EDGE Taskforce Meeting
April 7 & 8, 2010
Minutes

Members participating: Beck Craik, Julie Fritz, Laura Gilchrist, Joe Godges, Andrew Guccione, Jay Irrgang, Caroline Jansen, Pam Levangie, Barb Norton, Jane Sullivan, Carolee Winstein, Steve Wolf, KMac McCulloch (via phone)
Staff attending (as able): Marc Goldstein, Dave Scalzetti, Ken Harwood, Mary Fran Delaune, Jan Reynolds
Chairing: Edee Field-Fote

APRIL 7TH, 2010

I. Welcome and review of mission
Guide the development of core sets of standardized outcome measures (within specific practice areas) to measure change resulting from PT intervention

II. Brief presentation: Planning for Change -- based on Grol R. Beliefs and evidence in changing clinical practice. BMJ. 1997; 315:418-421 (please find this article posted on the EDGE Taskforce page on the SOR website: (http://www.ptresearch.org/article.php?id=14))
   a. Changing clinical practice
      i. Various perspectives exist about the best approach to changing practice
      ii. Approaches are based more on beliefs than evidence
      iii. Implementing change usually requires planning and a combination of strategies
      iv. Obstacles to change must be identified before a strategy for change can be implemented
   b. Educational approach
      i. Driving force: internal striving for professional competence
      ii. Strategy: stimulate motivation
      iii. Intervention: small group interaction, individuals "own" the change
      iv. Advantage: links change to experiences of practitioners
   c. Epidemiological approach
      i. Driving force: assumes individuals make rational decisions based on evidence
      ii. Strategy: develop guidelines and strategies
      iii. Intervention: publications, presentations
      iv. Advantage: sound evidence-based guidelines save practitioner time
   d. Marketing approach
      i. Driving force: attractive message that meets the needs of the group
      ii. Strategy: use multiple channels to spread the message
      iii. Intervention: mass media, networks, personal interaction
      iv. Advantage: message can be adapted to target audience

e. Behavioral approach
    i. Driving force: classical conditioning, behavior modification, reward/punishment
    ii. Strategy: performance reviews, feedback, reminders
    iii. Intervention: incentives/sanctions
    iv. Advantage: familiar to practitioners as elements are already in place with some payors
f. Social interaction approach
    i. Driving force: people are influenced by the opinion of important people
    ii. Strategy: opinion leaders spread the message
    iii. Intervention: peer outreach, networking
    iv. Advantage: emphasizes professional communication , role models, peer support
g. Organizational approach
    i. Driving force: larger organization mandates change
    ii. Strategy: emphasize systematic change rather than rely on individuals
    iii. Intervention: create the conditions for change to occur
    iv. Advantage: expedited implementation
h. Coercive approach
    i. Driving force: pressure and control from outside source
    ii. Strategy: laws and regulations require compliance
    iii. Intervention: reimbursement tied to compliance
    iv. Advantage: outside pressure compels change of habits/routines

III. Review of progress to date
a. EDGE: Evaluation Database to Guide Effectiveness (first meeting CSM06)
b. Objective : to assist in identification of core sets of outcome measures to measure (across ICF domains) change due to intervention
c. Development, and subsequent refinement, of Outcome Measure Rating Form
d. CSM 2008 (Nashville) symposium: Learning from Babel
e. Identification of Section SIGs as target dissemination group (as opposed to Section Practice Chairs [1st selection] or Research Chairs [2nd selection])
f. Consideration (and rejection) of NIH Toolbox
g. Webpage on SOR website
h. Recurring themes:
    i. Consideration of what clinical endpoints to be captured will guide selection of OM
    ii. Core sets must be dynamic to allow use of better OMs that become available
    iii. Instructions must stress need to standardize test procedure

iv. Psychometric properties of an OM are specific to the group in which the OM was tested
v. Hooked on Evidence (HOE) clinical scenarios should recommend standardized OMs
vi. Update of Guide Catalog of Tests and Measures

IV. Update on on-line version of Catalog of Tests and Measures (Dave)

V. Update on standardization-related projects of Section representatives
a. Neurology Section (Jane)
i. Standardization of OMs included as a Strategic Planning goal
ii. Taskforce appointed to develop continuing education course to educate members about need to use standardized OMs
1. Select OMs to be included in Neurologic Practice Toolbox
a. Used modified version of EDGE OM rating form
b. Criteria established for inclusion of OMs in Toolbox
i. Sound psychometric properties
ii. Freely available
iii. Clinical utility (time to administer, used equipment commonly available)
2. Course based on patient scenarios
3. Measures represented each domain of ICF
4. Interactive format allowed participants to work thru barriers to implementation
5. Feedback from courses led to recognition of member request for recommendations about which OMs to use
iii. Member requests resulted in formation of a taskforce to identify core set of OMs.
1. Neuro OM Taskforce will begin with OMs for individuals with stroke
2. EDGE OM Rating form modified by 7-member Neuro OM Taskforce
3. OM selection process
a. Goal is to identify all OMs that evaluate a specific construct, then make recommendations about which OM to use for that construct
b. Two reviewers will come to consensus on rating of each OM, possible ratings:
i. This OM should be used by all
ii. This OM may be useful but there is limited evidence
iii. This OM does not have sufficient evidence for its use OR evidence suggests it should not be used

