Medical Rehabilitation: Program Measurement & Management Report
Reporting Period: July 1, 2022 – June 30, 2023

Performance Measurement and Management Process

This quality framework focuses on integrating program functions while effectively engaging input from all stakeholders, including the persons served. It provides a logical, action-oriented approach to ensure that organizational purpose, planning, and activity result in the desired outcomes.

This analysis is based off a performance measurement and management plan that produces information an organization can act on to improve results for the persons served, other stakeholders, and the organization itself. The results of performance analysis are used to identify and implement data-driven actions to improve the quality of programs and services and to inform decision making.

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.

Age	Program	Organization
Age 0 – 3	4%	1%
Age 4 – 17	23%	25%
Age 18 – 59	47%	66%
Age 60 +	26%	8%

Based on the breakdown above, the average age of those served by the medical rehabilitation department is similar for age ranges 0 – 3 and 4-17 to the average age of those served by the entire organization. Ranges over the age of 18 (18 – 59 and 60+) change drastically from that of the entire organization.

Gender	Program	Organization
Male	57%	53%
Female	43%	47%
Other		

Based on the breakdown above, the gender of those served by the medical rehabilitation department is a similar percentage of those served by the entire organization.

Ethnicity	Program	Organization
Asian	5%	6%
First Nation/Aboriginal	-	-
Non-Hispanic African American	36%	18%
Non-Hispanic White	44%	61%
Hispanic/Latino	15%	16%
North American Indian and Alaska Native	-	1%
Native Hawaiian and Other Pacific Islander	-	2%
Multiple Ethnicity	-	-
Other	-	-

Based on the data above, the ethnicity of those served by the Medical Rehabilitation department is unlike the percentages of those served by the entire organization in the categories or Non-Hispanic African American and Non-Hispanic White.

Diagnoses of Persons Served

Below is the breakdown of diagnosis codes of the persons served during this reporting period for the Medical Rehabilitation department compared to the entire organization.

Code Range	Section Description	Program	Organization
A00-B99	Certain infectious and parasitic diseases	-	-
C00-D49	Neoplasms	-	-
D50-D89	Diseases of the blood and blood-forming organs and certain disorders involving the immune mechanism	-	-
E00-E89	Endocrine, nutritional, and metabolic diseases	0.91%	0.11%
F01-F99	Mental, Behavioral and Neurodevelopmental disorders	44.55%	77.99%
G00-G99	Diseases of the nervous system	10.00%	4.31%
H00-H59	Diseases of the eye and adnexa	-	0.22%
H60-H95	Diseases of the ear and mastoid process	-	-
I00-I99	Diseases of the circulatory system	9.09%	1.33%
J00-J99	Diseases of the respiratory system	-	-

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	14.55%	1.77%
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	2.73%	2.32%
R00-R99	Symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified	12.73%	6.97%
S00-T88	Injury, poisoning and certain other consequences of external causes	4.55%	1.44%
V00-Y99	External causes of morbidity	-	-
Z00-Z99	Factors influencing health status and contact with health services	0.91%	1.44%
		100%	100%

During this reporting period, the highest percentage of diagnosis codes for persons served falls under “Mental, Behavioral and Neurodevelopmental Disorders” at 44.55%, followed by “Diseases of the Musculoskeletal System & Connective Tissue” at 14.55%. Both are appropriate for a medical rehabilitation department that had all services – physical therapy, occupational therapy, and speech-language therapy - during this reporting period. The section description shows data that might seem to be inconsistent with the number of persons served within a medical rehabilitation department. Below, the categories are drilled down further to examine the classification breakdown of persons served.

Code Range	Section Description		Medical Rehabilitation	Entire Organization
A00-B99	**Certain infectious and parasitic diseases**		-	-
C00-D49	**Neoplasms**		-	-
D50-D89	**Diseases of the blood and blood-forming organs and certain disorders involving the immune mechanism**		-	-
E00-E89	**Endocrine, nutritional and metabolic diseases**		**0.91%**	**0.11%**
	E65-E68	Overweight, obesity and other hyperalimentation	0.91%	0.11%
F01-F99	**Mental, Behavioral and Neurodevelopmental disorders**		**44.55%**	**77.99%**
	F01-F09	Mental disorders due to known physiological conditions	-	1.33%
	F10-F19	Mental and behavioral disorders due to psychoactive substance use	-	0.55%
	F20-F29	Schizophrenia, schizotypal, delusional, and other non-mood psychotic disorders	-	4.87%
	F30-F39	Mood [affective] disorders	-	11.06%
	F40-F48	Anxiety, dissociative, stress-related, somatoform and other nonpsychotic mental disorders	0.91%	14.16%
	F50-F59	Behavioral syndromes associated with physiological disturbances and physical factors	-	0.11%
	F60-F69	Disorders of adult personality and behavior	-	0.55%
	F70-F79	Intellectual disabilities	2.73%	10.07%
	F80-F89	Pervasive and specific developmental disorders	36.36%	20.24%
	F90-F98	Behavioral and emotional disorders with onset usually occurring in childhood and adolescence	4.55%	15.04%
G00-G99	**Diseases of the nervous system**		**10.00%**	**4.31%**
	G10-G14	Systemic atrophies primarily affecting the central nervous system	1.82%	0.22%
	G20-G26	Extrapyramidal and movement disorders	0.91%	0.44%
	G30-G32	Other degenerative diseases of the nervous system	-	0.77%
	G35-G37	Demyelinating diseases of the central nervous system	1.82%	0.22%
	G40-G47	Episodic and paroxysmal disorders	0.91%	0.11%
	G80-G83	Cerebral palsy and other paralytic syndromes	4.55%	2.54%
H00-H59	**Diseases of the eye and adnexa**		**-**	**0.22%**

	H53-H54	Visual disturbances and blindness	-	0.22%
H60-H95	**Diseases of the ear and mastoid process**		**-**	**-**
I00-I99	**Diseases of the circulatory system**		**9.09%**	**1.33%**
	I30-I52	Other forms of heart disease	0.91%	0.11%
	I60-I69	Cerebrovascular diseases	8.18%	1.22%
J00-J99	**Diseases of the respiratory system**		**%**	**%**
	J30-J39	Other diseases of upper respiratory tract	%	%
	J40-J47	Chronic lower respiratory diseases	-	%
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**		**14.55%**	**1.77%**
	M15-M19	Osteoarthritis	0.91%	0.11%
	M20-M25	Other joint disorders	4.55%	0.55%
	M45-M49	Spondylopathies	0.91%	0.11%
	M50-M54	Other dorsopathies	3.64%	0.44%
	M60-M63	Disorders of muscles	2.73%	0.33%
	M70-M79	Other soft tissue disorders	1.82%	0.22%
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**		**2.73%**	**2.32%**
	Q00-Q07	Congenital malformations of the nervous system	0.91%	0.44%
	Q10-Q18	Congenital malformations of eye, ear, face and neck	-	0.22%
	Q65-Q79	Congenital malformations and deformations of the musculoskeletal system	-	0.11%
	Q80-Q89	Other congenital malformations	-	0.22%
	Q90-Q99	Chromosomal abnormalities, not elsewhere classified	1.82%	1.33%
R00-R99	**Symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified**		**12.73%**	**6.97%**

	R25-R29	Symptoms and signs involving the nervous and musculoskeletal systems	8.18%	1.11%
	R40-R46	Symptoms and signs involving cognition, perception, emotional state and behavior	1.82%	4.98%
	R47-R49	Symptoms and signs involving speech and voice	0.91%	0.22%
	R50-R69	General symptoms and signs	1.82%	0.66%
S00-T88	**Injury, poisoning and certain other consequences of external causes**		**4.55%**	**1.44%**
	S00-S09	Injuries to the head	1.82%	1.11%
	S60-S69	Injuries to the wrist, hand and fingers	2.73%	0.33%
V00-Y99	**External causes of morbidity**		**-**	**-**
Z00-Z99	**Factors influencing health status and contact with health services**		**0.91%**	**1.44%**
	Z00-Z13	Persons encountering health services for examinations	-	0.33%
	Z55-Z65	Persons with potential health hazards related to socioeconomic and psychosocial circumstances	-	0.77%
	Z68	Body mass index (BMI)	-	0.22%
	Z69-Z76	Persons encountering health services in other circumstances	0.91%	0.11%
			100%	100%

Plan Elements

In designing this plan, input has been received from the patient survey as well as conversations held with patients and caregivers. Input received from personnel occur during team and staff meetings. Input received from other stakeholders is by surveys and conversations held with referral sources and other stakeholders. This plan gives consideration to the characteristics of the persons served by using input from surveys as well as review of characteristics such as demographic and diagnostic data of persons served. The expected results are based on targets that have been set in accordance with organizational priorities.

Extenuating or influencing factors that may impact the results include patients and/or stakeholders not returning surveys (i.e. self-withdrawals, patients ending treatment before discharge), patients not adhering to their treatment plan, lacking desire to improve, and stakeholders too busy. The comparative data that is used for this process includes historical organizational data.

Measures that will be tracked at all the following time frames: at intake, at a predetermined point during service delivery, upon discharge, and a follow-up will be relevant from the Functional Assessment Measures which are gathered at initial evaluation, discharge, and follow-up. During initial evaluations, the projected discharge is also assessed. The Director of Rehabilitation Services is responsible for data collection. To ensure the data collected actually measures what is it intended to measure (validity), the Director sits in during randomly selected evaluations. Both the treating therapist and Director compare ratings to ensure they match. The rating scaled used is discussed in the Program Management Report.

To ensure the data is obtained in a consistent manner (reliability), documentation software requires selection of ratings at evaluation (evaluation and projected rating at time of discharge). For discharge notes, software requires selection of rating at discharge. Follow-up are conducted 90 days post discharge. To ensure the data obtained is complete, software requires selection of at least two functional measures. During initial evaluations, current and projected selections are required. A progress note allows for updating the functional measures. Therapists track patients on their caseload to ensure discharge notes are completed, thus having the discharge rating.

