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School of Occupational Therapy

Utilizing Program Development to Address Industry Trends:

Thrive, a Successful Care Transitions Program

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A Capstone Project Entitled

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Thrive, a Successful Care Transitions Program

Submitted to the School of Occupational Therapy at University of Indianapolis in partial fulfillment for the requirements of the Doctor of Occupational Therapy degree.

By

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Abstract

This doctoral capstone experience (DCE) sought to expose a DCE student to rehabilitation administration and management at the corporate level at Healthcare Therapy Services, Inc. (HTS), a contract therapy provider in the Midwest. The student was exposed to various aspects of the corporate rehabilitation industry including administration/management, corporate compliance, marketing and business development, program development, and operations. The primary project for this DCE was development of an interdisciplinary successful care transitions program known as *HTS Thrive: Successful Care Transitions Program*. The program was chosen as the chief project in response to recent insurance and industry regulations incentivizing value-based care and transitions to the next level of care as soon as necessary supports can be obtained, and additionally in response to rehabilitation in skilled nursing facilities being highly scrutinized for the misuse of Medicare dollars in the form of unnecessary long lengths of stay and excessive Ultra-high Resource Utilization Group (RUG) utilization. The doctoral student, in collaboration with corporate executives, therapists, and other relevant healthcare experts developed an interdisciplinary successful care transitions program to be utilized in HTS-partnered facilities. The outcome of the DCE is a comprehensive interdisciplinary program that will allow HTS-partnered facilities to adhere to recent industry and insurance regulation trends while providing patients with quality care and a complete discharge process to promote a successful care transition to the next level of care.

HTS Thrive: Successful Care Transitions Program

Background/Literature Review

Aging Population

According to the U.S. Census Bureau (Ortman, J., Velkoff, V., and Hogan, H., 2014), by year 2030 more than 20% of the U.S. population will be aged 65 and older, a projected increase from 13% in 2010, and 9.8% in 1970. The "oldest old" age group (age 85 and over) is estimated to increase from 5.9 million in 2012 to 8.9 million in 2030 climbing to 18 million by year 2050 (Ortman, J., Velkoff, V., and Hogan, H., 2014). Many consequences will accompany the anticipated increase in the aging population. The expected growth in the older adult population will exponentially increase the need for healthcare for older adults in the United States. Medicare spending is expected to increase annually on average 4.1% per beneficiary from 2016-2025 compared to 1.6% per beneficiary from 2010-2015 (Centers for Medicare and Medicaid, 2017)

Medicare Reform

With these projections, the pressure to reduce Medicare spending is high and the Centers for Medicare & Medicaid Services (CMS) has consistently implemented programming to increase quality of care without increasing spending and in some cases while reducing spending over the past several years. Healthcare corporations are working hard to comply with CMS regulations in order to provide excellent care while sustaining revenues. Among these, post-acute care facilities such as skilled nursing facilities experience the burden of new regulations dually, as these facilities must comply with CMS regulations while also attempting to appeal to hospitals and potential clients for referrals. Recent CMS legislation affecting these facilities includes the Improving Medicare Post-Acute Care Transformation (IMPACT) act of 2014, which requires all post-acute care settings to report standardized patient assessment data by means of the SNF

Quality Reporting Program (RTI International, 2017). Measures reported (current and to be implemented in FY 2020) include skin integrity, falls, functional, change in self-care, change in mobility, discharge self-care score, discharge mobility score, potentially preventable 30-day readmissions, discharge to community, and Medicare spending per beneficiary (RTI International, 2017). Post-acute care facilities face a 2% penalty for failing to report this data. Additionally, the SNF Value-Based Purchasing program as required by the 2014 Protecting Access to Medicare Act (PAMA) will withhold 2% of all SNF Medicare payments beginning October 1, 2018 and will provide incentive payments from 50-70% of the funds from this pool for facilities ranking highest on performance measures (SNF Value-Based Purchasing, 2017). Incentive payments will be based upon the 30-day All Cause Readmission Measure (SNFRM) which will transition to the SNF Potentially Preventable 30-day Readmission (SNFPPR) "as soon as practicable" (SNF Value-Based Purchasing, 2017).

Similarly, hospitals are also required to participate in the Hospital Value-based Purchasing Program, which provides incentive payments to hospitals scoring highest on the Clinical Care domain, Patient and Caregiver Centered Experience of Care/Care Coordination domain, Safety domain, and Efficiency and Cost Reduction domain (Efficiency and cost reduction domain, n.d.). Of special interest to post-acute care facilities, the Efficiency and Cost Reduction domain is based on an "assessment of payment for services provided to a beneficiary during a spending-per-beneficiary episode that spans from 3 days prior to an inpatient hospital admission through 30 days after discharge" (Efficiency and cost reduction domain, n.d.) meaning that costs incurred in post-acute care facilities up to 30 days post hospital discharge will directly affect hospital reimbursements. Hospitals are also scored on readmission rates through the Hospital Readmission Rate Reduction Program (HRRP) initiated in 2012 and are penalized for

high hospital readmission rates (Boccuti and Casillas, 2017). Hospitals participating in bundled payment programs are also particularly interested in hospital readmission rates as well as length of stay in post-acute care settings, as it has a direct effect on hospital reimbursement.

