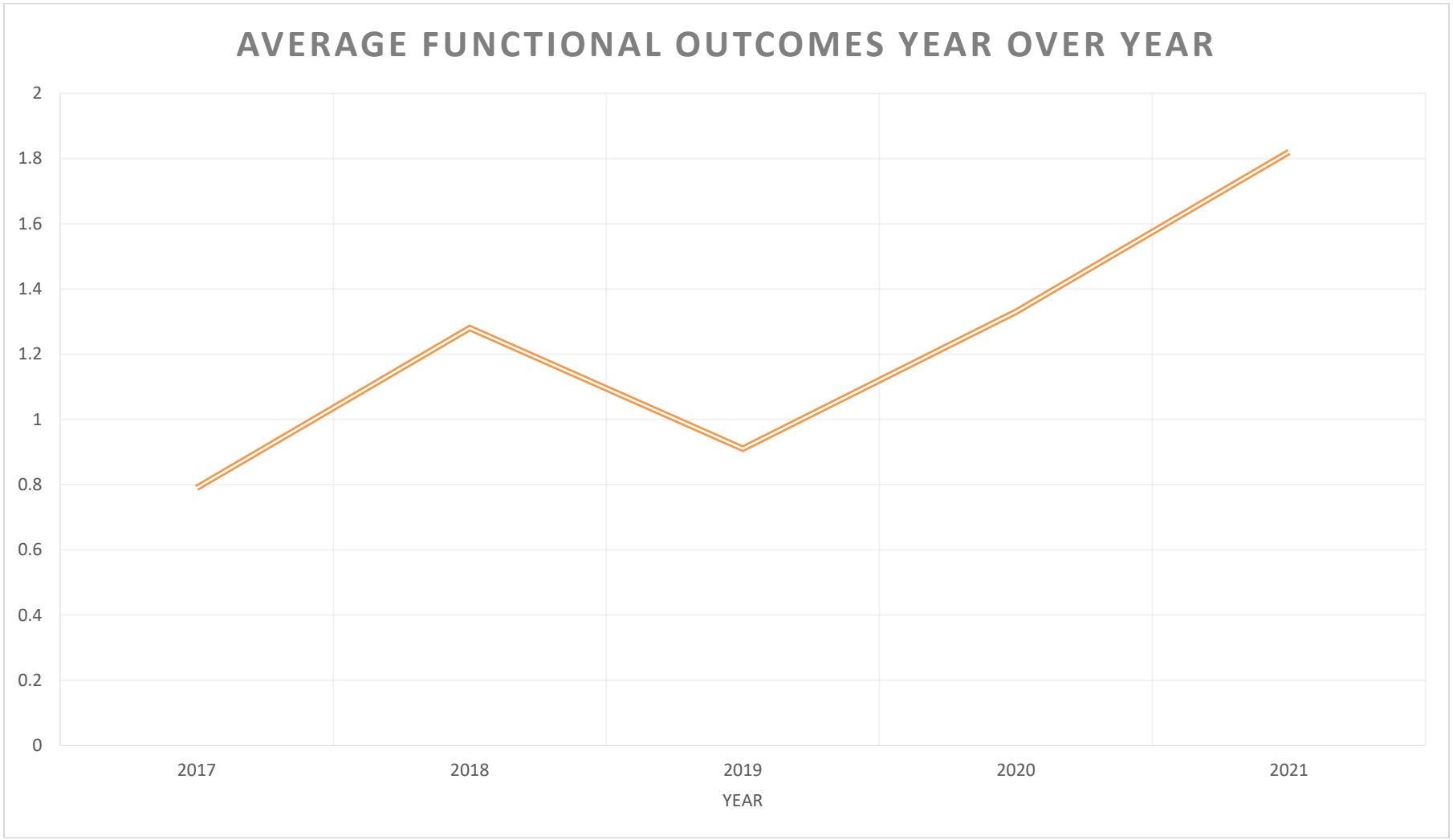
Table 5
Functional Outcomes Each Year

Major Area	2017	2018	2019	2020	2021
1. Self-Care	0.32	1.08	-	-	-
2. Mobility	0.37	1.33	0.33	1.00	-
3. Locomotion	0.23	0.45	0.43	1.57	1.00
4. Communication	0.63	2.50	-	-	-
5. Psychosocial-Adjustment	-	2.00	-	-	-
6. Cognitive Function	1.90	0.50	-	-	-
7. Orthopedic	0.88	1.38	1.96	1.42	2.63
8. Community Re-Entry	1.18	1.00	-	-	-
Simple Average	0.79	1.28	0.91	1.33	1.82

The chart below shows a visual of the comparisons for year over year from 2017 until the most recent year, 2021. One of the two assessed categories increased from 2020 to 2021.



The graph below shows the simple average of functional outcomes for patients per year.