To ensure the data obtained is accurately coded, data entered by therapists is double-checked by Financial Case Manager prior to being billed out. The Director of Rehabilitation Services is responsible for data analysis. The Director is responsible for the development of performance improvement plans from this data and uses input from patient and stakeholder surveys. Results are communicated to persons served by posting in the building as well as to the website at the end of the fiscal year after data is compiled. Patient satisfaction results are also updated in the patient handbook. Results are communicated to staff as surveys are received, at team meetings to discuss new implementations, and also once the fiscal year's data is compiled. Results are communicated to other stakeholders by posting the results on the website and in the newsletter. The technology used to support implementation of this plan is Raintree, Excel, and Google Forms.

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 outpatient medical rehabilitation services, the primary therapist compiles an assessment of a patient's functional capacity on up to forty-nine 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 based on relevance to the types of patients served and therapeutic services provided by our therapists. Major areas and their respective functional capacities are summarized in Table 1 below.

Functional Capacity Measures

Major Area	Functional Capacities Measured		
1 Self-Care	A. Feeding B. Grooming C. Bathing	E. Dressing Lower Body D. Dressing Upper Body	F. Toileting G. Swallowing
2 Mobility-Transfers	A. Bed/Chair/Wheelchair B. Toilet	C. Tub or Shower D. Car	
3 Mobility-Locomotion	A. Wheelchair/Ambulation B. Walking	C. Stairs D. Community Mobility	
4 Communication	A. Comprehension/Auditory B. Comprehension/Reading C. Expression/Verbal D. Expression/Writing E. Reading	F. Writing G. Speech Intelligibility H. Speech Sound Production I. Functional Communication J. Social Pragmatics	K. Vocal Quality L. Vocabulary
5 Psychosocial-Adjustment	A. Social Interaction B. Emotional Status	C. Adjustment to Limitation D. Employability	
6 Cognitive Function	A. Problem Solving B. Memory	C. Orientation D. Attention	E. Safety Judgment F. Time Management
7 Orthopedic	A. Fine Motor Coordination B. Range of Motion	C. Strength D. Pain	E. Edema F. Gait
8 Community Re-Entry	A. Community Ambulation B. W/C Community Mobility	C. Communication D. Executive Function	E. Food Preparation F. Medical Management

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

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 developed with patient input for the functional capacities that will be addressed through therapy services. During this initial assessment, projections of functional capacity levels at discharge are also provided. These same functional capacities are measured at discharge and again at follow up.

Data is aggregated into the eight major functional areas to understand the impact of treatment we provide. In addition to outcomes, data is collected on units of treatment provided, service intensity, and costs. While the number of visits is usually externally controlled by way of authorizations from insurance carriers, we have an additional measure to examine treatment efficiency. As an assessment of comparative efficiency, a measure has been established for units of functional capacity gained per ten (10) visits of direct treatment. The intent of this measure is to have a proximate rate of gain which is independent of how many treatment sessions may be authorized by a third-party payor. During this reporting period all areas were assessed. The main functional deficit for patients seen during this reporting period was cognitive function and community re-entry.

Analysis

As the measurement domain of program effectiveness relates to the plan, the objectives include increase of independence level, and successfully completed treatment. To determine if an individual's independence level increased, three indicators were reviewed – change in self-care, as well as mobility as it relates to locomotion, and verbal expression from admission to discharge.

Effectiveness Objective	Indicator	Target	Result
Individual independence level increased	Selfcare f(x) level at discharge – Selfcare f(x) level at admission	Average increase in functioning will be at least 1.0 units	0.75
	Locomotion level at discharge – Locomotion level at admission	Average increase in functioning will be at least 1.0 units	1.10
	Expression/verbal at discharge – Expression/verbal at admission	Average increase in functioning will be at least 1.0 units	0.53

Indicator 1: Selfcare f(x) level is applied to all discharged patients for whom a self-care goal was set, regardless of basis for discharge. The target for self-care is an increase of at least 1.0 units. Patients were assessed in self-care based on their needs which included grooming and dressing upper/lower body. During this reporting period, self-care increased 0.75 – from the higher end of maximum assistance to the higher end of moderate assistance.

Indicator 2: Locomotion level is applied to all discharged patients for whom a locomotion goal was set, regardless of basis for discharge. The target for locomotion is an increase of at least 1.0 units. Patients were assessed in locomotion based on their needs which included walking and stairs. During this reporting period, locomotion increased 1.10.

Indicator 3: Expression/verbal level is applied to all discharged patients for whom an expression/verbal goal was set, regardless of basis for discharge. The target for expression/verbal is an increase of at least 1.0 units. During this reporting period, communication increased 0.53.

The second objective is if an individual successfully completed treatment. Records for patients seen during the reporting period were reviewed to determine this objective. For those seen, nineteen percent were seen for wheelchair and other durable medical equipment evaluations and did not receive treatment. Of the eighty-one percent seen for treatment, approximately forty-one percent were still active in treatment and therefore not included.

Effectiveness Objective	Indicator	Target	Result
Individual successfully completed treatment	% of functioning level goals achieved, with success defined as achieving at least 70% of the goals set at admission	At least 85% of discharged evidence the 70% level signifying successful treatment	42%
	% of patients that terminate treatment prior to goal achievement or maximum medical benefit	No more than 15% of discharged patients fall into this grouping	58%

Indicator 4: An indicator for this objective is achieving functioning level goals, with success defined as achieving at least 70% of the goals set at admission. This indicator is assessed on all discharged patients, regardless of basis for discharge. The target is at least 80%. During this reporting period, only 42% met at least 70% of the goals set at admission.

Indicator 5: The second indicator for this objective is patient termination of treatment prior to goal achievement or medical benefit. This indicator is assessed on all discharged patients, regardless of basis for discharge. The target is to be no more than 15%. This target was not met due to this reporting period yielding 58% of discharged patients terminating treatment prior to goal achievement or maximum medical benefit. Reasons for this target not being achieved include patients being compliant in order to move onto the next phase of their treatment (i.e. – patient's doctor or insurance requiring a trial of medical rehabilitation therapy, patients being content with minimal improvement). An example would be a patient who comes in for therapy but wants to get back to work as soon as possible; where the patient might not meet their original goal of lifting 30 pounds, but they are content with lifting 15 pounds.

As mentioned above, patients made gains in many areas assessed. The target for all major areas is an increase of at least 1.0 units. This target was successfully met on average. The average discharge was 4.07 and the average admission was 3.06 which results in a change of 1.01 units. Across the areas, patients were presenting at time of admission in the range of 2.00 to 4.45, reflecting a need for significant physical, organizational, and/or structural assistance. At the time of discharge, however, patients had made gains in the areas of self-care, mobility-locomotion, communication, cognitive function, orthopedic, and community re-entry. The magnitude of increase ranged from no increase in areas of mobility-transfers and psychosocial-adjustment, to a high of 2.50 for community re-entry.

Functional Outcomes for Patients

Major Area	Admission	Projected	Discharge	Difference	Follow-Up
1. Self-Care	2.88	5.38	3.63	0.75	4.00
2. Mobility - Transfers	3.50	5.00	3.50	0.00	3.00
3. Mobility - Locomotion	4.45	6.35	5.55	1.10	4.46
4. Communication	2.77	4.06	3.16	0.39	3.08
5. Psychosocial-Adjustment	3.33	6.33	3.33	0.00	0.00
6. Cognitive Function	2.56	5.44	3.89	1.33	5.00
7. Orthopedic	3.00	6.08	5.03	2.03	5.12
8. Community Re-Entry	2.00	7.00	4.50	2.50	5.00
Simple Average	3.06	5.71	4.07	1.01	3.71

Areas of comparative strength in terms of pre- vs. post-treatment change are Orthopedic, Cognitive Function, Community Re-Entry, and Mobility-Locomotion. The increase in these functions speaks to an increasing presence as a provider of interdisciplinary medical rehabilitation services in the community. While significant gains were made (i.e., average increase of 1.01), the data reviewed for each area shows gains fell short of projections.

Percent of Expected Increase Achieved

Major Area		% Increase Achieved
1.	Self-Care	30%
2.	Mobility-Transfers	0%
3.	Mobility-Locomotion	58%
4.	Communication	30%
5.	Psychosocial-Adjustment	0%
6.	Cognitive Function	46%
7.	Orthopedic	66%
8.	Community Re-Entry	50%

