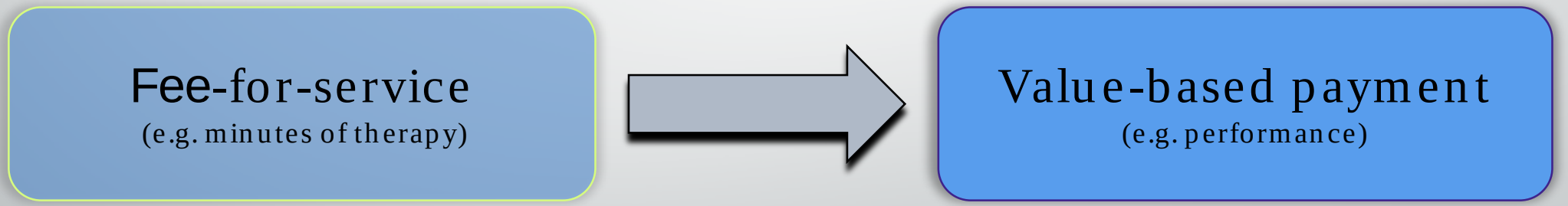
Value Based OT

Implications and Opportunities During the PDPM Transition

Why the Change in Payment?

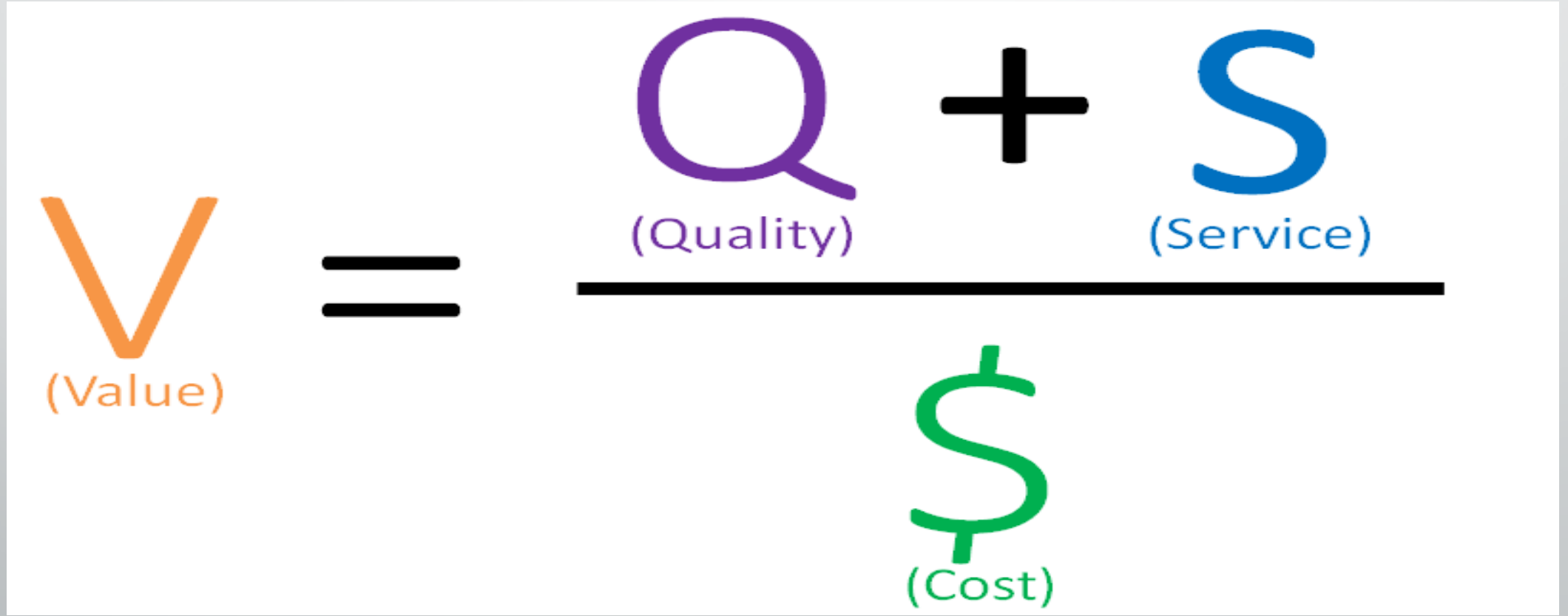
Shift to value-based care

Payments are based on the provision of high quality care, not volume of care



Occupational Therapy's Value Add

The Value Proposition



https://uofuhealth.utah.edu/value/

Quality Measures

Q

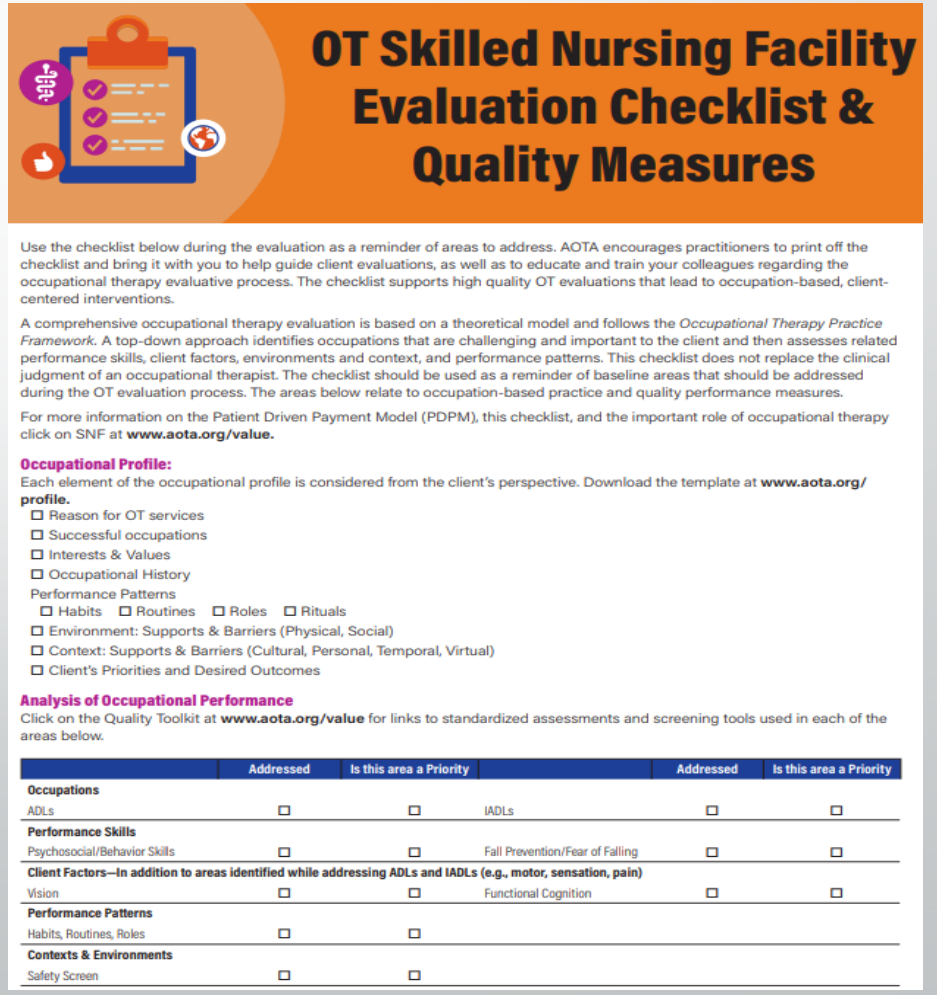
(Quality)

- Occupational Therapy professionals must be aware of the quality measures CMS uses to score facilities
- It is important to understand how my facility is scoring on these measures
- I also must be able to identify how my practice influences the score on the quality measures

AOTA SNF Evaluation Checklist & Quality Measures

- Front includes checklist of items connected to OT Practice, high-value care, and quality performance measures
- Occupational Profile
- Areas to be addressed or considered during the OT evaluation

www.aota.org/value



OT Skilled Nursing Facility Evaluation Checklist & Quality Measures

Use the checklist below during the evaluation as a reminder of areas to address. AOTA encourages practitioners to print off the checklist and bring it with you to help guide client evaluations, as well as to educate and train your colleagues regarding the occupational therapy evaluative process. The checklist supports high quality OT evaluations that lead to occupation-based, client-centered interventions.