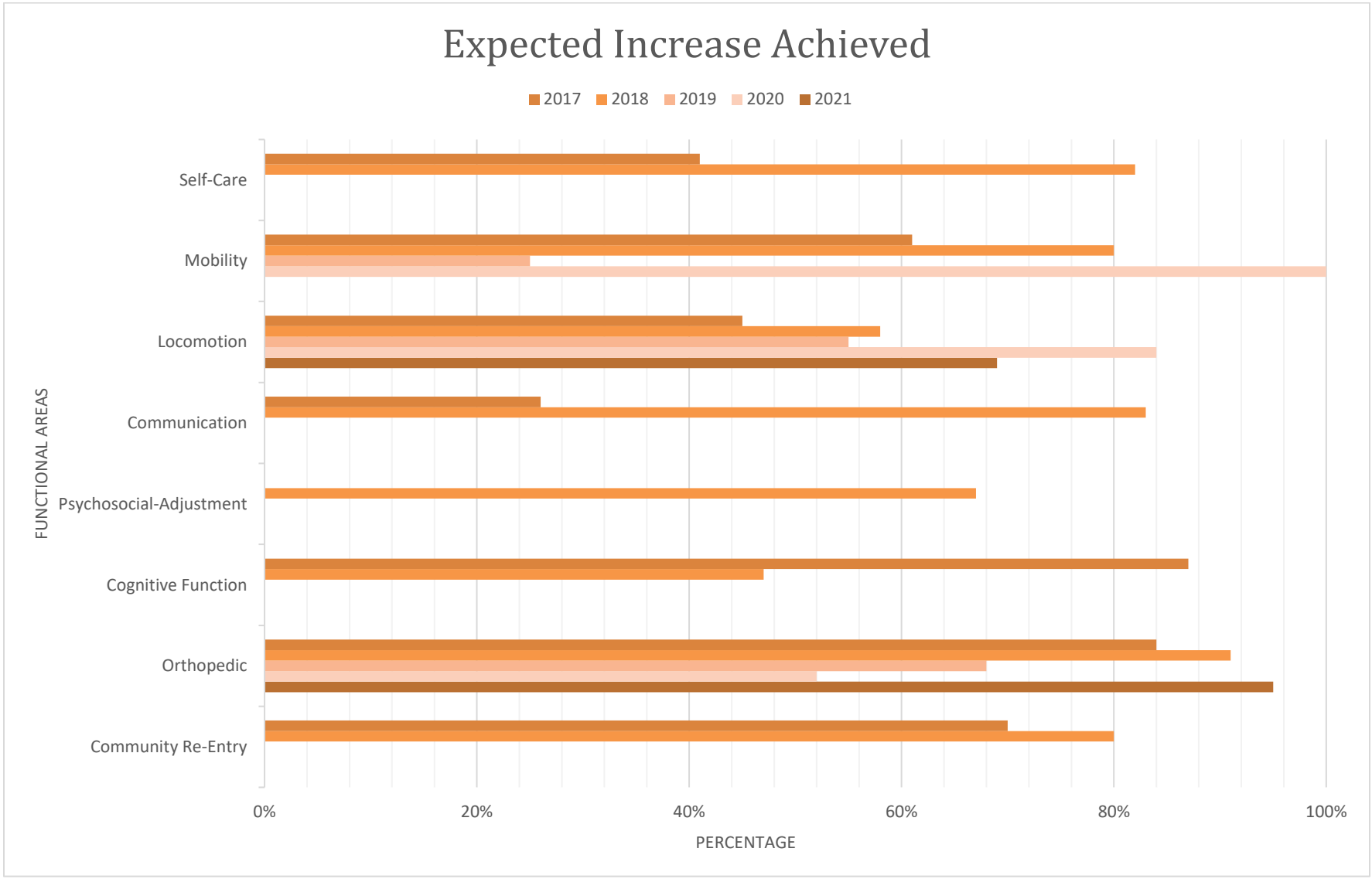


Below is the data from 2017, 2018, 2019, 2020, and 2021 which shows the percentage of expected increase achieved. The established target for each category is 75%. The data from 2021 shows the projections in the categories of mobility-locomotion are closer to the rating the patient is when discharged from the program. The orthopedic category improved during this reporting period and shows the projections in this category are closer to the rating the patient receives at discharge from the program, while mobility-locomotion decreased.

Table 6
Percentage of Expected Increase Achieved Each Year

Major Area	2017	2018	2019	2020	2021
1. Self-Care	41%	82%	N/A	N/A	N/A
2. Mobility	61%	80%	25%	100%	N/A
3. Locomotion	45%	58%	55%	84%	69%
4. Communication	26%	83%	N/A	N/A	N/A
5. Psychosocial-Adjustment	N/A	67%	N/A	N/A	N/A
6. Cognitive Function	87%	47%	N/A	N/A	N/A
7. Orthopedic	84%	91%	68%	52%	95%
8. Community Re-Entry	70%	80%	N/A	N/A	N/A

Below is a graphic of the data represented in the table above.



Action Plan

It is clear that the overall results evidence significant gains in functional capacity and overall treatment effectiveness. Results and tentative action plans were presented to staff for review and comment. The findings and suggested strategies will be presented to the Board of Directors at its next meeting. That plan is summarized in Table 7 below.

The Program Manager shall assume responsibility for implementation and monitoring of all action items. All action items will be immediately implemented upon Board review and approval.

Table 7
Action Items

	Finding	Action
1.	Gains did fall short of the projections for one functional measure domain that was assessed during this reporting period due to only offering physical therapy in Med Rehabilitation other than Neuropsychological Testing.	Secure providers for other disciplines to provide a better range of functional measures.
2.	In reviewing the outcomes in comparison to goals, the need for patient and family participation in the treatment advocacy process was flagged.	Coordinate with Med Rehab team to develop a system for bringing the patient and his/her family into the "care coordination" process.

Program Efficiency Summary & Analysis

Summary & Analysis

To assess the program efficiency, data from Table 3 is utilized which is shown below for reference. As the measurement of efficiency relates to the plan, there are two objectives. These objectives are: patient gains in treatment reflect an efficient use of treatment sessions and staff maximizing the amount of time spent each workday engaged in billed/reimbursed services.

Patient gains in treatment reflect efficient use of treatment sessions is determined by the change in functional gain in the area of self-care per 10 treatment visits. The target for this indicator is the average increase in self-care functioning per 10 visits will be at least 0.40 units. During this reporting period, patients were not assessed for self-care. Patient gains in treatment reflect efficient use of treatment sessions will also be determined by the change in functional gains in the area of locomotion per 10 treatment visits. The target for this indicator is the average increase in locomotion per 10 visits will be at least 0.40 units. During this reporting period, the average increase in locomotion per 10 visits was 0.77 units which met the target.

The objective of staff maximizing the amount of time spent each workday engaged in billed/reimbursed services will be measured by hours of billed services dividing by total hours

clocked in. The target for this indicator will be 80% of hours worked during the year were billable hours. During this reporting period only 53.16% of total worked hours was billable. Another indicator of this objective is the percent of billed services that are not collected or written off as uncollectible 12 months after billing. This target is at least 85% of amounts billed during the prior fiscal year have been collected within 12 months of billing. During this reporting period 87.35% was collected with 12.65% still outstanding. Of this 12.65% outstanding, 10.24% of the outstanding belongs to one patient account.

Functional Outcomes for Patients

Major Area	Admission	Projected	Discharge	Difference	Follow-Up
1. Self-Care	-	-	-	-	-
2. Mobility - Transfers	-	-	-	-	-
3. Mobility - Locomotion	5.38	6.63	6.38	1.0	6.07
4. Communication	-	-	-	-	
5. Psychosocial-Adjustment	-	-	-	-	
6. Cognitive Function	-	-	-	-	
7. Orthopedic	3.13	5.88	5.75	2.63	5.24
8. Community Re-Entry	-	-	-	-	
Simple Average	4.26	6.26	6.07	1.82	5.66

Comparing treatment efficiency (i.e., gains per 10 hours of treatment) across the assessed functional domains, we see that greatest gains were made for orthopedic, wherein a lower number of visits coupled with strong gains resulted in a rate almost double the rate seen for mobility-locomotion. This may also be a function of a lower number of visits and additional evidence that the higher ranking is confounded by the number of visits. On the other hand, the 0.77 gain per 10 visits seen for Mobility-Locomotion suggests that continuing gains were made throughout the average 13 visits.