c. All 7 members of taskforce will vote on inclusion/exclusion of measure

b. Orthopedic Section (Joe)
    i. Clinical practice guidelines (CPGs)
        1. Developed in response to payor request for information about "what works?"
        2. CPGs formed around impairment-based classification
        3. 3 guidelines in place
        4. goal is to develop 4/year
    ii. Facilitates ability to evaluate *process* of care, and
        1. Identification of who is practicing according to CPG
        2. How outcomes differ among PTs who do vs don't follow CPG
    iii. Accepted on Guidelines.gov (CMS consults these guidelines for "what works")
        1. Guidelines.gov has a structured process for guideline development
        2. Only open-access OMs may be included in guidelines posted on Guidelines.gov
    iv. Published in JOSPT
    v. Process of CPG development/refinement
        1. Uses evidence where available
        2. Opinion of recognized leaders used when evidence is lacking
        3. Capitalized on energy of "young stars" under mentorship of recognized leaders
        4. Transparency of development process is critical
        5. Involve stakeholders in development
            a. Some states require MD involvement in CPG development for CPG to valid basis for reimbursement
        6. Refinement of the CPG facilitated by queries to database

c. Oncology Section (Laura)
    i. BOD recognized that current OMs placed too much emphasis impairment level
    ii. Team wrote a manuscript published in PTJ: *Measuring outcomes in oncology rehabilitation based on ICF model*
    iii. Laura charged with developing mechanism to identify OMs
    iv. Incentive provided by external pressure from clinical trial in pediatric oncology, PTs charged to submit function-related data
    v. RCTs are not as developed in adult oncology

d. Hand Rehabilitation Section (Caroline)

i. Opportunities exist to coordinate efforts with American Society of Hand Therapists
ii. An outdated manual of OMs for hand rehab exists
    1. Manual is heavily impairment oriented
iii. Hand function crosses many practice areas, therefore much potential for sharing of OMs exists

VI. OMs in the broader context of efforts at APTA (Ken)
a. Goal is for the PT Now portal to merge the Guide, HOE, Catalogue of Tests and Measures
b. Guide revision process
    i. First step is conversion to ICF language
c. National Outcomes Database (NOD)
    i. Issue: what is most efficient way to structure the NOD to incorporate a minimum data set
    ii. Without established OMs it is possible only to determine whether a particular pt outcome is an outlier from the norm…no determination can be made about whether the optimal outcome was achieved
    iii. Goal is to be able to provide information about the value of additional treatment in terms of outcome measures that the payor values

APRIL 8TH, 2010

VII. Challenges, Things to change, Things that worked
a. Neurology Section (Jane, KMac)
    i. Motivation: Focus on OMs is part of strat plan
    ii. Challenges:
        1. differences of opinion among group about what product should be
        2. Time load of volunteer time
    iii. What worked well:
        1. asking grassroots members what their needs were and barriers they faced
        2. Making format fluid and interactive
        3. EDGE outcome rating form provided structure
        4. Having participants identify the barriers in their own institution
b. Orthopedic Section (Joe, Jay): development of clinical practice guidelines
    i. Motivation: knowing that current state was unacceptable
    ii. Challenges:
        1. Being unsure at the start what the end product would be
        2. Volunteer time

3. Real barrier is what PT gets reimbursed for (Julie)
    a. This is the incentive of coercion
    b. Pay for performance now based on process
    c. But credibility of the CPGs will depend on outcomes

iii. Things that worked:
1. Process was grounded in a diagnostic classification
2. Having prior history of a develop classification scheme
3. Selecting experts to lead the process
4. Picking a target disorder for which there was agreement
5. Picking measures for which there is evidence that change makes a different
6. Sought feedback from members (CSM, on-line), reviewers, residency programs
7. Getting feedback via the publication process
8. Let industrious members of the younger generation pick up the charge
9. Included physicians in process (some state laws require MD be an author for it be considered for claims review)
10. Rating OMs based on green, yellow, red

c. Oncology (Laura)
i. Motivation
1. BOD recognized need
ii. Challenges:
1. Finding the right people to lead the charge
2. Multitude and diversity of diagnostic categories
3. Need to adhere to a language that would cross disciplines
iii. Things that worked:
1. Having a member with a strong interest in leading the effort
2. Having support from Oncology BOD

d. Hand Rehabilitation (Caroline)
i. Motivation
1. Current heavy focus on impairment-level measures is out of date
2. Recognized need to groom the next generation
ii. Challenges:
1. Complacency since there was an old guideline in place
2. Specialized nature of group)
3. Inter-professional society
4. Possibly lack of awareness of upper extremity activities outside of the section.
iii. Things that worked:
1. Partner society that has similar interests
2. Small, cohesive group
3. Funding may be available for small projects