Scrutiny of SNF rehabilitation services. As healthcare facilities and providers struggle to adhere to CMS regulations, they are faced with the task to provide quality care to patients in shorter amounts of time with the threat of potential consequences if unable to do so. For many years, post-acute care facilities have provided patients with care and rehabilitation services for long lengths of time in order for them to return to their prior level of function before discharging to the community. However, trends in steadily increasing Ultra High RUG utilization and patients receiving the minimum allowed minutes for each RUG category in skilled nursing facilities have led to accusations of skilled nursing facilities managing RUG levels for financial gains instead of patient needs (Acumen, 2017). For this reason, rehabilitation services in skilled nursing facilities have been highly scrutinized. Consequently, efforts to reduce this type of abuse of the system are being enacted including a proposed potential payment system that would eliminate the RUG system entirely. The Resident Classification System Version 1 (RCS-1) is the proposed payment model for rehabilitation services in skilled nursing facilities (Acumen, 2017). RCS-1 would pay facilities based on resident characteristics rather than volume of services provided. Although the RCS-1 system is intended to be budget neutral, many facilities may still feel the financial impact of this system, and contract rehabilitation providers are uncertain how the new payment system will affect them (Acumen, 2017). With no regulations on the amount of services provided to each patient proposed at this time, it is imperative that rehabilitation providers are able to articulate the value of their services in order to ensure that patients receive the rehabilitation services they desperately need.

Justification for Student Project

The rapidly growing aging population combined with a recent focus on quality care measures and reducing CMS spending in CMS legislation serve as the basis for this doctoral capstone project. As hospitals strive for lower readmission rates and shorter lengths of stay and post-acute care facilities are focused on reducing readmission rates and hoping to appeal to hospitals for referrals with shorter lengths of stay, a focus on successful care transitions is essential for patient success. In order to provide quality care in post-acute care facilities, successful care transitions from the hospital are vital, and additionally, to facilitate successful community reintegration and reduce hospital readmission rates for patients after a post-acute care stay, successful care transitions to the community are essential (Coleman, Parry, Chalmers, & Min , 2006). As our society ages and healthcare costs continue to grow, providers must be willing to shift type of care provided to meet societal needs. Hospitals and post-acute care facilities will no long be able to treat and rehabilitate patients to their prior level of function in the inpatient setting, as this has become too costly and will only continue to do so as the number of older adults requiring services grows. Avenues for reducing inpatient lengths of stays and readmission rates are potential methods to address this need. Among these, completing successful care transitions to the next level of care whether it is to home health services, outpatient services, or only follow-up with a primary care physician will be essential to provide patients with the best care possible in order to facilitate excellent outcomes for our patients, facilities, and society at large.

Theoretical Basis

This doctoral capstone project is primarily focused on developing advanced knowledge and skills in management and administration in the rehabilitation setting. Throughout the

experience I have been embedded into the corporate rehabilitation setting including a focus on corporate compliance issues and quality improvement. Developing a new care transitions program for this site will serve as the main project for this experience and will provide an excellent opportunity to develop and showcase my ability to contribute effective healthcare solutions at the corporate level addressing both societal and facility needs.

Dynamic Systems Theory. The Dynamic Systems Theory (DNS) will serve as the theoretical basis for this project. DNS is based upon "chaos, complexity, and dynamic systems" (Royeen, 2011, p. 63). With the unreliable healthcare climate today, it is only fitting that the theoretical framework to guide an effort to find solutions for societal healthcare needs would take into account the dynamic system that is healthcare in the United States. DNS allows consideration of this project to include potential varying outcomes that may become factual depending on the legislative actions that may take place within the next few months. Using DNS as a framework for this project forces consideration of the potential small changes that could undeniably impact the need for and execution of this program in the future. In considering DNS as a frame of reference for management, Royeen (2011) proposes that management in occupational therapy be renamed to "facilitation of change" (p. 67). I found this very fitting for the project, as it attempts to facilitate change within post-acute care facilities across the Midwest in order to provide patients with the support they need to transition between hospitals, post-acute care facilities, and the community successfully. It is my hope that I am able to facilitate change to provide better outcomes for our patients, facilities, and communities.