Table 8
Treatment Efficiency

Major Area	Net Gain	Visits	Gains Per 10 Visits
1. Self-Care	-	-	-
2. Mobility-Transfers	-	-	-
3. Mobility-Locomotion	1.00	13.00	0.77
4. Communication	-	-	-
5. Psychosocial-Adjustment	-	-	-
6. Cognitive Function	-	-	-
7. Orthopedic	2.63	10.00	2.63
8. Community Re-Entry	-	-	-
Simple Average	1.82	11.50	1.70

Benchmarking

Following is the data from 2017, 2018, 2019, 2020, and 2021 that shows the treatment efficiency in the major areas assessed. This data is based on gains made per 10 visits. The established target for each category is 0.40. Based on the data below, 2021 showed a significant increase in treatment efficiency over 2020 in the category of orthopedic; whereas the mobility-locomotion area showed a decline of 1.04. For 2019 & 2020, only three major areas were assessed, with 2021 only having two. The limited areas assessed can be attributed to having only physical therapy as part of medical rehabilitation during this reporting period.

Table 9
Treatment Efficiency Each Year

Major Area	2017	2018	2019	2020	2021
1. Self-Care	0.47	1.41	-	-	-
2. Mobility	1.22	1.51	0.58	1.18	-
3. Locomotion	0.18	0.55	0.58	1.81	0.77
4. Communication	0.92	5.56	-	-	-
5. Psychosocial-Adjustment	-	2.00	-	-	-
6. Cognitive Function	0.76	0.74	-	-	-
7. Orthopedic	0.85	1.87	2.10	1.91	2.63
8. Community Re-Entry	2.61	2.00	-	-	-
Simple Average	1.00	1.96	1.09	1.63	1.70

Below is a graphic of the data represented in the table above.

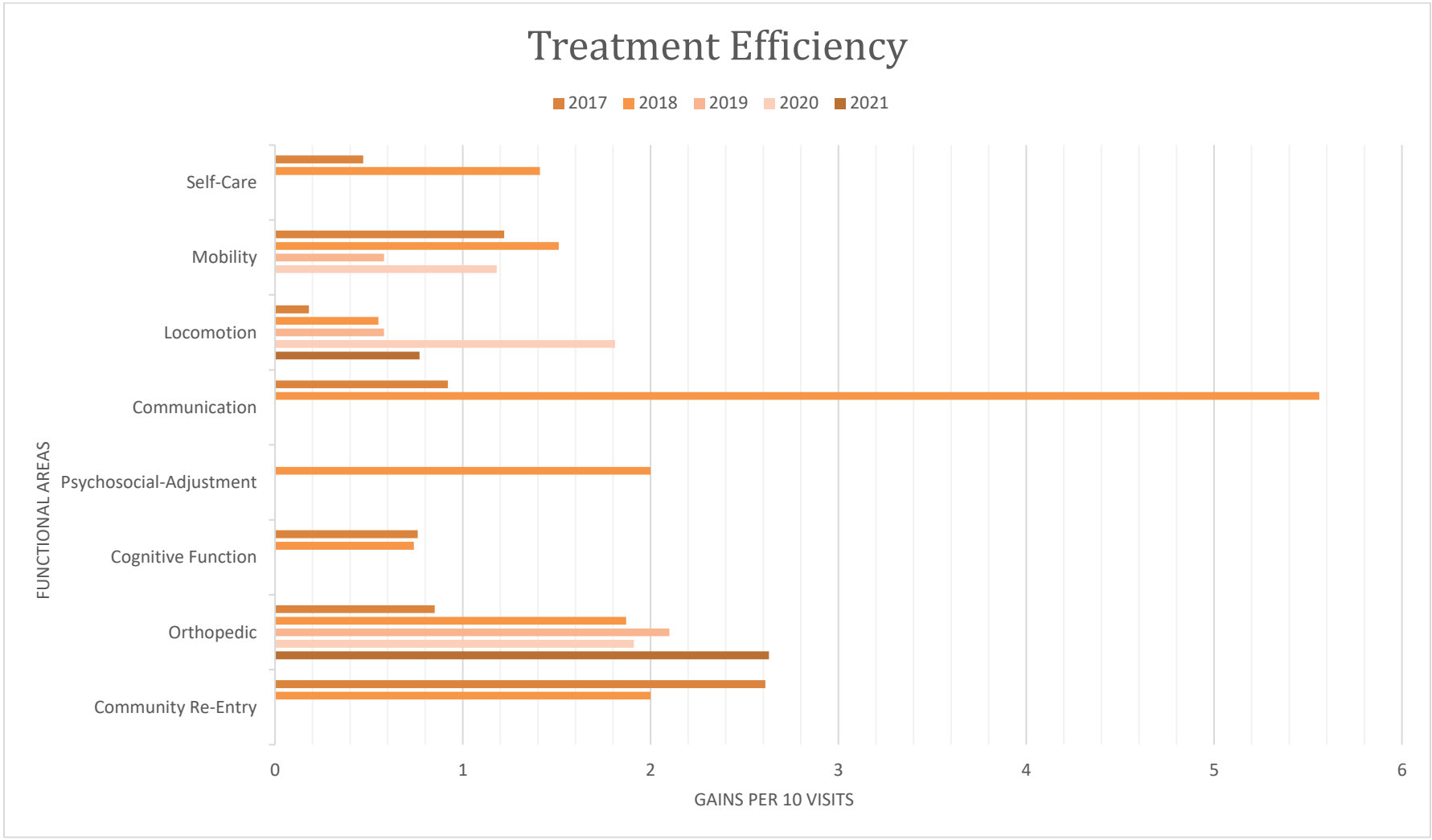


Table 10
Action Plan

	Finding	Action
1.	In reviewing the outcomes, only mobility-locomotion and orthopedic were assessed in patients during the reporting period.	Meet with providers to discuss value in assessing self-care as a functional measure as it can relate the level of independence of a patient.
2.	Total worked hours that were billable was considerably lower than the target set.	Work with providers to find new ways to market that will in turn increase the total worked hours that were billable.

Program Satisfaction and Experience of Persons Served Summary & Analysis

Characteristics of Persons Served

Data was compiled on the persons served for medical rehabilitation during this reporting period. Data for the organization is also included for comparison purposes. The data is summarized in the tables below.

