JOINTS
Joint replacement Outcomes in IRFs and Nursing Treatment Sites

EXECUTIVE SUMMARY
Clinical Practice Team Meeting
October 25-26, 2005
Columbia, MD

MEETING PARTICIPANTS

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MEETING GOALS

1. Familiarize facility partners with the JOINTS project;
2. Review JOINTS project study design, site responsibilities, and timeline;
3. Continue work on point-of-care documentation forms to collect intervention data beyond what is documented in traditional documentation;
4. Begin to define JOINTS patient, process, and outcome variables to study.

JOINTS OVERVIEW [Meeting Notebook, Tab 1 (yellow) "JOINTS Overview" and Tab 2 (orange) "PBE/CPI"

The JOINTS study will conduct a full and open inquiry on the relative strengths of SNF and IRF rehabilitation for patients with hip or knee replacements and identify best practices in both settings. The study comes at a precipitous time given the stepwise enforcement of the 75% rule by the Centers for Medicare and Medicaid Services (CMS) and the desire of the rehabilitation industry to determine which joint replacement patients are served best in various settings of care.

We will employ a practice-based evidence (PBE) approach to achieve clinical practice improvement (CPI). Using this approach, we will collect detailed data about patient characteristics (including severity of illness and functional impairment) and the timing, intensity, frequency, and duration of rehabilitation therapies along with other processes of care that will allow us to uncover exemplary processes of care that can enhance the quality and efficiency of IRF and SNF care.

PBE is a type of observational cohort study that offers a naturalistic view of rehabilitation treatment by examining what actually happens in the care process, while not disrupting the natural milieu of the treatment setting. The PBI approach values the input of participating clinicians who become integral members of the Clinical Practice Team and are involved in all aspects of project implementation.

STUDY DESIGN DISCUSSIONS [Meeting Notebook Tab 3 (red) "Study Design"]

We reviewed the JOINTS study design, allowing meeting participants to contribute to clinical design decisions. See discussions below. A revised Study Design was distributed to all on Friday, October 28, 2005.

Facility Selection and IRB

Meeting participants agreed with the facility selection description in the meeting notebook. Each facility is proceeding with obtaining IRB approval per facility protocol and with the assistance of Matt Elrod at NRH. As soon as the NRH/Medstar IRB approves the project, the confirmation letter will be shared with all.

Patient Inclusion Criteria

Meeting participants agree we should differentiate between patient **enrollment** criteria and patient **inclusion criteria**. Enrollment criteria will be used at the point of admission to trigger use of point-of-care documentation forms. Study inclusion criteria will be used post patient discharge to include patients in the project database. Patients that meet enrollment criteria may not meet inclusion criteria.

Enrollment criteria:

All patients who meet the following criteria and admitted to a participating SNF or IRF after the yet-to-be defined start date of the enrollment period (anticipate Jan/Feb 2006) will be enrolled as a potential study patient:

- Age 21 years of age or older
- Received a hip and/or knee **replacement of any type for any reason**
- Admitted from **any source**

Points of clarification:

→ Include hip fracture patients
→ Include all replacements – total and partial
→ Include revisions
→ Include patients admitted from another IRF, SNF, or home
→ Do not include joint repairs (pinning, nailing)

Discussion reasoning:

→ We should include hip fracture patients because, that although the treatment of elective and trauma-induced joint replacement are different, we need to capture both to identify which population may be better served in a specific setting.
→ Including fracture patients will ensure we capture a picture of the frail elderly patient with multiple comorbidities that may be most difficult to treat. In many of these patients, replacement is preferred to joint repair in order to mobilize patient more quickly after surgery.
→ SNFs proportion of replacement post fracture at participating SNFs is 30->50%. If we do not include them, SNFs will not achieve the goal of 100-200 patients per site.
→ We will capture reasons for surgery, including revisions and type of replacement – full or partial
→ Including patients admitted from another IRF, SNF, or home will provide a picture of patients who may be better treated in one setting or another.
→ We are able to control for patient differences at the time of analysis.

Inclusion Criteria:
Patients are included in the study by the site data collector following patient discharge. Patients will be included in the study database if

- The above enrollment criteria are met
- Minimum rehabilitation length of stay (LOS) of 3 days
- Patient has a complete admission and discharge FIM

Point of clarification:

→ A 3-day minimum length of stay coincides with FIM guidelines. If the LOS is less than 3 days, there is no discharge FIM.
→ A patient's rehabilitation stay may be interrupted (to acute care or other setting), but if patient returns to participating facility, the patient remains in the study.

We will review enrollment and inclusion numbers periodically throughout the study period to ensure an adequate distribution of knee and hip patients. The Project Team will create an enrollment form to help track enrollment and inclusion of patients into the study. Larger participating facilities may be asked to include more than 200 patients if smaller facilities are unable to meet this projection.

SITE RESPONSIBILITIES AND COMPENSATION [Meeting Notebook, Tab 4 (blue) "Site Responsibilities"]
We reviewed site responsibilities, allowing meeting participants to ask questions of the project team. A revised Site Responsibility document was distributed to all on Friday, October 28, 2005.

The JOINTS project will pay $200 for each JOINTS study patient for whom data are submitted to the project database. Site responsibilities are listed below without further discussion because they were not edited (other than timeline revisions) based on meeting discussions.