Benchmarking

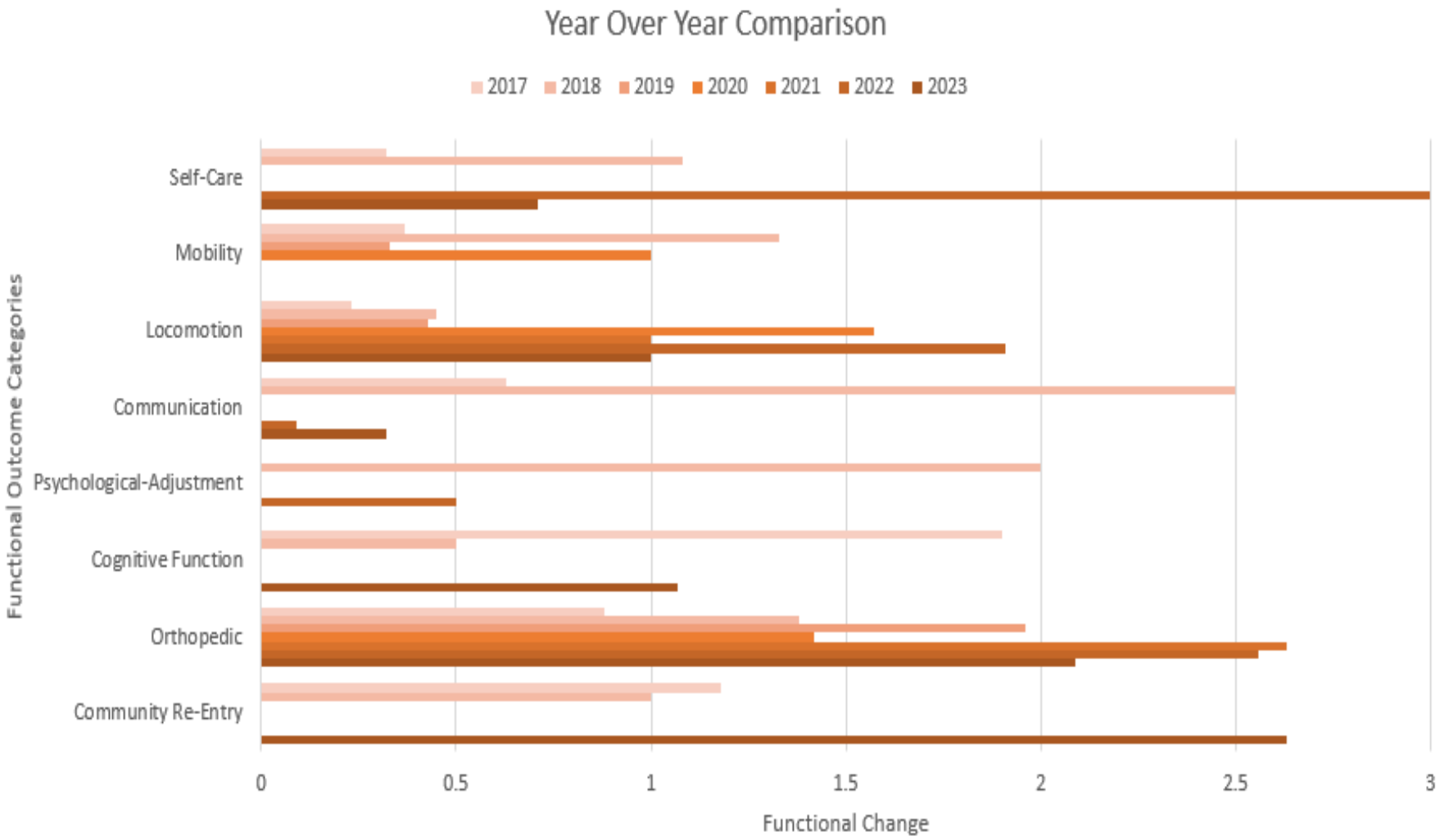
Below is the data from 2017 through the most recent year for functional outcomes for patients. For 2019 & 2020, only three major areas were assessed, with 2021 only having two major areas assessed. With the return of other medical rehabilitation services during the last quarter of calendar year 2021, 2022 saw seven of the eight areas assessed. During the current reporting period, all areas were assessed. This has not been done since 2018. By having each discipline for 2022 and 2023, with the reporting period ending June 2024, years 2017 through 2021 will be removed.

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 the major areas assessed, the average shows patients improved by at least one functional capacity rating level and in the case of Orthopedic, and Community Re-Entry. This shows services were effective, shows patients were getting one level closer to independence, and are in line with our mission "to lead the way to 100% equity, inclusion, and access for people with disabilities, families and communities by enriching education, enhancing health, expanding employment and elevating community."

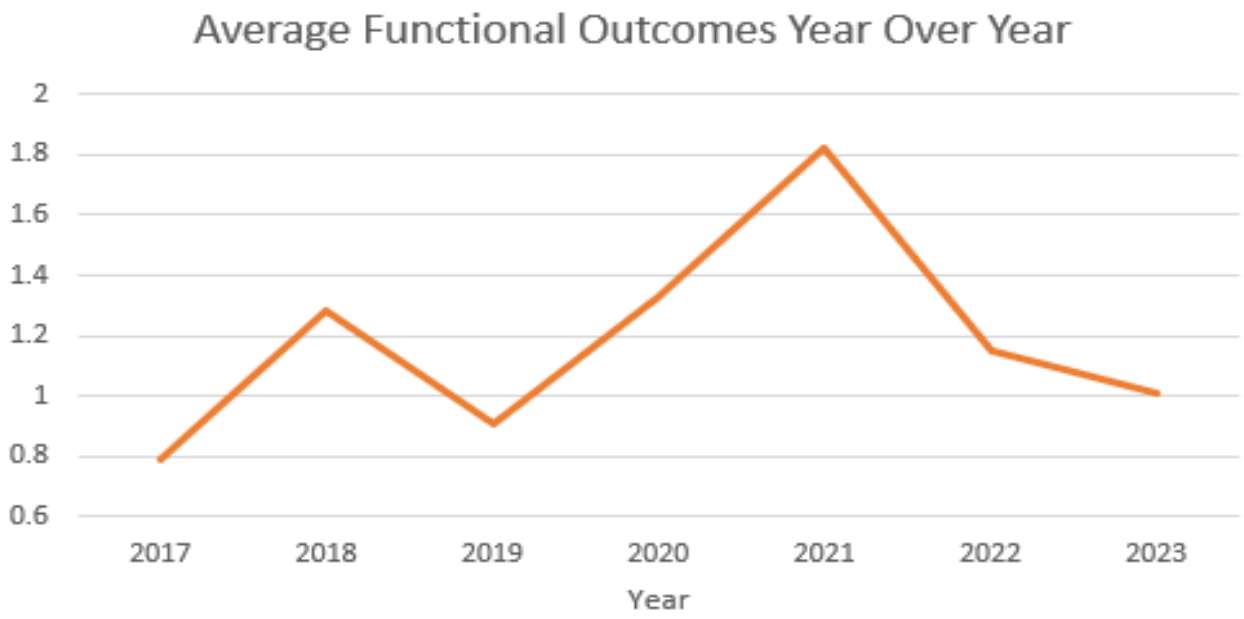
Functional Outcomes Each Year

Major Area	2017	2018	2019	2020	2021	2022	2023
1. Self-Care	0.32	1.08	-	-	-	3.00	0.75
2. Mobility	0.37	1.33	0.33	1.00	-	-	0.00
3. Locomotion	0.23	0.45	0.43	1.57	1.00	1.91	1.10
4. Communication	0.63	2.50	-	-	-	0.09	0.39
5. Psychosocial-Adjustment	-	2.00	-	-	-	0.50	0.00
6. Cognitive Function	1.90	0.50	-	-	-	0.00	1.33
7. Orthopedic	0.88	1.38	1.96	1.42	2.63	2.54	2.03
8. Community Re-Entry	1.18	1.00	-	-	-	0.00	2.50
Simple Average	0.79	1.28	0.91	1.33	1.82	1.15	1.01

The chart below shows a visual of the comparisons for year over year from 2017 through the most recent year, 2023. The current reporting period saw an increase in the areas of Communication, Cognitive Function, and Community Re-Entry over the previous reporting period.



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

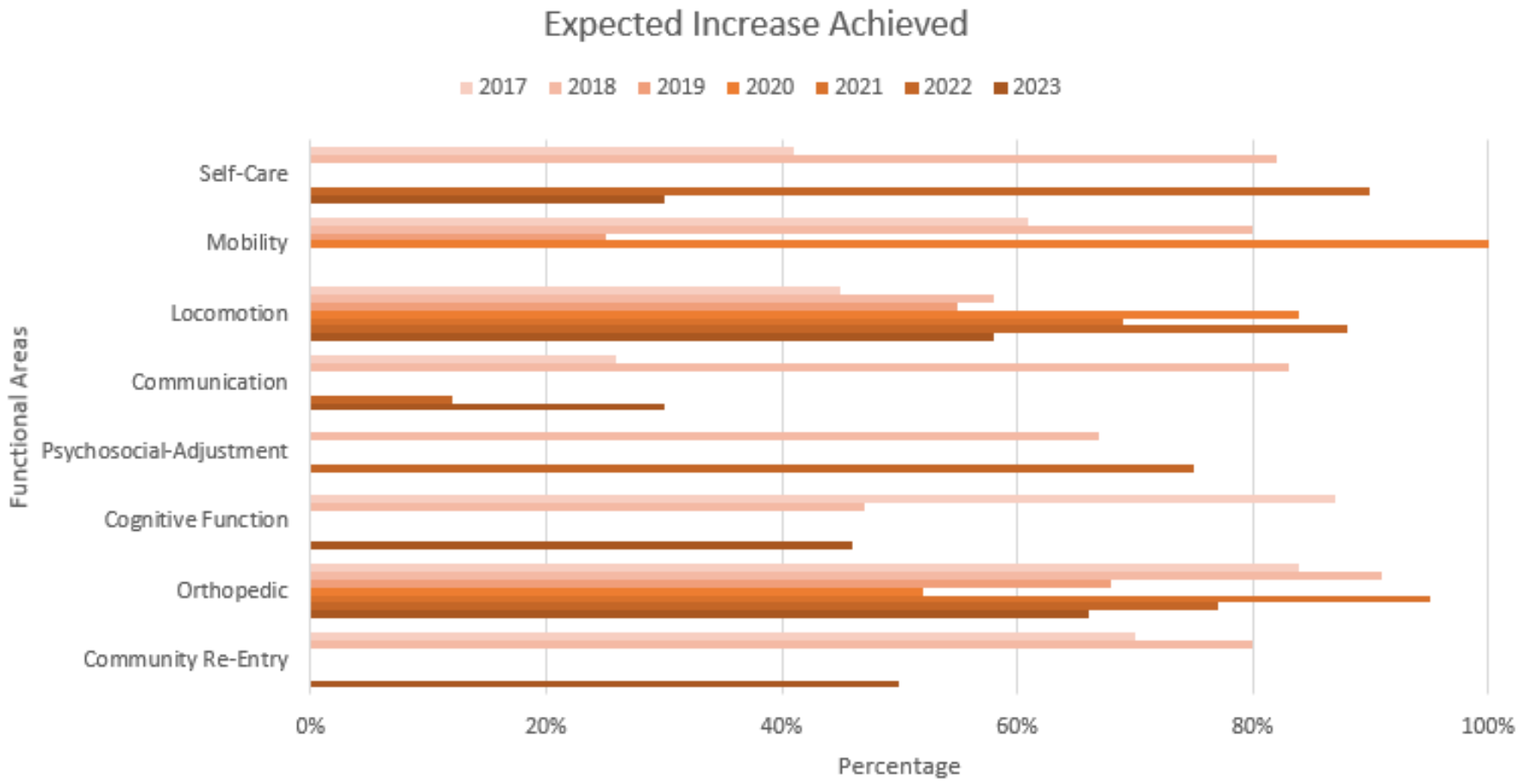


Below is the data from 2017 through the current reporting period ending June 30, 2023, which shows the percentage of expected increase achieved. The established target for each category is 75%. The areas of Communication, Cognitive Function, and Community Re-Entry improved during this reporting period and shows the projections in this category are closer to the rating the patient received at discharge from the program, while Orthopedic, Mobility-Locomotion, and Self-Care decreased.