	Medical Rehabilitation	Entire Organization
Age		
Age 0 – 3	-	-
Age 4 – 17	4%	23%
Age 18 – 59	68%	63%
Age 60 +	28%	14%

Based on the breakdown above, the average age of those served by the medical rehabilitation department is close to the average age of those served by the entire organization.

	Medical Rehabilitation	Entire Organization
Gender		
Male	56%	58%
Female	44%	42%

Based on the breakdown above, the gender of those served by the medical rehabilitation department is close to the percentages of those served by the entire organization.

	Medical Rehabilitation	Entire Organization
Ethnicity		
Asian	4%	1%
Aboriginal	-	-
Non-Hispanic African American	24%	18%
Non-Hispanic White	56%	62%
Hispanic	16%	14%
North American Indian and Alaska Native	-	1%
Native Hawaiian and Other Pacific Islander	-	1%
Multiple Ethnicity	-	1%
Other	-	2%

Based on the data above, the ethnicity of those served by the medical rehabilitation department is close to the percentages of those served by the entire organization.

Diagnosis Codes of Persons Served

Below is the breakdown of diagnosis codes of the persons served during this reporting period for the medical rehabilitation department and the entire organization.

Code Range	Section Description	Medical Rehabilitation	Entire Organization
A00-B99	Certain infectious and parasitic diseases	-	-
C00-D49	Neoplasms	-	0.26%
D50-D89	Diseases of the blood and blood-forming organs and certain disorders involving the immune mechanism	-	-
E00-E89	Endocrine, nutritional and metabolic diseases	4%	0.26%
F01-F99	Mental, Behavioral and Neurodevelopmental disorders	20%	83.56%
G00-G99	Diseases of the nervous system	16%	3.45%
H00-H59	Diseases of the eye and adnexa	-	0.27%

H60-H95	Diseases of the ear and mastoid process	-	0.13%
I00-I99	Diseases of the circulatory system	-	-
J00-J99	Diseases of the respiratory system	4%	0.13%
K00-K95	Diseases of the digestive system	-	-
L00-L99	Diseases of the skin and subcutaneous tissue	-	-
M00-M99	Diseases of the musculoskeletal system and connective tissue	24%	0.93%
N00-N99	Diseases of the genitourinary system	-	-
O00-O9A	Pregnancy, childbirth and the puerperium	-	-
P00-P96	Certain conditions originating in the perinatal period	-	-
Q00-Q99	Congenital malformations, deformations and chromosomal abnormalities	-	2.52%
R00-R99	Symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified	16%	5.96%
S00-T88	Injury, poisoning and certain other consequences of external causes	12%	1.19%
V00-Y99	External causes of morbidity	-	0.13%
Z00-Z99	Factors influencing health status and contact with health services	4%	1.06%
		100%	100%

During this reporting period, the highest percentage of diagnosis codes for persons served falls under “Diseases of the musculoskeletal system and connective tissue” at 24% which is appropriate for a medical rehabilitation department that had a physical therapist during the entire duration and an occupational therapist briefly. The category overview shows data that might seem to be inconsistent with persons served within a medical rehabilitation department. Below, the categories are drilled down further to see where persons served were classified.

Code Range	Section Description		Medical Rehabilitation	Entire Organization
A00-B99	**Certain infectious and parasitic diseases**		**-**	**-**
C00-D49	**Neoplasms**		**-**	**0.26%**
	C69-C72	Malignant neoplasms of eye, brain and other parts of central nervous system	-	0.13%
	D10-D36	Benign neoplasms, except benign neuroendocrine tumors	-	0.13%
D50-D89	**Diseases of the blood and blood-forming organs and certain disorders involving the immune mechanism**		-	-
E00-E89	**Endocrine, nutritional and metabolic diseases**		**4%**	**0.26%**
	E65-E68	Overweight, obesity and other hyperalimentation	4%	0.13%
	E70-E88	Metabolic disorders	-	0.13%
F01-F99	**Mental, Behavioral and Neurodevelopmental disorders**		**20%**	**83.56%**
	F01-F09	Mental disorders due to known physiological conditions	4%	1.46%
	F10-F19	Mental and behavioral disorders due to psychoactive substance use	-	0.66%
	F20-F29	Schizophrenia, schizotypal, delusional, and other non-mood psychotic disorders	-	7.69%
	F30-F39	Mood [affective] disorders	-	14.19%
	F40-F48	Anxiety, dissociative, stress-related, somatoform and other nonpsychotic mental disorders	4%	12.20%
	F60-F69	Disorders of adult personality and behavior		0.13%
	F70-F79	Intellectual disabilities	4%	12.60%
	F80-F89	Pervasive and specific developmental disorders	8%	18.17%
	F90-F98	Behavioral and emotional disorders with onset usually occurring in childhood and adolescence	-	14.60%
	F99	Unspecified mental disorder	-	1.86%
G00-G99	**Diseases of the nervous system**		**16%**	**3.45%**
	G30-G32	Other degenerative diseases of the nervous system	-	0.27%
	G60-G65	Polyneuropathies and other disorders of the peripheral nervous system	4%	0.13%
	G80-G83	Cerebral palsy and other paralytic syndromes	12%	2.92%
	G89-G99	Other disorders of the nervous system	-	0.13%

H00-H59	**Diseases of the eye and adnexa**		**-**	**0.27%**
	H53-H54	Visual disturbances and blindness	-	0.27%
H60-H95	**Diseases of the ear and mastoid process**		**-**	**0.13%**
	H90-H94	Other disorders of ear	-	0.13%
I00-I99	**Diseases of the circulatory system**		**-**	**-**
J00-J99	**Diseases of the respiratory system**		**4%**	**0.13%**
	J40-J47	Chronic lower respiratory diseases	4%	0.13%
K00-K95	**Diseases of the digestive system**		**-**	**-**
L00-L99	**Diseases of the skin and subcutaneous tissue**		**-**	**-**
M00-M99	**Diseases of the musculoskeletal system and connective tissue**		**24%**	**0.93%**
	M15-M19	Osteoarthritis	4%	0.13%
	M20-M25	Other joint disorders	8%	0.40%
	M50-M54	Other dorsopathies	8%	0.27%
	M70-M79	Other soft tissue disorders	4%	0.13%
N00-N99	**Diseases of the genitourinary system**		**-**	**-**
O00-O9A	**Pregnancy, childbirth and the puerperium**		**-**	**-**
P00-P96	**Certain conditions originating in the perinatal period**		**-**	**-**
Q00-Q99	**Congenital malformations, deformations and chromosomal abnormalities**		**-**	**2.52%**
	Q00-Q07	Congenital malformations of the nervous system	-	0.40%
	Q65-Q79	Congenital malformations and deformations of the musculoskeletal system	-	0.13%
	Q80-Q89	Other congenital malformations	-	0.40%
	Q90-Q99	Chromosomal abnormalities, not elsewhere classified	-	1.59%
R00-R99	**Symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified**		**16%**	**5.96%**
	R25-R29	Symptoms and signs involving the nervous and musculoskeletal systems	16%	0.53%
	R40-R46	Symptoms and signs involving cognition, perception, emotional state and behavior	-	5.17%
	R47-R49	Symptoms and signs involving speech and voice	-	0.13%
	R50-R69	General symptoms and signs	-	0.13%

