No Longer Lost in Translation: Closing the Know-Do Gap in Locomotor Training

I. The Urgency for Knowledge Translation
   a. Environmental Scan: The changing reimbursement environment
   b. Variability: “If there were no variation in PAC spending, variation in total Medicare spending would fall by 73 percent. If there was no variation in both acute care and PAC spending, total Medicare spending variation would drop by 89 percent.” (IOM, 2013)
   c. Key legislation
      i. Affordable Care Act (2010)
      iii. Improving Medicare Post-Acute Care Transformation Act of 2014
   d. Market Drivers
      i. Adoption of alternative payment models (APMs)
         1. By 2018, at least 50% of U.S. health care payments will be linked to quality through APMs
         2. Moving from volume to value
            a. In 2016, 25% of health care spending in APMs and/or population-based payment models
         3. Accountable Care Organizations
            a. Now cover more than 10% of U.S. population
      4. Medicare APMs
         a. Represent over 30% of Medicare payments in 2016
      5. Medicare Advantage
         a. Total enrollment in 2016 = 31% of Medicare beneficiaries
   e. Organizational Strategies
      i. Systems
         1. Standardized approaches to outcomes measurement and therapy delivery
         2. Model for Improvement (PDSA)
      ii. Information
         1. Quantified patient
      iii. People
         1. Achieve clinical leadership
         2. Culture of excellence

II. Knowledge Synthesis - The Science Behind High Intensity Stepping
   a. Rationale for application of specific training parameters during clinical rehabilitation
      i. Theoretical bases of higher intensity, task specific intervention to improve locomotor function
ii. Primary evidence underlying application of specific training parameters to patient populations

iii. Preliminary data regarding the feasibility, safety and preliminary efficacy of applying these training variables in the clinical setting

b. Potential variables that assist with implementation of research evidence in the clinical setting

iv. Need for selecting and implementing the “right” evidence

v. Personnel
   1. Resident or available “experts” versed in the available evidence
   2. Local champions who advocate for implementation
   3. Willingness of the team to implement the evidence

vi. Higher administration/physician support
   1. Ability to successfully direct staff
   2. Resources (time, equipment)
   3. Support

vii. Loosely structured attempts at therapist trial-and-error practice
   1. Get up on the horse
   2. Fall down
   3. Brush yourself off
   4. Repeat

III. The Knowledge to Action Gap and Assessing Barriers to Knowledge Use
   a. Formal and informal observations
   b. Review of facility and environmental barriers and selecting a site
   c. Clinician Survey

IV. Adapting Knowledge to the Local Context and Using a Knowledge Broker
   a. Is there a difference between neurological patients and more general geriatric patients?
      i. How might the intervention need to be adapted?
   b. The decision to add a Knowledge Broker
      i. Defining the essential functions
      ii. Finding the right person
      iii. Integrating the Knowledge Broker into the organization

V. Select, Tailor, and Implement Interventions
   a. Reassessing local knowledge gaps and barriers to knowledge use
   b. Staff training model
   c. Incorporate staff into program development
      i. Adaption to special patient populations
      ii. Development of Knowledge tools
      iii. Documentation and adherence requirements
      iv. Patient education and messaging about program
      v. Workflow and scheduling procedures
   d. Process for sharing program updates and new information
VI. Monitor Knowledge Use and Evaluating Outcome
   a. Skill appraisal
   b. Adherence meetings
   c. Knowledge broker presence on site
   d. Process for data extraction
   e. Data comparison groups
   f. Plans for future data analysis

VII. Sustain Knowledge Use
   a. “Train the trainer”
   b. “Remote” mentorship
   c. Shift in accountability amongst stakeholders
   d. Defined workflow
   e. Modifications to adherence monitoring
   f. Messaging and staff engagement
   g. Building High Intensity Stepping into the broader clinical model

VIII. Questions and Answers

IX. References