Percentage of Expected Increase Achieved Each Year

Major Area	2017	2018	2019	2020	2021	2022	2023
1. Self-Care	41%	82%	N/A	N/A	N/A	90%	30%
2. Mobility	61%	80%	25%	100%	N/A	N/A	0%
3. Locomotion	45%	58%	55%	84%	69%	88%	58%
4. Communication	26%	83%	N/A	N/A	N/A	12%	30%
5. Psychosocial-Adjustment	N/A	67%	N/A	N/A	N/A	75%	0%
6. Cognitive Function	87%	47%	N/A	N/A	N/A	0%	46%
7. Orthopedic	84%	91%	68%	52%	95%	77%	66%
8. Community Re-Entry	70%	80%	N/A	N/A	N/A	0%	50%

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



Action Plan

The overall results evidence 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 the table 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.

	Finding	Action
1.	All of the eight areas were assessed, half of which met the target. Those that did not include self-care was 0.75 and communication was 0.39. Two remaining saw no increase/decrease.	Encourage scheduling after evaluation and follow-up sooner with those who drop off the schedule for an unknown reason.
2.	While communication saw an increase of 0.30 over the last reporting period, there is still difficulty with the rating scale when small gains are harder to identify.	The rating scale does not allow for gains less than 25% since the functional rating would remain the same. Rating scale to be created based off ASHA's ratings.

Satisfaction & Experience of the Persons Served Analysis

Survey Process and Findings

Patient satisfaction surveys were completed by patients, family members and/or caregivers at various points during their treatment process as well as 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 or caregivers. 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 target for formal complaints or grievances filed during this report period is < 1%.

As the measurement domain of satisfaction and experience of persons served in this program related to the plan, there are two objectives. The patient surveys are divided into two rating scales. The first eight questions have a rating scale of 1 (strongly disagree) to 5 (strongly agree) and not applicable. Questions nine through thirteen have a rating scale of 1 (poor) to 5 (excellent) and not applicable. These objectives are individuals indicating favorable impression of program provider – in this case Easterseals Capital Region & Eastern CT (also referenced as Easterseals in this report), and individuals indicate favorable impression of services received. The results of these data aggregations are presented in the table below.

Survey Response	Indicator	Target	Result
Successfully get a representative response rate from all surveys	To receive a target percentage of responses from Patient Surveys based on the total number of surveys sent.	At least 45% of all patient surveys will have a response.	6%

Responses were below target. Factors that influence the response can be those who drop out of treatment and do not engage with contact after. Having iPads available at the front desk for random survey participation should increase responses.

Satisfaction of Person Served Surveys Objective	Indicator	Target	Result
Individual indicates favorable impression of program provider (Easterseals)	% of individuals/best informant who rate the accuracy of program information as presented by staff, print, website with a score of 4 or higher (i.e., Good or Excellent) on the patient satisfaction survey.	At least 85% of respondents make a rating of 4 or higher for this survey item.	100%
	% of individuals/best informant who rate overall impressions of the Center with a score of 4 or higher (i.e., Good or Excellent) on the patient satisfaction survey.	At least 85% of respondents make a rating of 4 or higher for this survey item.	100%

Indicator 1: A 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 four or above on the patient satisfaction survey. This indicator is applied to all discharged respondents who completed the patient satisfaction survey. The target for this indicator is at least 85%. During this reporting period the level achieved was 100% rated as strongly agree.

Indicator 2: A favorable impression of program provider (Easterseals) is also determined by ratings overall impressions of the Center with a score of four or above on the patient satisfaction survey. This indicator is applied to all discharged respondents who completed the patient satisfaction survey. The target for this indicator is at least 85%. During this reporting period, the level achieved was 100% total – 43% excellent and 57% good.

Satisfaction of Person Served Surveys Objective	Indicator	Target	Result
Individual indicates favorable impression of services received	% of individuals/best informant who rate satisfaction with treatment outcome with a score of 4 or higher (i.e., Good or Excellent) on the patient satisfaction survey.	At least 85% of respondents make a rating of 4 or higher for this survey item.	100%
	% of individuals/best informant who rate staff consideration of their goals for therapy with a score of 4 or higher (i.e., Good or Excellent) on the patient satisfaction survey.	At least 85% of respondents make a rating of 4 or higher for this survey item.	100%

Indicator 3: A favorable impression of services provided is determined by ratings of satisfaction with treatment outcomes with a four or above on the patient satisfaction survey. This indicator is applied to all discharged respondents who completed the patient satisfaction survey. The target for this indicator is at least 85%. During this reporting period the level achieved was 100% total – 71% strongly agree and 29% agree.

Indicator 4: A favorable impression of services provided is also determined by ratings of staff considering the patient's goals for therapy with a score of four or above on the patient satisfaction survey. This indicator is applied to all discharged respondents who completed the patient satisfaction survey. The target for this indicator is at least 85%. During this reporting period the level achieved was 100% total – 71% strongly agree and 29% agree.

Benchmarking

Finding other CARF accredited CORFs that publish their results and are easily accessible continues 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 85% when combining strongly agree/excellent and agree/good ratings. Data for ratings strongly agree/excellent and agree/good ratings for the past six years as well as the results from this reporting period are listed below.

	Rating						
	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree	N/A	Strongly Agree or Agree
Promptness of admission	86%	14%	-	-	-	-	100%
Opportunity to participate in treatment planning	100%	-	-	-	-	-	100%
Appropriateness of frequency and duration	71%	29%	-	-	-	-	100%
Consideration of patient goals	71%	29%	-	-	-	-	100%
Promptness of issue resolution	71%	29%	-	-	-	-	100%
Opportunity to participate in discharge planning	67%	33%	-	-	-	-	100%

Satisfaction with treatment outcomes	71%	29%	-	-	-	-	100%
Accuracy of program information	100%	-	-	-	-	-	100%

	Rating						
	Excellent	Good	Neutral	Fair	Poor	N/A	Excellent or Good
How would you rate the services that were received	100%	-	-	-	-	-	100%
How would you rate the convenience of the location	100%	-	-	-	-	-	100%
Consideration of scheduling needs	86%	14%	-	-	-	-	100%
Staff was considerate of my culture and beliefs.	80%	-	-	-	-	20%	80%
Impression of the site.	43%	57%	-	-	-	-	100%

	Rating						
	2017	2018	2019	2020	2021	2022	2023
Promptness of admission	97%	98%	100%	100%	100%	92%	100%
Opportunity to participate in treatment planning	94%	100%	93%	92%	86%	100%	100%
Appropriateness of frequency and duration	94%	95%	100%	100%	86%	96%	100%
Consideration of patient goals	100%	98%	100%	92%	100%	96%	100%
Promptness of issue resolution	96%	81%	92%	85%	86%	100%	100%
Opportunity to participate in discharge planning	97%	86%	77%	77%	71%	92%	100%
Satisfaction with treatment outcomes	94%	90%	85%	92%	100%	80%	100%
Accuracy of program information	100%	90%	100%	100%	86%	96%	100%

All of the assessed categories have increased during this reporting period over the prior reporting period, thus all categories are over the established target of 85%.

It should be noted that the rating scale during this reporting period was modified to reflect more specified options. These include strongly agree, agree, neutral, disagree, and strongly disagree. There were also three new categories added to the survey which are designated by the (*) in the table below.