S00-T88	**Injury, poisoning and certain other consequences of external causes**		**12%**	**1.19%**
	S00-S09	Injuries to the head		0.80%
	S40-S49	Injuries to the shoulder and upper arm	4%	0.13%
	S80-S89	Injuries to the knee and lower leg	4%	0.13%
	S90-S99	Injuries to the ankle and foot	4%	0.13%
V00-Y99	**External causes of morbidity**		**-**	**0.13%**
	Y83-Y84	Surgical and other medical procedures as the cause of abnormal reaction of the patient, or of later complication, without mention of misadventure at the time of the procedure	-	0.13%
Z00-Z99	**Factors influencing health status and contact with health services**		**4%**	**1.06%**
	Z40-Z53	Encounters for other specific health care	-	0.80%
	Z55-Z65	Persons with potential health hazards related to socioeconomic and psychosocial circumstances	-	0.13%
	Z77-Z99	Persons with potential health hazards related to family and personal history and certain conditions influencing health status	4%	0.13%
			100%	100%

When the diagnosis categories are drilled down, the diagnosis code of the person served is more appropriate. For example, "Endocrine, nutritional and metabolic diseases" might not seem appropriate for a person served in medical rehabilitation; however, the subset of "Overweight, obesity and other hyperalimentation" might be appropriate for a person needing a wheelchair evaluation. This carries true for the category "Mental, Behavioral and Neurodevelopmental disorders" where the subset of "Intellectual disabilities", and "Disorders of adult personality and behavior" can be found.

Survey Process and Findings

Patient satisfaction surveys were completed by patients or family members at the time of completion/discharge from their medical rehabilitation program. Approximately seventy-one percent of responses were those of patients while the remaining twenty-nine percent were provided by family members. Patient satisfaction surveys are reviewed at the time of receipt resulting in the ability to rectify any potential issues timely. With this process in place, there were no formal complaints or grievances filed during this report period.

The results of these data aggregations are presented in Table 11 below.

Table 11
Patient Satisfaction Survey

	Rating				
	Excellent	Good	Fair/Poor	N/A	Excellent or Good
Promptness of admission	71%	29%	0%	0%	100%
Consideration of scheduling needs	71%	29%	0%	0%	100%
Opportunity to participate in treatment planning	86%	0%	14%	0%	86%
Appropriateness of frequency and duration	86%	0%	0%	14%	86%
Consideration of patient goals	71%	29%	0%	0%	100%
Promptness of issue resolution	72%	14%	0%	14%	86%
Opportunity to participate in discharge planning	72%	0%	14%	14%	72%
Satisfaction with treatment outcomes	86%	14%	0%	0%	100%
Accuracy of program information	72%	14%	0%	14%	86%
Overall impressions of Center	71%	29%	0%	0%	100%

Table 12, a summary of written comments, is offered to provide additional insight and perspective to the patients' reported experience with us:

Table 12 Summary of Written Comments	
1.	Thank you Judy & Debora.
2.	Very nice people.
3.	This has been one of the best places I have gone to PT. Such amazing people to help me out. Besides the ride malfunctions – all Veyo's fault. This place really helped me get back to work.
4.	All responded that they were very likely to refer a friend or family member to the Center.

Analysis

As the measurement domain of satisfaction and experience of persons served in this program related to the plan, there are two objectives. These objectives are: individuals indicating favorable impression or program provider – in this case Easterseals Capital Region & Eastern CT, and individuals indicate favorable impression of services received.

Favorable impression of program provider (Easterseals) is determined by rating the accuracy of program information as presented by staff, print, and website with a score of three or above on the patient satisfaction survey. The target for this indicator is at least 85%. During this reporting period the level achieved was 86% total – 72% excellent and 14% good. Favorable impressions of program provider (Easterseals) is also determined by ratings overall impressions of the Center with a score of three or above on the patient satisfaction survey. The target for this indicator is at least 85%. During this reporting period, the level achieved was 100% total – 71% excellent and 29% good.

Favorable impressions of services provided is determined by ratings of satisfaction with treatment outcomes with a three or above on the patient satisfaction survey. The target for this indicator is at least 85%. During this reporting period the level achieved was 100% total – 86% excellent and 14% good. Favorable impressions of services provided is also determined by ratings of staff considering the patient's goals for therapy with a score of three or above on the patient satisfaction survey. The target for this indicator is at least 85%. During this reporting period the level achieved was 100% total – 71% excellent and 29% good.

Benchmarking

Finding other CARF accredited CORFs that publish their results and are easily accessible has proved to be challenging. Since it is important that we benchmark our program, we have utilized our own historical data as the method to compare. The established target for each category is 90% when combining the excellent and good ratings.

Data for ratings "Excellent or Good" for the past four years as well as the results from this reporting period are listed below.