Screening and Evaluation

Screening and evaluation methods took place at the corporate office for Healthcare Therapy Services, Inc. (HTS). HTS provides contract rehabilitation services to over 100 skilled

nursing facilities, hospitals, and outpatient clinics across the Midwest, primarily serving the older adult population in the skilled nursing facility setting. AOTA (2014) describes organization level occupational therapy services as a "valid and important level of practice," claiming that the indirect application of occupational therapy services in administrative roles "support and enhance" the services provided to clients. The purpose of this doctoral capstone experience is exposure to administration duties and program development at the corporate level within the rehabilitation context. Thus the "client" for this experience is quite different than in traditional occupational therapy models. In this experience the client is the organization, Healthcare Therapy Services, Inc. To assess the needs of an organization it is important to perform a needs assessment. Sleezer, Russ-Eftt, and Gupta (2014) identify gathering data, data analysis, collaboration, and negotiation as important parts of identifying and addressing gaps in performance. Additionally, Sleezer et al (2014) states that a careful needs assessment builds support for program development with necessary data to substantiate the actions to follow.

To gather information about the needs of my client, I immersed myself into the workplace culture, attending meetings, performing interviews, visiting sites, and reviewing pertinent literature (Scaffa & Reitz, 2014). I attended meetings with the owner, CEO, Executive Director of Clinical Services, and Human Resources Director as well as marketing meetings that included skilled nursing facility administrators. This gave me an idea of what is most important to the organization, and how I might become part of the solution for issues they wish to address. Next, semi-structured face-to-face interviews were performed with key informants I had access to, including the Executive Director of Clinical Services, Marketing and Business Development Director, one regional director, and one occupational therapist. After all interviews were completed, the data was analyzed and placed into categories. Additionally, I was able to visit

several sites with my supervisor to gather more information about the varying needs of the facilities HTS serves and how my project might impact them. Finally, a thorough review of scientific literature concerning recent and upcoming legislative actions impacting the rehabilitation services HTS delivers provided a greater understanding of the current and potential issues at hand. From this process, a variety of needs emerged including the need to appeal to hospitals for referrals, strategies for improving quality indicators that are being tracked by the SNF Value-Based Purchasing Program, Skilled Nursing Facility Quality Reporting Program and Nursing Home Compare, creation of pathways to reduce lengths of stay, and an improved care transitions program.

Ultimately, through careful analysis of the data collected and literature reviewed, in collaboration with my site supervisor (the Executive Director of Clinical Services) it was determined that a successful care transitions program would be the best fit for the needs of the organization. Current literature also suggests that care transitions interventions may lead to better outcomes (Kind et al, 2012; Carnahan e al, 2017; Rahman e at, 2017). An improved, evidenced-based care transitions program would serve as a way to improve quality outcome measures, appeal to hospitals for referrals and to skilled nursing facilities for new contracts, and attempt to improve quality of care to their clients in the changing healthcare climate.

Baseline Measures

To prepare for future outcomes evaluation of the program, data was collected from the SNF Value-Based Purchasing Program Quarterly Interim Reports (Medicare Program, 2017). All-cause 30-day readmission rates from a convenience sample of HTS-partnered facilities were obtained for future comparison of objective, measurable outcomes.

Comparison and Contrast to Other Practice Areas

This screening and evaluation could be compared to that of the actual clients HTS occupational therapists serve in post-acute care facilities on a daily basis. When performing evaluations in post-acute rehabilitation and long-term care, occupational therapists are focused on determining the needs of the client through careful administration of standardized tests, completion of an occupational profile, and ultimate determination of the deficits that are currently limiting the client's occupational performance. Similarly, the needs assessment of HTS incorporated a process including semi-structured interviews, review of relevant literature, assessment of the client through site visits, and ultimately synthesizing the data to determine the needs of the "client" to promote optimal performance. Additionally, in both settings, the data is then used to develop goals and objectives for intervention. Although there are similarities in the screening and evaluation process for these two occupational therapy models, there are also great differences between them. Chiefly, the time and effort put into a post-acute care evaluation versus the screening and evaluation for an organization. An occupational therapy post-acute care evaluation may include review of patient chart, evaluation including administration of standardized assessment and occupational profile, and finally the written evaluation which may take a therapist 1-3 hours to complete. In comparison, the process of screening and evaluation of the needs of an organization can take several weeks or longer to gather the necessary information in order to provide the most fitting services to the client. Additionally, when treating individuals, occupational therapists are most often focused on creating improvement in occupational performance, whereas in considering an organization it may more often be focused on limiting poor outcomes such as reducing the risk of financial penalties, rather than being solely focused on improvement of performance.