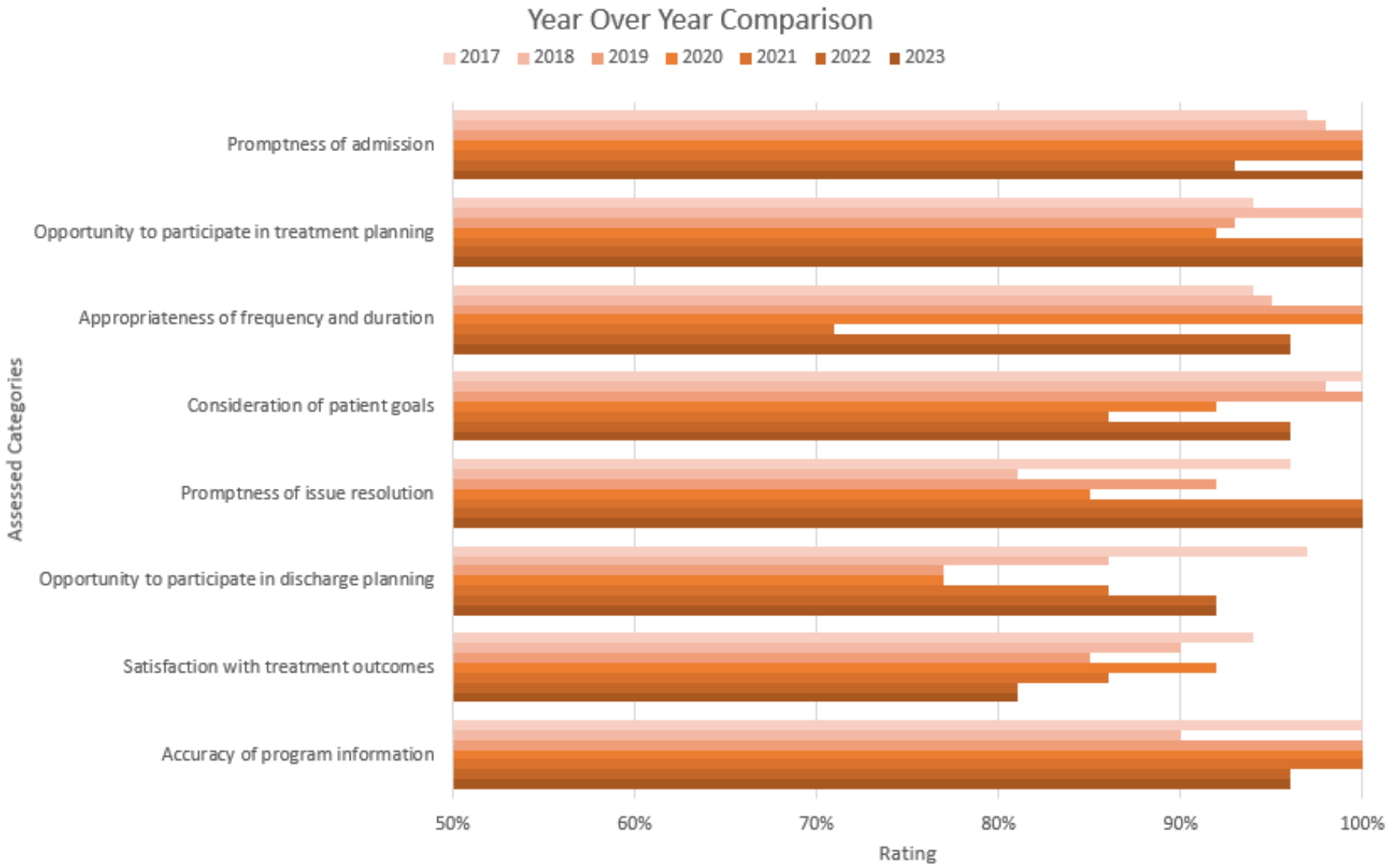
	Rating						
	2017	2018	2019	2020	2021	2022	2023
How would you rate the services that were received*	N/A	N/A	N/A	N/A	N/A	N/A	100%
How would you rate the convenience of the location*	N/A	N/A	N/A	N/A	N/A	N/A	100%
Consideration of scheduling needs	95%	100%	100%	92%	86%	100%	100%
Staff was considerate of my culture and beliefs*	N/A	N/A	N/A	N/A	N/A	N/A	80%
Impression of the site.	97%	91%	100%	100%	100%	96%	96%

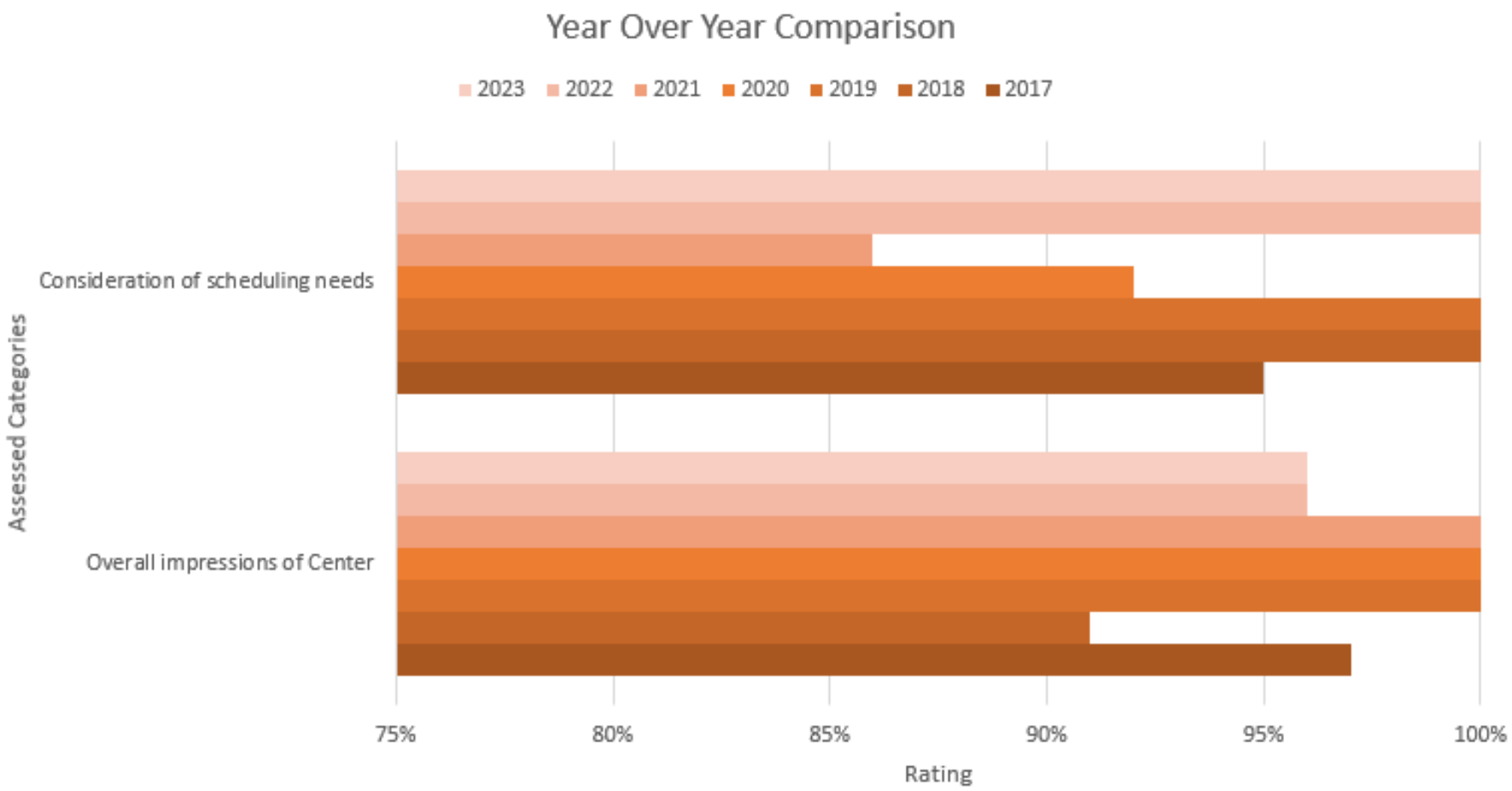
As was the case in 2022, this reporting period had respondents select N/A which provided different results. If the selection of N/A was absorbed into the other selections or excluded, the category would not have missed the 85% target. This category was "Staff was considerate of my culture and beliefs" where selecting N/A would be appropriate if culture and beliefs were not conveyed to staff as being something they should take into consideration.

The table below is a summary of written comments which provides additional insight and perspective to the patients' reported experience with us.

Summary of Written Comments
1. I would happily refer others.
2. Marta was wonderful! Appointments at 4-4:30 would have best fit our needs.
3. The question "On a scale of 1-10, how likely are you to recommend Easterseals Capital Region & Eastern CT to a friend or family member?" received an average of 9.25 out of 10.

The chart below provides a visual of the year over year comparison.




Year Over Year Comparison
2023
2022
2021
2020
2019
2018
2017
Assessed Categories
Consideration of scheduling needs
Overall impressions of Center
75%
80%
85%
90%
95%
100%
Rating

Results demonstrate 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 giving a rating of "excellent" (now also "strongly agree") was flagged for additional review and development of strategies to improve future performance. This reporting period had no items less than 50% of respondents selecting a rating of "excellent" or "strongly agree".

Additionally, any issue that was identified through the written comments were 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 the table below. The program manager will be responsible for implementation and monitoring of all strategic action items.

Action Plan

	Finding	Analysis	Action
1.	The completion rate continues to be lower than desired.	While the completion rate is lower than desired, it is still higher than it has been in many years.	Continue to encourage patients receiving treatment services to complete Patient Experience Surveys by having clipboards with surveys available in the lobby. Near the end of the fiscal year, iPads were setup to go directly to the surveys. These will be handed out randomly.
2.	Comment received: "Appointments at 4-4:30 would have best fit our needs."	Ages of patients have been trending toward school-age. Most parents have been requesting appointment times close to the end of the school day or after.	Providers have shifted their start and end times, as well as modify length of some patient appointments to allow for scheduling of more school-aged patients.

Satisfaction & Experience of the Stakeholders Analysis

Process

Stakeholder satisfaction surveys were completed by referral sources and other stakeholders at various points during the reporting period. Stakeholder satisfaction surveys are reviewed at the time of receipt resulting in the ability to rectify any potential issues timely. Stakeholder survey respondents were also invited to provide open-ended feedback regarding our program feedback which is listed below.

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.

Survey Response	Indicator	Target	Result
Successfully get a representative response rate from all surveys	To receive a target percentage of responses from stakeholders surveys based on the total number of surveys sent.	At least 30% of all stakeholder surveys will have a response.	4%

Responses were below target. Factors that influence the response can be those who do not have the time capabilities to complete the survey. Having electronic versions available should increase responses.

Satisfaction of Stakeholder Survey Objective	Indicator	Target	Result
External stakeholders indicate favorable program provider (Easterseals)	% of stakeholders who rate the accuracy of program information as presented by staff, print, website with a score of 4 or higher (i.e., Good or Excellent) on the stakeholder satisfaction survey.	At least 85% of respondents make a rating of 4 or higher for this survey item.	50%
	% of stakeholders who rate overall impressions of the Center with a score of 4 or higher (i.e., Strongly Agree or Agree) on the stakeholder satisfaction survey.	At least 85% of respondents make a rating of 4 or higher for this survey item.	100%

Indicator 1: 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 four or above on the stakeholder satisfaction survey. This indicator is assessed on all respondents who submit stakeholder satisfaction surveys. The target for this indicator is at least 85%. During this reporting period the level achieved was 50% total – 50% excellent and 50% as N/A.