1. Identify Clinical Practice Team Representative
2. Identify lead Therapists (PT and OT), nurse, and physician
3. Sign Study Participation and Limited License Agreement
4. Participate in Documentation Form Development and Training
5. Enroll patients into the project and maintain study log
6. Use Point-of-Care Documentation Forms
7. Provide IRF-PAI FIM data
8. Provide laptop computer
9. Hire/Assign a Data Collector
10. Data Collector:
    - 10a: Attend Training Session
    - 10b: Participate in Conference Calls
    - 10c: Collect Reliable Data for 200 Patients
11. Send Data to ISIS

TIMELINE [Meeting Notebook, Tab 7 (green) "Timeline"]

We reviewed the project timeline, and based on meeting discussions and the fact that we are still recruiting SNFs to participate, we moved clinician training for point-of-care documentation and FIM training (SNF) forward to January 2006. This means that patient enrollment will begin in February 2006. A revised Site Responsibility document was distributed to all on Friday, October 28, 2005.

DATA CAPTURE

All data will be obtained for the patient's medical record or from supplemental data sources that become part of the medical record or are made available to the data collector with the medical record at the time of chart data abstraction.

Point-of-Care Intervention Documentation Forms [Meeting Notebook, Tab 5 (teal) "Point of Care Documents"]
Clinicians will capture details about specific activities performed during patient treatment sessions/encounters beyond what is included in traditional documentation on point-of-care documentation forms; we believe this is essential to open the "black box" of rehabilitation care. The Project Team initiated forms for PT, OT, nursing, and physicians. Meeting participants, especially SNF participants, suggested we also include point-of-care documentation for speech therapists, who have an integral role in rehabilitation for SNF patients.

We formed work groups for each discipline; meeting participants self-selected a group to participate in. Revised forms, based on subgroup discussions, are attached to the same e-mail as this Summary. Deliberations in each workgroup are summarized:

Occupational and Physical Therapy: Both groups agreed that:

i. It would be advantageous to allow therapists to complete ONE form per day if the same therapist treats the patient for multiple sessions during that day. This could be accomplished by including the time of each session, however, we need to work out the details of how to account for different activity time periods within each session. If different therapists treat the patient in a single day, each therapist completes a separate form.

ii. We should not have aides complete documentation forms.

iii. We should include space to indicate payer changes, as therapists are most likely to know that a change has occurred. It may or may not be evident in the chart – will be included in the ADM. This applies primarily to SNFs.

iv. Include an example of how to complete the form on the form if room allows.

v. We need to begin work on definition of terms used on the forms.

vi. Add a column to indicate overlapping treatment with other patients.

vii. Add wound care as an activity.

viii. Each group refined respective activity and intervention code descriptions.

ix. Each group worked on optimizing form layout/format.

Nursing:

i. The draft nursing form used for generating discussion suggested capturing the frequency of components of nursing care that are not captured in traditional documentation, namely education and transfers (#times per shift).

ii. Discussions ranged from not capturing any nursing information that is not contained in traditional documentation to capturing number of minutes (estimated) spent on specific activites such as transferring and teaching by nurse provider type.

iii. Subcommittee members suggest we examine current documentation sources, such as treatment logs and bedside charting, and consider adding these components if not recorded currently.

iv. The coordination of care box at the top of the draft nursing form should be deleted.

v. Separation of reinforcement of therapy and non-therapy teachings is not reasonable. Combine these sections and eliminate any overlap.

vi. Change frequency reporting to 4 groups: 1-3 times, 4-6 times, 7-9 times, and >=10 times.

vii. Other activities to possibly add include interdisciplinary communication, cognitive prompting (cueing, orientation, memory, attention, and problem solving), discharge planning, and educational reinforcement about DVTs, Ted hose, hypertension management, and toileting.

Physician:

i. Subcommittee members added medication management, DVT prevention, dialysis, hydration, and pain management.

SLP:

i. SNF team members want to include SLP therapies because they believe their patients have cognitive deficits that greatly impact outcomes and are treated typically by SLP therapists.

ii. Subcommittee members reviewed the post-stroke SLP form and deleted interventions that did not apply to joint replacement patients. The format will be similar to the PT/OT forms.

IRF-PAI FIM data in SNFs
IT HealthTrack, a company that certifies IRF therapists in FIM documentation, will provide a training session for 1-2 representatives from each participating SNF. This training will be conducted immediately following the clinician training for point-of-care documentation form use. SNFs will receive additional compensation for providing FIM data.

Chart review data [Meeting Notebook, Tab 6 (green) "Chart review"]
All study variables (including point-of care and IRF-PAI FIM information) will be abstracted from study patients' medical records (may include a supplement of the extra forms that do not become part of the permanent record) following patient discharge and entered into the data collection software.

The Clinical Practice Team began its task of identifying and defining key patient, process, and outcome variables that will be contained in an auxiliary data module (ADM) in the CSI data collection software. We began this process by reviewing a draft ADM created by the Project Team and based on suggestions from the JOINTS Policy Advisory Panel and the stroke rehabilitation project. We will revise the ADM based on our discussions. It will be the focus of an upcoming conference call.

ANALYSIS PLAN
The ICOR team will perform all analyses, which will be directed by the PI, Co-PI, and members of the multi-disciplinary Clinical Practice Team. Clinical Practice Team members were invited (and encouraged) to look forward to participating in analyses and distribution of project findings. Our Project Team employs a very open and sharing approach to authorship on peer-reviewed papers and looks for assistance in presenting project findings at professional meetings. Clinical strengths of the Clinical Practice Team combined with analytic strengths of the NRH/ICOR Project Team will result in clinically meaningful, statistically sound data analyses.

PROJECT INFORMATION RESOURCES
All project information will be available in downloadable format on the JOINTS project website as a backup to regular project e-mail communications. The site will serve as the project's central document repository and as a portal to other project media such as FIM training videos. Meeting participants discussed various software options for site implementation, such as Blackboard and WebCT; however, the project plan is to keep the web site simple and accessible to all.