Implementation Phase

Healthcare Therapy Services, Inc (HTS) services a large geographic location including over 100 facilities across Indiana, Kentucky, Tennessee, and Michigan. Many of these facilities are privately owned, non-profit organizations. The Centers for Disease Control and Prevention reports that 69.8% of nursing facilities in the United States are for-profit, making the HTS' clientele quite different from the norm in the long-term care world (Harris-Kojetin, Sengupta, Park-Lee, et al., 2016). These types of facilities do not possess large corporate management, and consequently must often depend on HTS for education regarding regulations and best practice in long-term care. As discussed previously, recent Centers for Medicare & Medicaid Services (CMS) legislation and initiatives including the IMPACT Act, SNF Quality Reporting Program, and SNF Value-Based Purchasing Program all place great emphasis on quality outcomes, including safe care transitions to the community and 30-day hospital readmissions (RTI International, 2017; SNF Value-Based Purchasing, 2017). Based on the current healthcare climate in the wake of recent CMS legislation, it was decided by the doctoral capstone student and site supervisor that development of a successful care transitions program would be the most beneficial project the student could develop for the organization at this time. The following paragraphs will discuss the process of implementation of the program.

Program implementation within HTS poses unique challenges. First, the large geographic area makes implementing various programs and disseminating information problematic. One way HTS has combated this issue is to provide virtual presentations utilizing ZOOM online meeting software. ZOOM combines a slideshow with video conferencing to allow for face-to-face meetings miles apart. Recording a ZOOM webinar presentation discussing the program will be the first step in implementing the HTS Thrive: Successful Care Transitions Program. The

student will provide a virtual presentation via ZOOM explaining the need and purpose for, evidence behind, and implementation guide for the voluntary successful care transitions program provided by HTS. The presentation will be provided first to all HTS regional directors at a "lunch and learn" presentation. It will be sent to the regional directors a week prior to being sent out to the facilities in order to give the regional directors sufficient time to become familiar with the program and ask necessary questions. This is an important step in the implementation process, as regional directors are available to communicate with facilities more frequently and have a closer relationship with facility administrators than other corporate employees may. Next, the presentation will be presented to all HTS facilities that are appropriate for program utilization. This presentation will also be presented at a "lunch and learn" meeting for facility administrators. Presenting at a designated time in which viewers must log on to view will create more accountability for administrators to view the presentation. The presentation will be available at a later date to administrators who are unable to view the live presentation. Along with the presentation, facilities will be provided with a written program manual including specific guidelines for each discipline involved and interactive tools for the facility to use in their facility-specific transitions program. Information will also be included concerning reporting program outcomes to HTS for continuous evaluation of the program. This will be discussed further in the next section.

After educating regional directors and facility administration, implementation will continue with rehabilitation, nursing, and social services managers. The program includes a large portion to be completed by nursing staff, signifying the need for facility-wide participation for successful implementation. Nursing managers will be provided with the virtual presentation as well as a complete step-by-step guide detailing the type of staff required to carry out the program and the

specific duties these staff members will provide as part of the HTS Thrive: Successful Care Transitions Program. Additionally, the rehabilitation and social services managers will also receive the virtual presentation and a written step-by-step guide detailing the duties of each rehab discipline and social services representative as part of the safe care transitions program. It will then be the responsibility of the managers to relay information regarding the specific job duties to each staff member involved. This may include requiring staff members to view the provided virtual presentation, reviewing the HTS Thrive: Successful Care Transitions Program manual, and holding a department education meeting about the implementation of the program. Specific training needs will be determined by department managers on a facility-by-facility basis.

Creating Buy-In

Additionally, it is important to note the unique relationship HTS has with its "clients" (partnered facilities). HTS provides therapy services within facilities and often provides consultation and occasionally marketing services; however, HTS does not have directive over the facilities it serves. Thus, programming that includes personnel other than those employed by HTS is completely voluntary. Consequently, buy-in from facility administrators and staff is essential for the success of this program. In order for the program to be utilized and given the chance to provide successful outcomes for the facilities and patients served, buy-in from administrators and other staff members must be generated. In addressing this area, the student has been able to develop leadership skills further by carefully considering and planning how to create buy-in from these facilities. To create buy-in the student must be able to successfully and professionally articulate the need for this type of program, the research completed to determine the best actions to promote successful outcomes, and why the student feels she is qualified to develop and oversee the implementation of this program. The development of this project has

helped to improve the student's leadership skills by providing opportunities for high-level conversations regarding real facility and patient issues in the current healthcare climate. It has also forced the student to be very professional in the development of the program, as the student understands the large consequences this program has the potential to provide. Although the large scope of the project has felt overwhelming to the student at times, she is confident that the development of this program has helped her grow as a leader in the profession and in the healthcare industry.

Staff Development and Program Outcomes

The implementation of this program combines efforts to improve patient outcomes with staff education. Educating staff on current regulations and updates within the healthcare climate, as well as best practice for successful care transitions promotes an understanding of the effect that current legislation is and will continue to have on rehabilitation service provision within the skilled nursing facility setting. The outcome of the program is two-fold. It will provide facilities with strategies to combat poor outcomes, allowing them to be looked upon more favorably by consumers, potential partners, and CMS. Additionally, it will provide staff with education regarding strategies for improving outcomes and patient care, as well as educating them on the current healthcare climate and its effect on rehabilitation service provision in the skilled nursing setting.