Indicator 2: Favorable impressions of program provider (Easterseals) are also determined by ratings overall impressions of the Center with a score of four or above on the stakeholder satisfaction survey. This indicator is assessed on all respondents who submit stakeholder satisfaction surveys. The target for this indicator is at least 85%. During this reporting period, the level achieved was 100% total – 50% strongly agree and 50% agree.

Satisfaction of Stakeholder Survey Objective	Indicator	Target	Result
External stakeholders indicate favorable services provided	% of stakeholders who rate satisfaction with the patient outcomes with a score of 4 or higher (i.e., Good or Excellent) on stakeholder survey.	At least 85% of respondents make a rating of 4 or higher for this survey item.	100%
	% of stakeholders who rate intensity, frequency, and duration of treatment with a score of 4 or higher (i.e., Good or Excellent) on stakeholder survey.	At least 85% of respondents make a rating of 4 or higher for this survey item.	100%

Indicator 3: Favorable impressions of services provided are determined by ratings of satisfaction with treatment outcomes with a four or above on the stakeholder satisfaction survey. This indicator is assessed on all respondents who submit stakeholder satisfaction surveys. The target for this indicator is at least 85%. During this reporting period the level achieved was 100% strongly agree.

Indicator 4: Favorable impressions of services provided are also determined by ratings of intensity, frequency, and duration of treatment with a score of four or above on the stakeholder satisfaction survey. This indicator is assessed on all respondents who submit stakeholder satisfaction surveys. The target for this indicator is at least 85%. During this reporting period the level achieved was 100% total – 50% strongly agree and 50% agree.

Benchmarking

The historical data for the program will be utilized for benchmarking purposes. Targets established for the stakeholder input are at least 90% for the combined ratings of excellent and good. Overall, 2023 met these targets in all categories except "Discharge planning" and "Information regarding program was accurate" were below this target but only due to both categories having N/A as responses which provides skewed results. If those selections for "Discharge planning" and "Information regarding program was accurate" were not considered, strongly agree/excellent would have been 100% for both 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, as well as the current reporting period are shown below.

	Rating						
	Excellent	Good	Neutral	Fair	Poor	N/A	Strongly Agree or Agree
Satisfied with services provided*	50%	50%	-	-	-	-	100%
Information re program was accurate	50%	-	-	-	-	50%	50%
Staff available to answer questions*	-	-	-	-	-	100%	-

	Rating						
	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree	N/A	Strongly Agree or Agree
Promptness of admission	50%	50%	-	-	-	-	100%
Promptness in addressing issues	50%	50%	-	-	-	-	100%
Staff accessibility and availability	50%	50%	-	-	-	-	100%
Type, frequency, & duration of service	50%	50%	-	-	-	-	100%
Treatment plan appropriate for diagnosis	50%	50%	-	-	-	-	100%
Discharge planning	50%	-	-	-	-	50%	50%
Progress reports received timely	100%	-	-	-	-	-	100%
Satisfaction with outcome of treatment	100%	-	-	-	-	-	100%
Overall impressions of Center	50%	50%	-	-	-	-	100%

Key interpretive findings are as follows:

1. The data strongly suggests overall satisfaction with Center services evidenced by 100% of all respondents indicating “Strongly Agree” or “Agree” for 77.78% of the categories.
2. Stakeholders selected 10 (extremely likely) for recommending us to a colleague, friend, and/or family.
3. One stakeholder completing the survey mentioned they have been familiar with Easterseals over the years.

Stakeholder survey respondents were also invited to provide open-ended feedback regarding our program feedback which is listed below.

Summary of Written Comments

1. Great to treat complicated patients with a team approach.

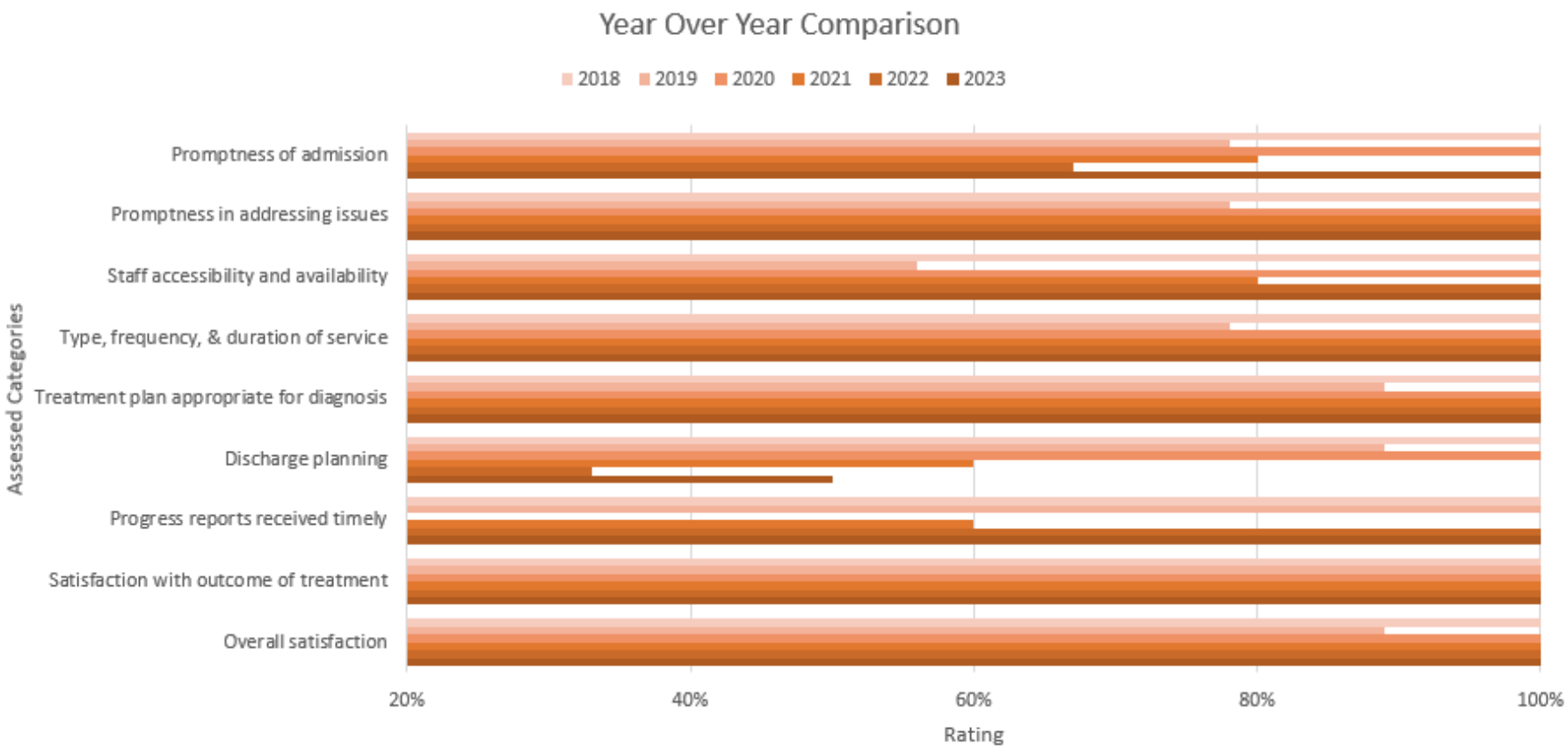
Stakeholder Satisfaction Survey Each Year

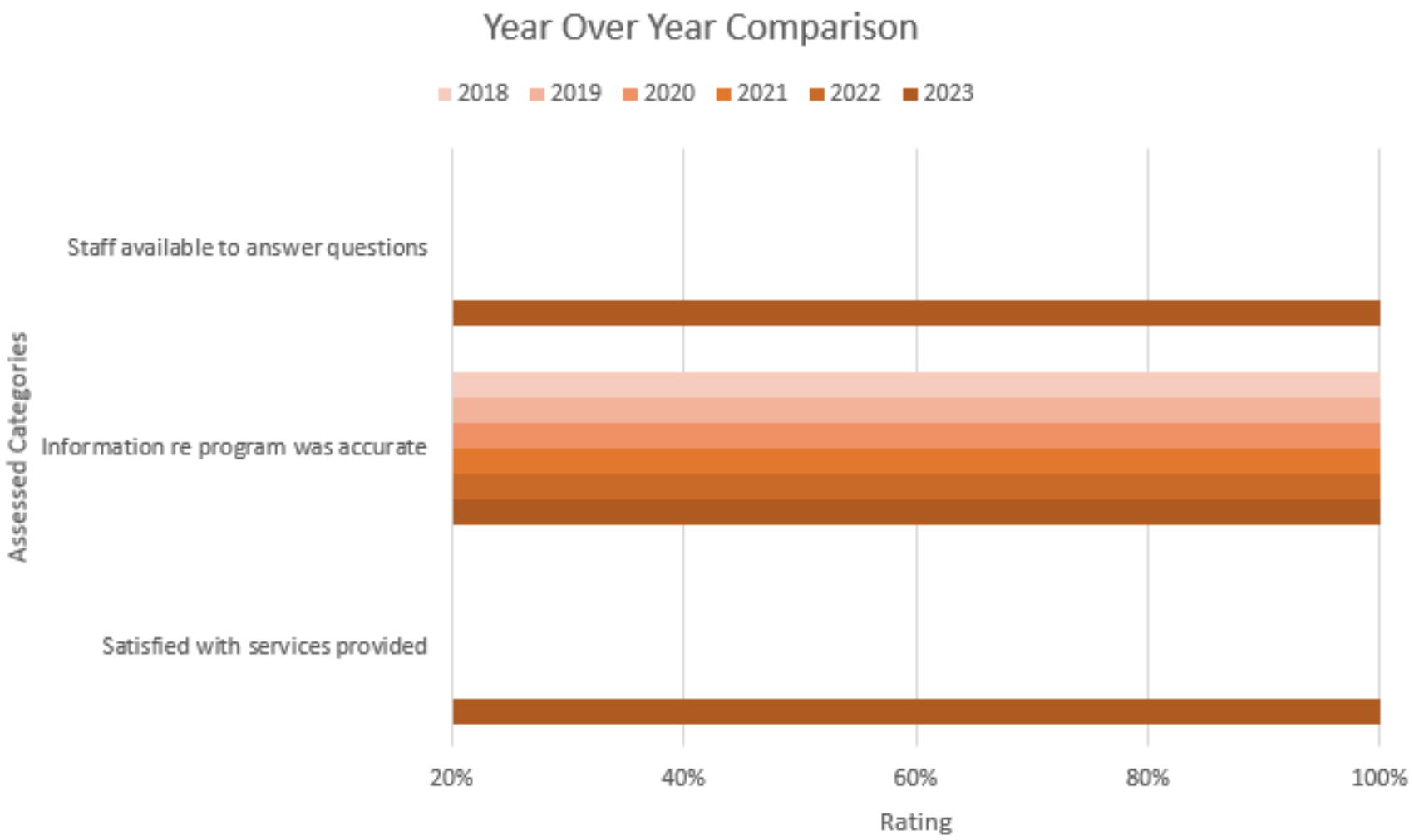
	Rating					
	2018	2019	2020	2021	2022	2023
Promptness of admission	100%	78%	100%	80%	67%	100%
Promptness in addressing issues	100%	78%	100%	100%	100%	100%
Staff accessibility and availability	100%	56%	100%	80%	100%	100%