Table 13
Patient Satisfaction Survey Each Year

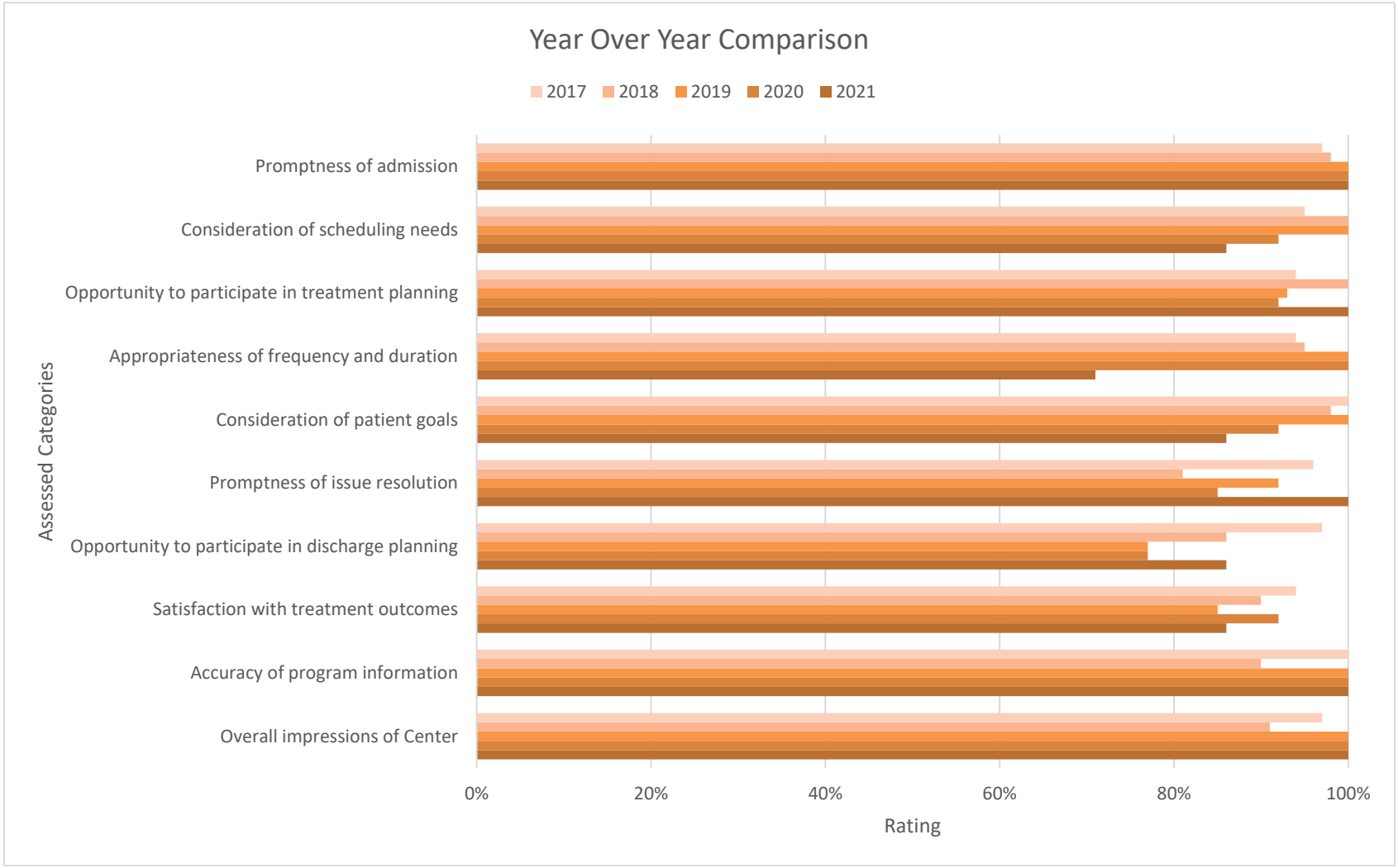
	Rating				
	2017	2018	2019	2020	2021
Promptness of admission	97%	98%	100%	100%	100%
Consideration of scheduling needs	95%	100%	100%	92%	100%
Opportunity to participate in treatment planning	94%	100%	93%	92%	86%
Appropriateness of frequency and duration	94%	95%	100%	100%	86%
Consideration of patient goals	100%	98%	100%	92%	100%
Promptness of issue resolution	96%	81%	92%	85%	86%
Opportunity to participate in discharge planning	97%	86%	77%	77%	71%
Satisfaction with treatment outcomes	94%	90%	85%	92%	100%
Accuracy of program information	100%	90%	100%	100%	86%
Overall impressions of Center	97%	91%	100%	100%	100%

While a few of the assessed categories have increased this reporting period over the prior reporting period, there are categories that have decreased. It should be noted that nine of the categories are over the established target, while one has decreased since the 2020 survey results. These include "Opportunity to participate in treatment planning", "Appropriateness of frequency and duration", Opportunity to participate in discharge planning", and "Accuracy of program information".

Only one of the categories did not make the established target of at least 85%. This was "Opportunity to participate in discharge planning". Regarding this category, there was no comments to provide background or allow staff to determine circumstances as to why this feedback was offered.

For 2021, respondents selected N/A which altered the results. If the selection of N/A was absorbed into the other selections or excluded, none of the categories would have missed the 85% target. Therapy patients who receive treatment are included in their treatment and discharge plan – and are vital in said planning. Based on this, those who completed the survey and opted for N/A would be patients for wheelchair/DME evaluations and neuropsychology services – all of which do not have treatment after evaluation.

The chart below provides a visual of the change year over year to compare.



Action Plan

It is clear that the overall results evidence strong satisfaction; however, the data suggests additional considerations are warranted in a few select areas. In prior years, any item that had less than 50% of respondents making a rating of "excellent" was flagged for additional review and development of strategies to improve future performance. This reporting period had no items less than 50% of respondents making a rating of "excellent." Any issue that was identified through the written comments (bolded and italicized in Table 2) was also taken as warranting an improvement strategy. This reporting period had none of these types of written comments and instead all were very positive.

Results and prospective action plans were presented to staff for review and comment. The findings and suggested strategies will be presented to the Board of Directors and the plan finalized as illustrated in Table 14. The program manager will be responsible for implementation and monitoring of all strategic action items.

Table 14
Analysis and Action Plan

Finding	Analysis	Action
1. The completion rate is lower than desired.	During this reporting period there were a decreased number of patients who were taking part in medical rehabilitation services.	Encourage patients receiving treatment services to complete Patient Satisfaction Surveys by having clipboard with surveys and a drop box available in the lobby. Explore other means of issuing surveys including text and electronic.

Program Service Access Summary & Analysis

Process

As mentioned above, the patient satisfaction surveys are provided to patients and their caregivers to complete and return. Promptness of admission and consideration of scheduling needs are two areas respondents can provide feedback on service access.

Results & Analysis

As the measurement of service access relates to the plan, there are two objectives. These objectives are: successfully getting an appointment in a timely manner, and service hours and location will be convenient and timely.

Successfully getting an appointment in a timely manner is determined by the number of business days from receipt of referral to successful patient outreach contact (i.e. speaking to the patient in real time). The target for this indicator is at least 90% of patient referrals will successfully be contacted within two business days of referral. During this reporting period, only 37.5% per contacted within two business days from receipt of referral. Successfully getting an appointment in a timely manner is also be determined by the number of business days from successful patient outreach to first scheduled visit. The target for this indicator is at least 90% of successful contacts will have a first visit scheduled for no more than seven days from that contact. During this reporting period, the target was narrowly missed by 2.5%.