Discontinuation & Outcome Phase

Societal Need

The population served by HTS facilities is largely comprised of older adults, many with multiple comorbidities and complex care needs. Evidence suggests that elderly people are particularly vulnerable to issues with discontinuity of care, potentially resulting in adverse

outcomes (Coleman, 2003). In particular, elderly patients with cognitive deficits often experience repeated hospitalizations and uncoordinated care resultant from reliance on the healthcare system to effectively communicate and transfer care responsibilities to appropriate caregivers (Aase, Laugaland, Dyrstad, & Storm, 2013). The care success for the population served by HTS facilities is largely dependent on healthcare providers' ability to maintain continuity of care. This is especially important in the current healthcare climate that incentivizes shorter lengths of stay in inpatient facilities and various transitions to lower levels of care.

This DCE project is in response to the needs of the older adult population served by HTS in the context of recent industry trends in response to legislative and regulatory changes. These changes will determine the healthcare services and the amount of services that are provided to CMS patients, as well as the level of reimbursement facilities will receive for the services rendered. As previously discussed, the population in the United States is growing older at an exceptional rate with the number of seniors expected to double by the year 2030 and triple by the year 2050 (Ortman, J., Velkoff, V., and Hogan, H., 2014). This will put great strain on the United States government to support our aging population. Thus, efforts to reduce CMS spending while maintaining and/or improving quality of care are being implemented. These efforts will force service providers to render quality care in shorter amounts of time in order to transition patients to the next level of care at a lower cost to CMS. Thus, providers must learn to successfully transition their patients' care to the next level of care providers to maintain continuity of care. This will be essential for successful patient outcomes in the new healthcare climate (Coleman & Boult, 2003). This DCE project aims to meet the needs of HTS facilities in order to provide best care to patients in the context of recent healthcare climate changes. By providing facilities with the tools to combat these issues, this project will be a key component to

assisting HTS and its facilities to meet the needs of society in the context of a continually aging population and recent healthcare climate changes.

Outcomes of the Program

As previously described in the implementation phase, the relationship HTS has with its partnered facilities makes implementation and, consequently, measuring outcomes challenging. Due to the voluntary nature of the program, each facility may choose to implement or not implement the program. Additionally, facilities may choose to adapt parts of the program as necessary to meet that unique facility and patient population needs. To drive continuous improvement of the program, an established plan for measuring outcomes is imbedded within the program. The outcome measures for the program are largely focused on improving reported measures required by the SNF Value-Based Purchasing Program and SNF Quality Reporting Program such as SNF 30-Day All Cause Readmission Measures (SNFRM), average Medicare beneficiary spend, discharge to community rates, discharge mobility scores, discharge self-care scores, etc. Of these, the SNFRM is of chief importance, as it will determine the top ranking facilities that will receive the highest incentive payments via the SNF Value-Based Purchasing Program (VBP) beginning October 1, 2018 (SNF Value-Based Purchasing, 2017). Outcome measures for the HTS Thrive: Successful Care Transitions Program include monitoring 30-day hospital readmission rates via patient phone call surveys and SNF Value-Based Purchasing Program Quarterly Reports. Additionally, utility of the program will be evaluated via an HTS-administered facility survey of the program. To measure 30-day hospital readmission rates and the affect the program has on the rates, the facility will monitor 30-day hospital readmission rates via SNF VBP quarterly reports. These reports will give the facility an accurate measure of the facility's hospital readmission rates that they can compare to their patient-reported rates.

Quarterly rates should be monitored for one year, as the reports are sent several months after the quarter has ended. Additionally, the student has implemented a patient survey that includes items evaluating the patient's use of hospital services since being discharged from the hospital and skilled nursing facility. The patient will be called by an employee from the skilled nursing facility beginning at 30 days post skilled nursing facility discharge to complete the survey. A staff member other than the staff member that completed the patient post-discharge calls (part of the HTS Thrive program) will complete the survey call to reduce survey bias. A non-skilled staff member may complete the survey calls, as this call is meant only to gather information. The information gathered from the survey will be entered into an Excel workbook that the student created, which will allow the facility to document and monitor hospital readmission rates. The Excel workbook also allows for additional items such as education level, condition category, Allen Cognitive Level score, and primary language to be added based on each facility's unique needs to help identify and address facility-specific issues leading to hospital readmissions. The facility should note that patient reported rates may not be entirely accurate and should be compared to SNF VBP quarterly reports once they are available; however, patient-reported rates will give facilities a look at their readmission rates in real time.