Type, frequency, & duration of service	100%	78%	100%	100%	100%	100%
Treatment plan appropriate for diagnosis	100%	89%	100%	100%	100%	100%
Discharge planning	100%	89%	100%	60%	33%	50%
Progress reports received timely	100%	100%	0%	60%	100%	100%
Satisfaction with outcome of treatment	100%	100%	100%	100%	100%	100%
Overall impressions of Center	100%	89%	100%	100%	100%	100%

	Rating					
	2018	2019	2020	2021	2022	2023
Satisfied with services provided	N/A	N/A	N/A	N/A	N/A	100%
Information re program was accurate	100%	67%	100%	100%	66%	50%
Staff available to answer questions	N/A	N/A	N/A	N/A	N/A	100%

Below is the chart showing the data comparison for years 2018 through 2022, and the current reporting period.




Year Over Year Comparison
2018
2019
2020
2021
2022
2023
Staff available to answer questions
Information re program was accurate
Satisfied with services provided
Assessed Categories
20%
40%
60%
80%
100%
Rating

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 the table below.

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

	Finding	Comment	Action
1.	The number of stakeholder surveys completed were below the target.	Stakeholders do seem supportive of our services and have positive feedback overall but do not convey this via stakeholder surveys.	Send stakeholder surveys out more often (i.e. quarterly) – including to community partners. Determine feasibility of auto sending surveys.
2.	"Discharge planning" only achieved 50% strongly agree.	This percentage is due to other respondents selecting N/A. Those making this selection for this statement would be those stakeholders who referred for a DME evaluation. There are usually no subsequent appointments for treatment.	Investigate referral sources' interest of being brought into DME evaluation process.
3.	"Information regarding program was accurate" only rated at 50% excellent.	This percentage is due to other respondents selecting N/A. Those making this selection for this statement would be those stakeholders who are familiar with our services and have referred over the years, meaning they would not seek out programmatic information.	Review information related to programs to ensure it is up to date. Send material out regularly (i.e., semi-annually).

Program Efficiency Summary & Analysis

Process

To assess program efficiency, the table Functional Outcomes for Patients - is included below for easier reference. As the measurement of efficiency relates to the plan, there are two main 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 billable/reimbursable services.

Functional Outcomes for Patients

Major Area	Admission	Projected	Discharge	Difference	Follow-Up
1. Self-Care	2.88	5.38	3.63	0.75	4.00
2. Mobility - Transfers	3.50	5.00	3.50	0.00	3.00
3. Mobility - Locomotion	4.45	6.35	5.55	1.10	4.46
4. Communication	2.77	4.06	3.16	0.39	3.08
5. Psychosocial-Adjustment	3.33	6.33	3.33	0.00	0.00
6. Cognitive Function	2.56	5.44	3.89	1.33	5.00
7. Orthopedic	3.00	6.08	5.03	2.03	5.12
8. Community Re-Entry	2.00	7.00	4.50	2.50	5.00
Simple Average	3.06	5.71	4.07	1.01	3.71

The first objective - patient gains in treatment reflect efficient use of treatment sessions - is determined by the change in functional gain in self-care per 10 treatment visits.

Efficiency Objective	**Indicator**	**Target**	**Result**
Patient gains in treatment reflect an efficient use of treatment sessions.	Change in functional gain (discharge vs. admission) in the area of self-care per 10 treatment visits	Average increase in self-care functioning per 10 visits will be at least 0.50 units.	0.71
	Change in functional gain (discharge vs. admission) in the area of locomotion per 10 treatment visits	Average increase in locomotion per 10 visits will be at least 0.50 units.	1.00
	Change in functional gain (discharge vs. admission) in the area of expresssion/verbal per 10 treatment visits	Average increase in expression/verbal per 10 visits will be at least 0.50 units	0.35

Indicator 1: For this indicator - the average increase in self-care functioning per 10 visits - has a target of at least 0.50 units. This indicator is assessed on all discharged patients for whom a self-care goal was set, regardless of basis for discharge. During this reporting period, patients who were assessed for self-care saw gains of 0.71 per 10 units, which met the target.

Indicator 2: For this indicator - the average increase in locomotion functioning per 10 visits – has a target of at least 0.50 units. This indicator is assessed on all discharged patients for whom a locomotion goal was set, regardless of basis for discharge. During this reporting period, the average increase in locomotion per 10 visits was 1.00 units, which met the target.

Indicator 3: For this indicator - the average increase in expression/verbal functioning per 10 visits – has a target of at least 0.50 units. This indicator is assessed on all discharged patients for whom

an expression/verbal goal was set, regardless of basis for discharge. During this reporting period, the average increase in expression/verbal per 10 visits was 0.35 units, which did not meet the target.

Additional Treatment Efficiency Results

Comparing treatment efficiency (i.e., gains per 10 hours of treatment) across the assessed functional domains, we see that greatest gains were made for community re-entry, wherein a lower number of visits coupled with gains resulted in a rate about one-half unit the rate seen for mobility-locomotion and orthopedic. 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 gains per 10 visits, ranging from 0.32 – 2.63, were seen in the areas of Self-Care, Mobility-Locomotion, Communication, Cognitive Function, and Community Re-Entry suggests that continuing gains were made throughout the average visits shown.

Treatment Efficiency

Major Area	Net Gain	Visits	Gains Per 10 Visits
1. Self-Care	0.75	10.50	0.71
2. Mobility-Transfers	0.00	2.50	0.00
3. Mobility-Locomotion	1.10	11.05	1.00
4. Communication	0.39	12.19	0.32
5. Psychosocial-Adjustment	0.00	1.67	0.00
6. Cognitive Function	1.33	12.40	1.07
7. Orthopedic	2.03	9.73	2.09
8. Community Re-Entry	2.50	9.50	2.63
Simple Average	1.01	8.69	0.98

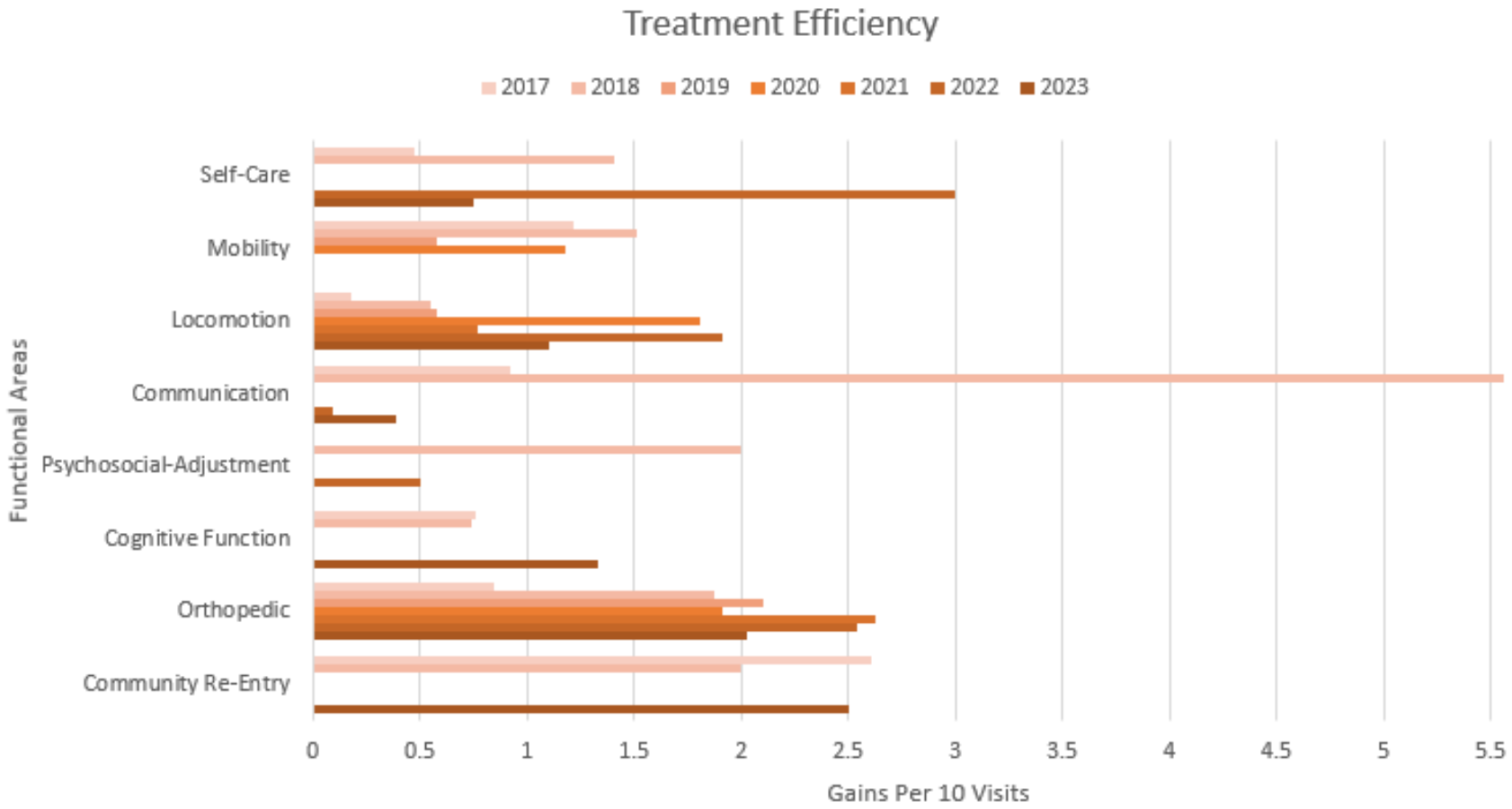
Benchmarking

The following data is from 2017 through 2022, as well as this reporting period 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, 2023 showed a significant increase in treatment efficiency over 2022 in the category of cognitive function, whereas the other areas showed declines. 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 those reporting periods. The data from 2017 & 2018 are included for reference since those were the last two years where most of the functional areas were assessed. This reporting period continued to have regularly scheduled staff for physical therapy, occupational therapy, speech-language pathology, and social work. By including data from 2017 & 2018, it provides better comparison for this reporting period. This will be the last report to include years 2017 through 2021.