Table 15
Service Access Averages

Process Points	Average Business Days
Business Days from Referral Received to Processed	0.63
Business Days from Referral Received to First Attempt to Contact	5.50
Business Days from Referral Received to First Successful Contact	5.75
Business Days from Referral Received to First Appt Date	22.25
Business Days from First Successful Contact to First Appt Date	17.25

The above results include a case that involved the referring provider sending over the referral prior to patient having surgery. The request for the patient to receive physical therapy was meant for after the patient had surgery. If the outlier is removed, the averages are a little more reasonable as can be seen below.

Process Points	Average Business Days
Business Days from Referral Received to Processed	0.63
Business Days from Referral Received to First Attempt to Contact	3.00
Business Days from Referral Received to First Successful Contact	3.29
Business Days from Referral Received to First Appt Date	7.14
Business Days from First Successful Contact to First Appt Date	3.86

Using the data above, the average number of business days from first successful contact to first appointment date is well below the target of seven. In fact, it is almost half of the target at 3.86 business days. The average number of business days from referral received to first successful contact is 3.29. This is well above what it should be and when looking at the indicator, the target is two days for 90% of referrals.

Service hours and locations will be convenient and timely is determined by the rating of satisfaction with their needs being considered when scheduling appointments with a score of three or above on the patient satisfaction survey. The target for this indicator is at least 85%. During this reporting period the level achieved was 100% total – 71% excellent and 29% good. Whether service hours and locations will be convenient and timely will also be determined by the number

of patients on a waiting list each day. The target for this indicator is the number of days with a waiting list of one or more patients will be less than 2% of operating days. During this reporting period the number of patients on a waiting list each day was 0%.

	Rating				
	Excellent	Good	Fair/Poor	N/A	Excellent or Good
Promptness of admission	71%	29%	0%	0%	100%
Consideration of scheduling needs	71%	29%	0%	0%	100%

	Rating				
	2017	2018	2019	2020	2021
Promptness of admission	97%	98%	100%	100%	100%
Consideration of scheduling needs	95%	100%	100%	92%	100%

Benchmarking

While the feedback relating to patient access has been captured on the patient satisfaction survey each year (specifically promptness of admission and consideration of scheduling needs), the number of business days from each reference point in the process has not. Unfortunately, this means there is no historical data to compare the numbers from the current reporting period.

Action Plan

While the number of business days from first successful contact to first appointment date is below the target of seven, this can be reduced further by adding additional staff or having current staff flex their working hours and days.

	Finding	Action
1.	In reviewing the referrals and scheduling data, it was determined that it takes on average 3.86 business days from first successful contact to first appointment.	Ongoing – new staff are able to flex their hours and days. Physical therapist is not able to at this time and we have been unsuccessful in finding a qualified PTA to add additional availability for patients.

Program Satisfaction and Experience of Stakeholders
Summary & Analysis

Findings

The most recent round of stakeholder input surveys, including responses from referring physicians, health organizations, and human service organizations, have been analyzed and are presented in summary format in Table 1 below.

Table 16
Summary of Stakeholder Data

	Rating					
	Excellent	Good	Fair	Poor	N/A	Excellent Or Good
Promptness of admission	60%	20%	20%	0%	0%	80%
Promptness in addressing issues	80%	20%	0%	0%	0%	100%
Staff accessibility and availability	60%	20%	0%	0%	20%	80%
Type, frequency, & duration of service	80%	20%	0%	0%	0%	100%
Treatment plan appropriate for diagnosis	100%	0%	0%	0%	0%	100%
Discharge planning	60%	0%	0%	0%	40%	60%
Progress reports received timely	60%	0%	0%	0%	40%	60%
Satisfaction with outcome of treatment	100%	0%	0%	0%	0%	100%
Information re program was accurate	80%	20%	0%	0%	0%	100%
Overall impressions of Center	100%	0%	0%	0%	0%	100%

Key interpretive findings are as follows:

1. The data strongly suggests overall satisfaction with Center services evidenced by 100% of all respondents indicating “excellent” or “good” for more than half of the categories.

Stakeholder survey respondents were also invited to provide open-ended input regarding program satisfaction, changes, or needs. The comments received were for physical therapy and neuropsychology.

Table 17 Summary of Written Comments
1. I greatly appreciate your in-depth reports and attention to detail. You help me, therapists and schools best serve our mutual clients. They give me great feedback about interactions with your staff.
2. Thank you!
3. Very professional and knowledgeable staff. We refer patients to this Easter Seals branch often. Debora and Judy are a pleasure to work with!

Analysis

As the measurement of satisfaction and experience of stakeholders relates to the plan, there are two objectives. These objectives are: external stakeholders indicate favorable program provider (Easterseals) and external stakeholders indicate favorable services were provided.

Favorable impression of program provider (Easterseals) is determined by rating the accuracy of program information as presented by staff, print, and website with a score of three or above on the stakeholder satisfaction survey. The target for this indicator is at least 85%. During this reporting period the level achieved was 100% total – 80% excellent and 20% good. Favorable impressions of program provider (Easterseals) is also determined by ratings overall impressions of the Center with a score of three or above on the stakeholder satisfaction survey. The target for this indicator is at least 85%. During this reporting period, the level achieved was 100% as excellent.

Favorable impressions of services provided is determined by ratings of satisfaction with treatment outcomes with a three or above on the stakeholder satisfaction survey. The target for this indicator is at least 85%. During this reporting period the level achieved was 100% as excellent. Favorable impressions of services provided is also determined by ratings of intensity, frequency, and duration of treatment with a score of three or above on the stakeholder satisfaction survey. The target for this indicator is at least 85%. During this reporting period the level achieved was 100% total – 80% excellent and 20% good.