4. Supportive BOD

e. Univ of Pittsburgh Health Systems (Jay)
    i. Categorization of pts is an important first step. Ex with stroke (non-ambulatory, ambulatory with assistive devices, independently ambulatory assisted) helps in identification of appropriate outcome measures
f. Ortho section database (Joe)
    i. includes a minimum data set that is defined by the clinical practice guidelines (CPGs), while PTs can select from among different OMs at this time, but there will likely be a narrowing of the options

VIII. Discussion of related efforts ongoing within APTA
a. PT Now Portal project (Jan Reynolds)
b. Taskforce on Clinical Practice Guidelines (Mary Fran)
    i. Steering Committee in place to select section reps
    ii. Section reps will be trained
c. NOD group is budgeted for 2 more meetings this year (Mary Fran)

IX. Discussion of important points to consider for selection of OMs to be included in core sets
a. Measurement must be at the level at which the patient is performing (Steve)
b. Start with the construct that needs to be measured (Andrew)
c. Classify the condition in terms of function, impairment, timing (FIT)
d. Bear in mind that the construct being measured is influenced by the FIT (Steve)
e. Important to have representation from all sections (Barb)
f. It is not necessary to have a codified process, but get people excited and let them take the process their own way (Andrew)

X. Strategies and mechanisms to guide SIGs
a. Desired outcomes
    i. core sets of preferred OMs specific to pt condition/classification (FIT)
    ii. Searchable database with selected measures wherein search limits can be defined
b. Short-term process
    i. Coordinate with Mary Fran to work with national outcomes database (NOD) group that has members representing most sections
    ii. Edee, Jane, and Joe or Jay to work with NOD group at next NOD meeting
    iii. NOD members to select from available HOE clinical condition scenarios in their respective practice areas
        1. give preference to conditions that:

a. are high volume/cost/profile OR,
b. have other external pressures that make it a priority (such as other related efforts or a volume of evidence exists)

iv. Use HOE clinical scenarios as patient cases around which to identify appropriate outcome measures
v. Identify the ICF domains/subdomains that are pertinent for selected scenario
vi. Within the impairment domain, identify the impairments that must be measured
vii. Identify candidate measures that address the domain
viii. Use EDGE OM rating form to rate candidate measures
ix. Rank measures as strong, fair, weak
x. Select "preferred" measures from among candidate measure based on overall strength
xi. Strength is based on items to be considered include psychometric properties, utility

c. Middle-term process
   i. Full EDGE group (with NOD Section reps) to meet as a larger group at CSM
   ii. Acquire Section sanctioning of respective OMs as "preferred" OMs
   iii. Have preferred OMs included in NOD
   iv. Disseminated process and results in a supplement of PTJ
   v. On Catalog of Tests and Measures searchable database identify selected OMs as "preferred"
   vi. Identify keywords to facilitate finding preferred OMs in search

d. Longer-term process – points to keep in mind
   i. Need to make the tie-in that capturing outcomes will ultimately improve payment (Mark)
   ii. Selection of OMs is part of the process of CPG development
      1. CPGs can become compulsory – eg hospital accreditation relies on following stroke CPGs (Carolee)
   iii. Selection of OM is driven by condition/classification, link with efforts of Dx Dialog group
   iv. Coordinate efforts of EDGE Taskforce, Taskforce on Clinical Practice Guidelines, and NOD group through Mary Fran
   v. If CONNECT was available free then the PT is constrained to the OMs that are included (Beck)
   vi. Include content about OMs in clinical instructor training
   vii. Draw on residency programs as early adopters

viii. Target the individuals in the sections who put together the entry level education criteria to lobby for education about OMs (Jody Gandy)
ix. Recruit young stars within the sections
x. Involve other stakeholders: ed boards, advisory panel
    1. PT administrative practice heads in academic medical centers need to be targeted (Andrew)
    2. Clinical instructor training needs to have content in OMs (Andrew)
    3. Education Section needs to be involved as the process of using standardized outcome measures needs to begin early on (Jane)

XI. Next steps
a. Coordinate with Mary Fran for 3 EDGE members to participate in next NOD meeting at APTA
b. Plan meeting of full EDGE Taskforce with new Section reps from NOD group at CSM 2011
c. Coordinate with Jane Sullivan to include EDGE content in planned CSM 2011 program