A comprehensive occupational therapy evaluation is based on a theoretical model and follows the *Occupational Therapy Practice Framework*. A top-down approach identifies occupations that are challenging and important to the client and then assesses related performance skills, client factors, environments and context, and performance patterns. This checklist does not replace the clinical judgment of an occupational therapist. The checklist should be used as a reminder of baseline areas that should be addressed during the OT evaluation process. The areas below relate to occupation-based practice and quality performance measures.

For more information on the Patient Driven Payment Model (PDPM), this checklist, and the important role of occupational therapy click on SNF at **www.aota.org/value.**

Occupational Profile:

Each element of the occupational profile is considered from the client's perspective. Download the template at **www.aota.org/profile.**

- ☐ Reason for OT services
- ☐ Successful occupations
- ☐ Interests & Values
- ☐ Occupational History

Performance Patterns

- ☐ Habits ☐ Routines ☐ Roles ☐ Rituals
- ☐ Environment: Supports & Barriers (Physical, Social)
- ☐ Context: Supports & Barriers (Cultural, Personal, Temporal, Virtual)
- ☐ Client's Priorities and Desired Outcomes

Analysis of Occupational Performance

Click on the Quality Toolkit at **www.aota.org/value** for links to standardized assessments and screening tools used in each of the areas below.

	Addressed	Is this area a Priority		Addressed	Is this area a Priority
Occupations					
ADLs	☐	☐	IADLs	☐	☐
Performance Skills					
Psychosocial/Behavior Skills	☐	☐	Fall Prevention/Fear of Falling	☐	☐
Client Factors—In addition to areas identified while addressing ADLs and IADLs (e.g., motor, sensation, pain)					
Vision	☐	☐	Functional Cognition	☐	☐
Performance Patterns					
Habits, Routines, Roles	☐	☐			
Contexts & Environments					
Safety Screen	☐	☐			