Based on the impact on readmission rates and quality of care post implementation, the facility may choose to continue or discontinue implementing the program, make necessary changes to improve the implementation and utility of the program, and/or suggest edits for HTS to develop for the program as a whole. The Excel spreadsheet included in the program will allow the facility to monitor their readmission rates and potentially pinpoint issues that their readmitted patients have in common. Quality improvement should be completed on a facility-by-facility basis, as the needs of each facility may vary and tailoring the program to meet these unique

needs will allow for best outcomes. Facilities will be advised to evaluate and make necessary changes to the program each quarter.

In addition, a facility survey will be sent out bi-annually for the first year of implementation to assess the utility of the program. The survey will include items monitoring the facility's 30-day readmission rates, the facility's assessment of the qualitative improvements to care resulting from implementation of the program, as well as the ease of use of the program and potential issues related to the program. The results of the facility surveys will allow HTS to assess the outcomes and usefulness of the program. Based on these results, necessary changes and/or additions, to the existing HTS program may be completed.

Additional Doctoral Capstone Experiences

In addition to the development of the HTS Thrive: Successful Care Transitions Program, the student also engaged in various other skill developing and educational opportunities. The student participated in weekly corporate compliance meetings with the Proactive Medical Review consultant, all HTS regional directors, the Executive Director of Clinical Services, CEO, Marketing Director, and owner of HTS. The student completed various site visits with the Executive Director of Clinical services; the student was able to sit in on best practice trainings for staff and regional director trainings, attend facility marketing meetings, complete therapist performance observations, and more during the site visits. The student helped facilitate a Virtual Dementia Tour event at an HTS facility and was able to experience the tour at the site. Throughout her time at HTS, the student has been exposed to various professional organizations that HTS is involved in and that impact the rehabilitation world. The student became involved with various organizations in which HTS is a member. The student attended the American College of Health Care Administrators District 3 Midwest Post-Acute Care Leadership Summit

and completed a seven-hour Alzheimer's Disease and Dementia Care Seminar course qualifying her to receive recognition as a Certified Dementia Practitioner. She also attended the Samaritan Alliance Spring Leadership Forum and Proactive Medical Review "The New Long-Term Care Survey Process- What to Expect" seminar in person and attended The National Association for the Support of Long-Term Care (NASL) virtual committee meetings. Additionally, the student contributed to the site through development of and contribution to the therapist skills competency check-off list and guide that will be used to assess the competency of all therapists at HTS.

Evaluation/Outcomes of the Doctoral Capstone Experience

Outcomes of the student doctoral capstone experience (DCE) were evaluated based on the goal attainment scale (GAS) developed to assess the student's progress towards meeting the goals for this DCE. Goal attainment scaling as first described by Kiresuk and Sherman (1968) involves construction of a personalized goal attainment guide, and later quantifying progress through evaluation using the guide at a set time after the intervention or experience is completed. The goals determined to be most significant to the DCE were converted into a Goal Attainment Scale to be used for the student's evaluation at the end of the DCE. The site supervisor monitored the student's progress towards the goals by evaluating the advancement at midterm and final. At midterm, the student and site supervisor determined which goals were not yet met, how to work towards meeting these goals, and opportunities the student would still like to participate in prior to leaving the site. At the final evaluation, the site supervisor assessed the student's success in meeting the set goals using the GAS created seen in Figure 1.

	Goal #1	Goal #2	Goal #3	Goal #4
Goal Success at end of DCE	***Somewhat more than expected (+1)*** *The student spent time with therapists, managers, regional directors, and all members of the corporate office team. The student was also exposed to fiscal and operational aspects of corporate administration.*	***Somewhat more than expected (+1)*** *The student developed an interdisciplinary successful care transitions program for the company. The student created a presentation to educate staff on the program and set up a plan for continuous improvement of the program to take place.*	***Somewhat more than expected (+1)*** *The student was able to provide accurate and valuable educational material concerning industry and insurance regulations as they relate to the program she developed. This information will be used to educate facility administrators and guide them in best practice related to recent industry trends.*	***Somewhat more than expected (+1)*** *The student became familiar with all associations HTS is a part of and was able to attend events put on by the American College of Health Care Administrators, The Samaritan Alliance, and Proactive Medical Review during her DCE.*
Much less than expected (-2)	***Poor Understanding of Administrator's role*** - *Spend time with 1 levels of administration* - *No exposure to fiscal and business outcomes and corporate relations with both existing and new customers*	***Unable to identify appropriate area for program development***	***Familiar with corporate consultant role for industry regulations and insurance regulations*** - *Student demonstrates only general knowledge of industry and insurance regulations and is unable to navigate necessary resources*	***No direct or indirect involvement in professional associations that HTS is active in*** - *Poor understanding of how these associations support HTS and rehabilitation professions in general* - *Not able to attend any events*
Somewhat less than expected (-1)	***Fair Understanding of Administrator's role*** - *Spend time with 1-2 levels of administration* - *Little exposure to fiscal and business outcomes and corporate relations with both existing and new customers*	***Identify area for program development but not able to fully implement advances accordingly***	***Understand corporate consultant role for industry regulations and insurance regulations*** - *Become informed about CMS regulations and reimbursements and managed care and reimbursements* - *Learn to navigate CMS website and other resources for regulations* - *Understand corporate compliance with these regulations*	***Involvement in professional associations that HTS is active in*** - *Understand how these associations support HTS and rehabilitation professions in general* - *Not able to attend any events*
Expected (0)	***Understand administrators' role within HTS*** - *Spend time with several different levels of administration* - *Assist administrator in completing various duties to better acquaint myself with the role of rehabilitation administrators* - *Become well-informed*	***Identify areas for program development and implement advances accordingly, including research and education for best practice*** - *Observe company culture and interview practitioners, managers, admin, etc. to assess the needs of the company.* - *Develop a program/protocol to address said needs of the*	***Serve as assistant to corporate consultant for industry regulations and insurance regulations, ensuring compliance in all areas.*** - *Become well-informed about CMS regulations and reimbursements and managed care and reimbursements* - *Learn to navigate CMS website and other resources for regulations*	***Involvement in professional associations that HTS is active in*** - *Attend events when appropriate* - *Understand how these associations support HTS and rehabilitation professions in general*