Benchmarking

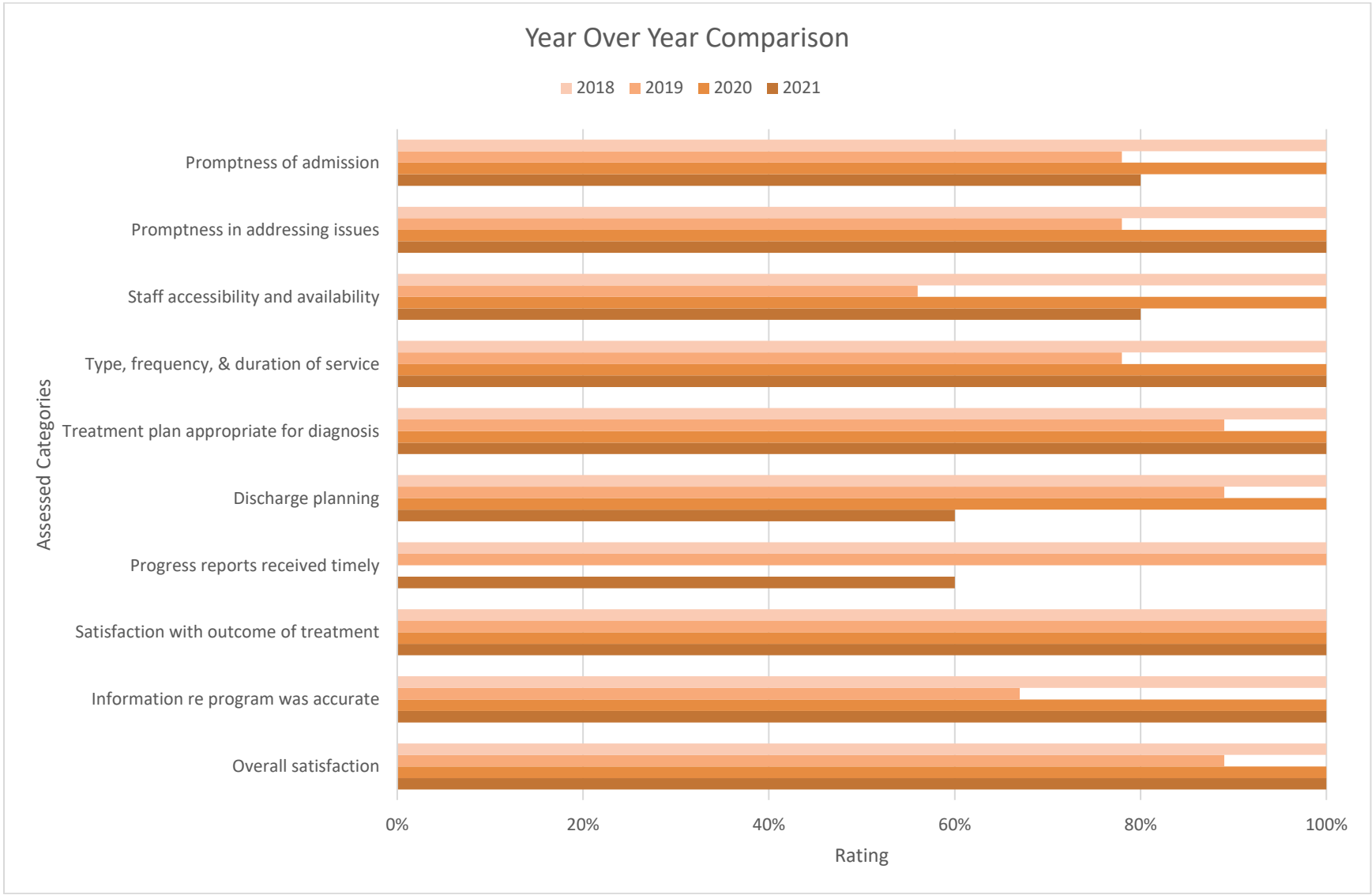
Benchmarking to be utilized is the historical data for the program. Targets established for the stakeholder input is at least 90% for the combined ratings of excellent and good. Overall, 2018 & 2020 met these targets. For 2021, the categories “Discharge planning” and “Progress reports received timely” were below this target. This was due to those who returned a completed stakeholder survey were those who do not usually receive progress reports or are involved in discharge planning – i.e., wheelchair vendor. These missed marks and some of those from 2020s were in part to those completing surveys selecting N/A which provides skewed results. If those were not taken into account, excellent would have been 100% for both of these categories.

The results from this fiscal year have been compared to our historical survey results. Data for "Excellent or Good" for the past four years are shown below.

Table 18
Stakeholder Satisfaction Survey Each Year

	Rating			
	2018	2019	2020	2021
Promptness of admission	100%	78%	100%	80%
Promptness in addressing issues	100%	78%	100%	100%
Staff accessibility and availability	100%	56%	100%	80%
Type, frequency, & duration of service	100%	78%	100%	100%
Treatment plan appropriate for diagnosis	100%	89%	100%	100%
Discharge planning	100%	89%	100%	60%
Progress reports received timely	100%	100%	0%	60%
Satisfaction with outcome of treatment	100%	100%	100%	100%
Information re program was accurate	100%	67%	100%	100%
Overall impressions of Center	100%	89%	100%	100%

Below is the chart showing the data comparison for years 2018, 2019, 2020, and 2021.



Action Plan

Results and tentative action plans were presented to staff for review and comment. The findings and suggested strategies will be presented to the Board of Directors at the next scheduled meeting. That plan is summarized in Table 19.

Responsibility for implementation and monitoring shall be that of the program directors. All action items will be immediately implemented upon Board review and approval.

Table 19
Analysis and Action Plan

Finding	Comment	Action
1. There has been a decline in stakeholder surveys received.	Stake holders do seem supportive of our services and strategy and have positive feedback overall.	Continue to monitor stakeholder perspectives and encourage their participation.

Program Improvement Plan

Finding	Analysis	Planning	Action
Staff noted that we are still experiencing the previously observed problem of incomplete referral information. Medical records have often not been received from referral sources on a timely basis prior to evaluations.	Incomplete referral information creating unnecessary delays in insurance precertification and scheduling. Prescription form was modified during reporting period to include request for pertinent records.	Will create a standard form to fax to referral sources upon receipt of any new referral without the requisite supporting documentation. Referral sources informed of needed records.	Marketing campaign to be started September 2021 that will include education on why records are needed.
Need for Spanish-speaking therapists.	In order to meet the diverse cultural needs of our patients, it would be helpful to have therapists who are conversationally fluent in Spanish.	Future postings to include desire for bilingual therapists.	Work with newly hired Human Resources Manager to develop recruitment plan.
Need to significantly increase number of referrals being made to the Medical Rehabilitation program.	Partnership with providers would significantly increase our ability to better serve the Greater Hartford community.	All therapy positions need to be filled in order to offer interdisciplinary treatment for patients.	Mailings to referral sources to provide education on the services we provide to start September 2021.
Booking of pediatric neuropsychological evaluations is late next year (2022).	Loss of one post doctoral fellow after only first year of program, second post-doctoral fellow not staying after program completed and licensed neuropsychologist departing.	Full time pediatric neuropsychologist needs to be secured.	Acceptance of new pediatric neuropsychology evaluation referrals has been placed on hold and will be reassessed February 2022.