

# Playing— with Numbers

Therapeutic recreation is more than fun and games. Measuring clinical outcomes satisfies managed care requirements while optimizing patient independence.

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It's a familiar story: A therapist spends 12 hours a week documenting one patient's progress. A lack of interdisciplinary charting leaves caregivers with incomplete information. Staff have difficulty comparing functional goals for patients with similar levels of injury. And they are drowning in a sea of triplicate forms and other assorted paper records.

That was the scenario at Shepherd Center in Atlanta before the specialty hospital re-evaluated its documentation process in 1994 and developed its own outcomes-based clinical pathway program. Called CarePaths, it is based on CareMaps, the clinical paths program developed by the Center for Case Management, South Natick, Mass.

Shepherd's CarePaths measures outcomes in seven functional categories: health status, mobility, activities of daily living, psychosocial/spirituality, education, discharge planning and community reintegration.

## Developing the TR section

To measure lifestyle functionality, the main focuses of the program are community reintegration, leisure skill development, leisure counseling and leisure education. All of these interven-

tions work toward five main goals or objectives: community access, problem-solving, self-advocacy/assertiveness, stigma management and leisure skill. The community reintegration section of CarePaths would reflect these intervention areas and goals.

Measuring a patient's status and progress toward achieving these goals presented a challenge. Other disciplines have the benefit of using mostly quantitative analyses. For example, physical and occupational therapists evaluate patients on activities such as transfers, bed mobility, feeding and grooming -objective measures that can be scored with fairly accurate precision.

Some of the objectives that the CTRSs and program specialists were looking to measure, however, such as stigma management and assertiveness, inherently lead to more qualitative measures and subjective analysis. Measuring these types of objectives meant devising a new quantitative evaluation tool.

## The TR measurement scale

Given shorter lengths of stay, higher levels of medical acuity, and the time of year when a patient is in the hospital, many of the interventions that the TR staff provide are educational and do not lend them-

selves to a functional analysis. For example, it is not realistic for an individual with an acute SCI to have the medical clearance to water-ski during an inpatient stay. Therefore, the TR staff provides the patient with the knowledge and resources to pursue such an activity at a later date.

They determined that educational information is just as important to measure and document as is functional ability and, thus, two new measurement tools were developed — the therapeutic recreation educational measure and the therapeutic recreation functional measure.

Both are based on a seven-point scale. TRFM is patterned after the functional independence measure. TREM was developed by Shepherd's TR staff.

The TREM scale is used for educational interventions, or the knowledge aspect of goal/outcomes areas. TREM is based on the amount of assistance a patient requires to recall information or resources discussed or provided. A score of 1 reflects that information was provided, a score of 7 reflects independence in recalling information and resources. Scores in between reflect different amounts of



For an expanded version of this story, and ordering information for Shepherd Center's CarePaths for paraplegia and quadriplegia, go to [www.rehabreport.com](http://www.rehabreport.com)

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prompting that a patient requires to recall information or resources.

The TRFM scale is used for hands-on interventions, or the skill aspect of goal/outcomes areas. TRFM is based on the percentage of the activity or skill that the patient performs independently. A score of 1 reflects total dependence; a score of 7 reflects independence. Scores in between reflect different levels of assistance that the patient requires to perform the activity or skill.

To make both measurement scales more user-friendly to staff, separate definitions, narrative explanations and “decision trees” were developed for each of the TR goal/outcomes areas of community access, problem solving, self-advocacy/assertiveness, stigma management and leisure skill.

Clinicians have found decision trees useful and accurate in determining functional scores as behaviors are being observed and measured. Decision trees ask questions that help lead the therapist to a score.

For example, if a therapist is scoring a patient for the ability to play billiards, the first question would be: “Does the patient need

help?” If the answer is no, another question will determine whether to give a score of 6 or 7. If the answer is yes, a separate series of questions that relate to the amount of assistance needed will determine whether the patient receives a score of 1,2,3,4 or 5.

## Measuring goals/outcomes

Which goal/outcomes areas are scored, and whether TREM and/or TRFM should be given, is based on what occurs during the treatment intervention.

For example, if a patient has an interest in fishing and is not able to fish while at Shepherd, he or she is educated on the process — how to maneuver down to a dock, how to transfer into a boat, what safety issues to consider, and what adaptive equipment and adaptive techniques would be needed. In this instance, only TREM scores would be given, and based on what is actually discussed, TREM scores could potentially be given for community access, problem-solving, self-advocacy/assertiveness, stigma management and leisure skill. If the patient actually goes on a fishing outing while at

Shepherd, he or she could also receive TRFM scores in all areas.

The community reintegration section’s standards are based on the treatment interventions that therapeutic recreation provides. Because a patient’s performance and functional abilities vary based on the specific activity or skill being performed (e.g., board games vs. basketball), standards reflect a patient’s accomplishment of certain tasks.

## Implications

CarePaths has definitely made an impact — both positive and negative. Shepherd Center now has an increased interdisciplinary focus. Because patient charts no longer have discipline-specific sections and discipline-specific documentation no longer exists, this has taught all interdisciplinary team members to be less territorial with regard to treatment interventions and goals.

Also, because documentation is no longer in triplicate and discipline-specific, less paper is used and the size of a patient’s medical record has decreased.

has also made it easier to

compare patients' functional status. Because the standards are included in the documentation, comparing patients with similar levels of injury is simplified.

The time spent documenting and in team conferences has decreased. Recreation therapists now spend about two to four hours per week documenting, a decrease of about eight to 10 hours per week. Team conference time has been cut in half, and variances and psychosocial, family and discharge issues are now the main focus. These savings allow more time for patient care.

## New attitudes

Getting all team members to embrace the interdisciplinary documentation approach has not been easy. Even though CarePaths is everyone's responsibility, staffers in the disciplines responsible for the weekly documentation and comparison of standards still feel responsible and territorial of their respective sections.

Some therapists believe others cannot document as well as they, and the TR staff has encountered this attitude more than

other disciplines because they document in more sections of CarePaths than do other team members. This is slowly changing and has improved since the beginning.

The benefit is an increased awareness of patient services, treatment interventions and differences in a patient's performance in the hospital compared with in the community. This is the result of the forms that show this information side by side, as opposed to many different sections of the patient's chart. Team members are now more aware of what other disciplines do.

Also, because TR documents in the mobility and activities-of-daily-living sections for community outings, team members are even more aware of the fact that outings are not done just for fun. Outings allow patients to carry the skills they learn daily in therapy into more real-life situations, and the TR staff is able to measure patients' abilities and provide this information to the team.

Charting by exception has led to a decrease in the amount of subjective and detailed information documented. TR staff have become as creative and as detailed as

possible when recording the type of treatment intervention provided.

TR students are at a greater disadvantage when they come to Shepherd because they do not learn pathways documentation in school. Conversely, the CarePaths process does not prepare students very well for a first job where they need to write narrative notes. To combat this, in addition to completing CarePaths documentation, students write narrative notes for some of their patients.

The advantages of developing consistent and measurable ways of incorporating a patient's goals into CarePaths are clear. By creating a documentation system that incorporates standards and more objective measures, and developing two new scales that measure a patient's functional ability and knowledge base, Sheperd staff can more accurately track and document outcomes. ■

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