	of fiscal and business outcomes and corporate relations with both existing and new customers	*company* *- Implement program/protocol* *- Evaluate success of program/develop outcome measure to assess success of programs*	*- Understand corporate compliance with these regulations*	
Somewhat more than expected (+1)	***Excellent Understanding of Administrator's role*** - *Spend time with all levels of administration* - *Frequent exposure to fiscal and business outcomes and corporate relations with both existing and new customers*	***Identify areas for program development, implement program fully, and educates staff on use of program professionally and successfully***	***Serve as a corporate consultant for industry regulations and insurance regulations AND is able to provide accurate information and guidance to corporation, ensuring compliance in all areas*** - *Able to assist in creating necessary content to educate staff on regulations and best practice related to new regulations*	***Involvement in professional associations that HTS is active in*** - *Understand how these associations support HTS and rehabilitation professions in general* - *Attend at least one event* - *Be an active participant in the event/conference*
Much more than expected (+2)	***Excellent understanding of Administrator's role & ability to act as a manger or administrator*** - *Spend time with all levels of administration* - *Ability to collaborate and contribute to conversation on fiscal and business outcomes and corporate relations with both existing and new customers*	***Develop program that meets needs of company, implement the program effectively, educate staff on the program, make continuous improvement changes to program based on measured outcomes of the program***	***Serve as a corporate consultant for industry regulations and insurance regulations AND is able to provide accurate information and guidance to corporation, ensuring compliance in all areas*** - *Able to create necessary content individually to educate staff on regulations and best practice related to new regulations*	***Involvement in professional associations that HTS is active in*** - *Understand how these associations support HTS and rehabilitation professions in general* - *Attend at least one event* - *Present information at an event/conference*

Figure 1. Goal Attainment Scale. This figure depicts the stated goals in a Goal Attainment Scale used to determine if the student's goals were accomplished and to what extent by the conclusion of the DCE.

Success of Goals

The student scored a *Somewhat more than expected (+1)* on the Goal Attainment Scale for each of the four established goals. Based on these scores, the student fulfilled and exceeded the expectations for this DCE. The success of each goal can be seen in Figure 1 and a description of each is found below.

Goal 1: Understand administrators' role within HTS

Objective: Spend time with several different levels of administration

Objective: Assist administrator in completing various duties to better acquaint myself with the role of rehabilitation administrators

Objective: Become well-informed of fiscal and business outcomes and corporate relations with both existing and new customers

Success of Goal 1: *Somewhat more than expected (+1.)* The student spent time with therapists, managers, regional directors, and all members of the corporate office team. The student was also exposed to fiscal and operational aspects of corporate administration.

Goal 2: Identify areas for program development and implement advances accordingly, including research and education for best practice

Objective: Observe company culture and interview practitioners, managers, admin, etc. to assess the needs of the company.

Objective: Develop a program/protocol to address said needs of the company

Objective: Implement program/protocol

Objective: Evaluate success of program/develop outcome measure to assess success of programs

Success of Goal 2: *Somewhat more than expected (+1.)* The student developed an interdisciplinary successful care transitions program for the company. The student created a presentation to educate staff on the program and set up a plan for continuous improvement of the program to take place.

Goal 3: Serve as assistant to corporate consultant for industry regulations and insurance regulations, ensuring compliance in all areas.

Objective: Become well-informed about CMS regulations and reimbursements and managed care and reimbursements

Objective: Learn to navigate CMS website and other resources for regulations

Objective: Understand corporate compliance with these regulations

Success of Goal 3: *Somewhat more than expected (+1).* The student was able to provide accurate and valuable educational material concerning industry and insurance regulations as they relate to the program she developed. This information will be used to educate facility administrators and guide them in best practice related to recent industry trends.