Treatment Efficiency Each Year

Major Area	2017	2018	2019	2020	2021	2022	2023
1. Self-Care	0.47	1.41	-	-	-	1.71	0.71
2. Mobility	1.22	1.51	0.58	1.18	-	N/A	0.00
3. Locomotion	0.18	0.55	0.58	1.81	0.77	2.46	1.00
4. Communication	0.92	5.56	-	-	-	3.60	0.32
5. Psychosocial-Adjustment	-	2.00	-	-	-	0.74	0.00
6. Cognitive Function	0.76	0.74	-	-	-	0.00	1.07
7. Orthopedic	0.85	1.87	2.10	1.91	2.63	2.56	2.09
8. Community Re-Entry	2.61	2.00	-	-	-	0.00	2.63
Simple Average	1.00	1.96	1.09	1.63	1.70	2.21	0.98

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



The second objective - staff maximizing the amount of time spent each workday engaged in billable/reimbursable services will be measured by hours of billed services divided by total hours clocked in.

Efficiency Objective	Indicator	Target	Result
Staff will maximize the amount of time spent each work day engaged in billed/reimbursed services.	Hours of billed services divided by total hours clocked in (i.e., excluding vacation, sick, holiday time)	At least 75% of hours worked during year were billed hours.	29.73%
	Percent of dollar amount of billed services that, 12 months after billing, are still not collected or written off as uncollectible.	At least 90% of amounts billed during the FY '22 target period have been collected within 12 months of billing	100%

Indicator 4: The target for this indicator will be 80% of hours worked during the year were billable hours. This indicator is assessed on each treating employee. During this reporting period only 29.73% of total worked hours was billable. This is an increase over the prior reporting period that had only 16.96% of total hours billable. While the number does not increase enough to meet the target, by adding in what would have been billable time for cancellations and no-shows, the percentage would increase to 37%.

Indicator 5: Another indicator of this objective is the percentage of billed services that are not collected or written off as uncollectible 12 months after billing. This indicator is assessed on all therapists who had billings during the period of 7/1/21 through 6/30/22, allowing 12 months for collection or write-off. 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 100.00% was processed and/or collected with 0% still outstanding. These numbers are due to a concerted effort to clear up prior fiscal year claims.

On a related note, it was observed that patients received an average of 8.5 treatment visits. This translates into slightly more than one visit every other week over the course of an average 16-week length of attachment. Direct care costs for this service totaled $917.90 per patient.

Action Plan

	Finding	Action
1.	In reviewing the outcomes, two categories did not have many patients assessed during this reporting period.	It was noted that the patients assessed in these areas stopped attending appointments and/or scheduling future appointments well before any measurable gains were realized. Contact to be made to patients who dropped off the schedule.

2. Total worked hours that were billable were considerably lower than the target set; however, did increase ~13% over the prior reporting period.	Continue to work with providers to find new ways to market that will in turn increase the total worked hours that are billable.

Service Access Summary & Analysis

Process

Patient satisfaction surveys are provided to patients, families, and/or their caregivers to complete and return. Promptness of admission and consideration of scheduling needs are two areas respondents can provide feedback as they relate to service access. 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.

Service Access Objective	Indicator	Target	Result
Successfully getting an appointment in a timely manner	Number of business days from receipt of referral to successful patient outreach contact (i.e., speak on phone; not just voice mail)	At least 90% of referrals successfully contacted within two business days of referral	55%
	Number of days from successful patient outreach contact to first scheduled visit.	At least 90% of successful contacts will have a first visit scheduled for no more than seven days from that contact.	67%

Indicator 1: 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). This indicator is assessed on staff who handle admissions. 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 55% were contacted within two business days from receipt of referral. This rating decreased from the previous reporting period of 76%.

Indicator 2: Successfully getting an appointment in a timely manner is also determined by the number of business days from successful patient outreach to first scheduled visit. The indicator is assessed on all patients admitted to the program. 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 said contact. During this reporting period, the target was not achieved due to a rating of 67%; however, this rating increased significantly over the previous reporting period of 24%.

Additional Service Access Results

Service Access Averages

Process Points	Average Business Days
Business Days from Referral Received to Processed	1.51
Business Days from Referral Received to First Attempt to Contact	3.00
Business Days from Referral Received to First Successful Contact	5.80
Business Days from Referral Received to First Appt Date	12.45
Business Days from First Successful Contact to First Appt Date	6.65

The above results include a case that involved the referring providers sending over referrals, but patients delayed getting in contact with us to schedule. If the outlier is removed, the averages are a little more reasonable as can be seen below. Unfortunately, when removing the outlier, the target for the indicator of at least 90% of successful contacts will have a first visit scheduled for no more than seven days from that contact was still not met; however, it came close at 86%.

Process Points	Average Business Days
Business Days from Referral Received to Processed	0.97
Business Days from Referral Received to First Attempt to Contact	1.52
Business Days from Referral Received to First Successful Contact	2.00
Business Days from Referral Received to First Appt Date	6.90
Business Days from First Successful Contact to First Appt Date	4.90

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 roughly 2.00 days less than the target at 4.90 business days. The average number of business days from referral received to first successful contact is 2.00. This is also the same number for this indicator: the target is two days for 90% of referrals. Unfortunately, that percentage was not met during this reporting period as only 74% of the patients were contacted at or below 2 days.

	Rating						
	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree	N/A	Strongly Agree or Agree
Promptness of admission	86%	14%	-	-	-	-	100%

	Rating						
	2017	2018	2019	2020	2021	2022	2023
Promptness of admission	97%	98%	100%	100%	100%	92%	100%

The second objective – service hours and locations will be convenient and timely is measured by survey responses relating to needs being considered when scheduling appointments as well as the number of patients on a waiting list each day.

Service Access Objective	Indicator	Target	Result
Service hours and locations will be convenient and timely	% of individuals/best informant who rate satisfaction with their needs being considered when scheduling appointments with a score of 4 or higher (i.e., Good or Excellent) on the patient satisfaction survey.	At least 85% of respondents make a rating of 4 or higher for this survey item.	100%
	Number of patients on a waiting list each day.	The number of days with a waiting list of one or more patients will be less than 2% of operating days.	0%

Indicator 3: Service hours and locations will be convenient and timely as determined by the rating of satisfaction with their needs being considered when scheduling appointments with a score of four or above on the patient satisfaction survey. This indicator is assessed on all discharged patients, regardless of the basis for discharge. The target for this indicator is at least 85%. During this reporting period the level achieved was 100% total – 86% excellent and 14% good.

Indicator 4: Whether service hours and locations will be convenient and timely is also determined by the number of patients on a waiting list each day. This indicator is assessed on all referrals. The target for this indicator is the average 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 operating day was 0%.

	Rating						
	Excellent	Good	Neutral	Fair	Poor	N/A	Excellent or Good
Consideration of scheduling needs	86%	14%	-	-		-	100%

	Rating						
	2017	2018	2019	2020	2021	2022	2023
Consideration of scheduling needs	95%	100%	100%	92%	100%	100%	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 was not. Unfortunately, this means there is little historical data to compare the numbers from prior reporting periods. The previous reporting period did include this data, so it is available for comparison purposes.

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.	By reviewing the referral and scheduling data, it was determined that it takes on average 6.65 business days from first successful contact to first appointment.	Ongoing – with the impending departure of our physical therapist, we have been actively looking for a replacement physical therapist with more availability as well as finding a qualified PTA to add additional availability for patients.

Program Improvement Plan

Finding	Analysis	Planning	Target Date
While the frequency has decreased, medical records have not been received from referral sources on a timely basis prior to evaluations.	Prescription form was modified during reporting period to include request for pertinent records.	Referral sources informed of needed records via phone. This also allows for mentioning other services we offer. Continue to mention the importance at each point of contact with referral sources and their office staff.	Will automate correspondence to referral sources via Raintree by 12/31/23.
While the number of referring providers has increased (68 2021-2022 to 75 this reporting period) it is still necessary to increase number of referrals being made to the Medical Rehabilitation program.	A relationship with new and previous referral sources would benefit provider caseloads.	Use a variety of methods to provide education to referral sources on the services we provide. This will include mailings, drop-ins, meetings, follow-ups.	Formal marketing plan of offices, etc to be completed by 10/31/23 with implementation by 11/01/23.
Comment received on patient survey: "Appointments at 4-4:30 would have best fit our needs."	The ages of patients have been trending toward school-age. Most parents have been requesting appointment times close to the end of the school day or after.	Providers will shift their start and end times, as well as modify length of some patient appointments to allow for scheduling of more school-aged patients.	Immediately.