Goal 4: Involvement in professional associations that HTS is active in

Objective: Attend events when appropriate

Objective: Understand how these associations support HTS and rehabilitation professions in general

Success of Goal 4: *Somewhat more than expected (+1).* The student became familiar with all associations HTS is a part of and was able to attend events put on by the American College of Health Care Administrators, The Samaritan Alliance, and Proactive Medical Review during her DCE.

Overall Learning

Throughout the doctoral capstone experience, the student was able to engage in various opportunities related to administration and management in rehabilitation at the corporate level, culminating in the overall learning experience. The student was exposed to several facets of the corporate rehabilitation industry throughout the experience including administration management duties concerning program development, corporate compliance, marketing and business development, and operations.

Program development

Program development comprised a large portion of this doctoral capstone experience. The student researched, collaborated on, and ultimately developed an interdisciplinary successful care transitions program for HTS. Through this experience, the student became knowledgeable about current industry and insurance regulations that guide current practice, effective strategies for increasing continuity of care after discharge from skilled nursing facilities, and the care transition needs of HTS clients and patients served. The student conversed with various HTS employees to gain an understanding of the current practices and needs as well as to gain feedback on the program as it was being developed. The student learned to express her ideas and work verbally and in writing in a professional and effective manner, which allowed her to gain the respect of her peers in the industry and will serve her well in future jobs and opportunities. The student also improved her professional presentation skills through a virtual presentation for all facilities receiving the program she had developed. The program was presented in such as way as to communicate the benefit of utilizing the program supported by evidenced-based research, and the potential for quality measure improvements in both quantitative and qualitative outcomes.

Corporate Compliance

Corporate compliance is of utmost importance at HTS, as the company strives "to be the performance proven and acknowledged industry leader in therapeutic services," providing effective solutions and ethical practices (Healthcare Therapy Services, Inc., n.d.). Throughout the DCE, the student was exposed to several issues and meetings concerning corporate compliance. The student sat in on weekly compliance meetings with regional directors and assisted with occasional compliance issues as they arose. The student attended a Proactive Medical Review annual quality assurance site visit with a Proactive consultant, where she was able to observe

first-hand the process of service quality audits at HTS. Additionally, the student assisted with therapist performance observations checking for best practice, accurate billing, and effective documentation. These experiences exposed the student to common compliance issues in the skilled nursing facility setting. As a result, the student now has an enhanced understanding of how care should be provided and documented to assure services are completed in a skilled and justified manner. In addition, the student was exposed to the ill consequences that poor compliance may lead to, further increasing her understanding of and appreciation for ethical provision of services in the skilled nursing setting.

Marketing and Business Development

This DCE has expanded the student's understanding of the role marketing and business development plays in healthcare. The student had the opportunity to work with the marketing/business development team on her successful care transitions program and witness various other marketing and business development efforts throughout the experience. Through the collaboration, the student gained an understanding of how the program might affect the experience of patients as well as the facilities from a marketing and business development perspective. It was also brought to the student's attention that the program may be used as a marketing effort to gain new partnered facilities, and thus edits were made to the program to make it more patient friendly and appealing to patients as well as potential partners. The student was also able to witness the marketing director/head of business development present the company to several potential partners. Prior to this experience, the student had a very narrow view of the role of marketing and business development in healthcare, believing that most of the work consisted of social media posts and brochures; however, this DCE has opened her eyes and allowed her to see the vast role and impact that marketing and business development plays in the

healthcare world, largely driving the opportunities for service provision. Through this exposure, the student has gained a greater appreciation for the entire healthcare team, including the supportive healthcare services such as marketing and business development that help make healthcare possible.

Operations

Throughout the DCE experience, the student was exposed to the operational side of the corporate rehabilitation administration world including financial concerns and how they affect rehabilitation service provision. Although no extensive knowledge of operational and financial management was gained, the student now has an overall greater understanding of operational management in this setting.

Patient care should always of utmost importance in healthcare provision; however, healthcare providers must be aware of the financial business that healthcare has become. This aspect of healthcare will to continue driving profitable margins for the companies and their employees; however, it may come with changes unwelcomed by employees. The student feels the knowledge and understanding she has gained concerning operations in healthcare will help her be a well-informed and flexible practitioner and potentially, manager one day.

Conclusion

Through this DCE, the student was exposed to rehabilitation administration and management at the corporate level. The student is grateful for this experience, as she understands that few practitioners have an opportunity to witness this side of the rehabilitation industry. The exposure and resultant knowledge and understanding of this industry gained are truly invaluable. The student feels that this experience will aid her in practicing as an effective and informed therapist and potential manager for many years to come.

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