The Occupational Profile

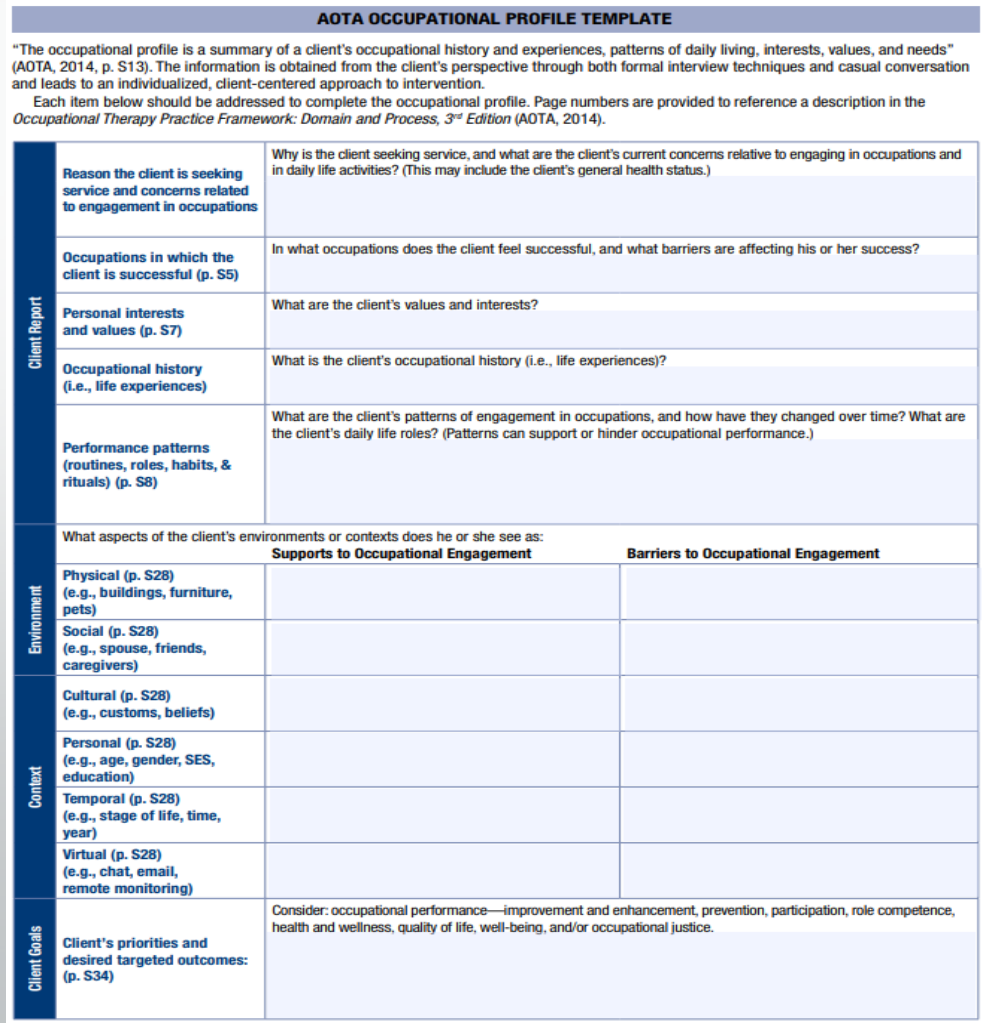
S

(Service)

- Identifies strengths and opportunities
- Environments & Contexts
- Habits, Routines, & Roles
- Client Goals
- And more…

AOTA Occupational Profile Template

- Part of the OT Evaluation
- What is it important?
  - Care and services that are based on the client's perspectives and goals contributes to the patient experience
  - Occupational Profile is a key component of the OT evaluation CPT codes
- Free for members and nonmembers at www.aota.org/value



AOTA OCCUPATIONAL PROFILE TEMPLATE

"The occupational profile is a summary of a client's occupational history and experiences, patterns of daily living, interests, values, and needs" (AOTA, 2014, p. S13). The information is obtained from the client's perspective through both formal interview techniques and casual conversation and leads to an individualized, client-centered approach to intervention.

Each item below should be addressed to complete the occupational profile. Page numbers are provided to reference a description in the *Occupational Therapy Practice Framework: Domain and Process, 3rd Edition* (AOTA, 2014).

Client Report	Reason the client is seeking service and concerns related to engagement in occupations	Why is the client seeking service, and what are the client's current concerns relative to engaging in occupations and in daily life activities? (This may include the client's general health status.)	
	Occupations in which the client is successful (p. S5)	In what occupations does the client feel successful, and what barriers are affecting his or her success?	
	Personal interests and values (p. S7)	What are the client's values and interests?	
	Occupational history (i.e., life experiences)	What is the client's occupational history (i.e., life experiences)?	
	Performance patterns (routines, roles, habits, & rituals) (p. S8)	What are the client's patterns of engagement in occupations, and how have they changed over time? What are the client's daily life roles? (Patterns can support or hinder occupational performance.)	
Environment	What aspects of the client's environments or contexts does he or she see as:	**Supports to Occupational Engagement**	**Barriers to Occupational Engagement**
	Physical (p. S28) (e.g., buildings, furniture, pets)		
	Social (p. S28) (e.g., spouse, friends, caregivers)		
Context	Cultural (p. S28) (e.g., customs, beliefs)		
	Personal (p. S28) (e.g., age, gender, SES, education)		
	Temporal (p. S28) (e.g., stage of life, time, year)		
	Virtual (p. S28) (e.g., chat, email, remote monitoring)		
Client Goals	Client's priorities and desired targeted outcomes: (p. S34)	Consider: occupational performance—improvement and enhancement, prevention, participation, role competence, health and wellness, quality of life, well-being, and/or occupational justice.	

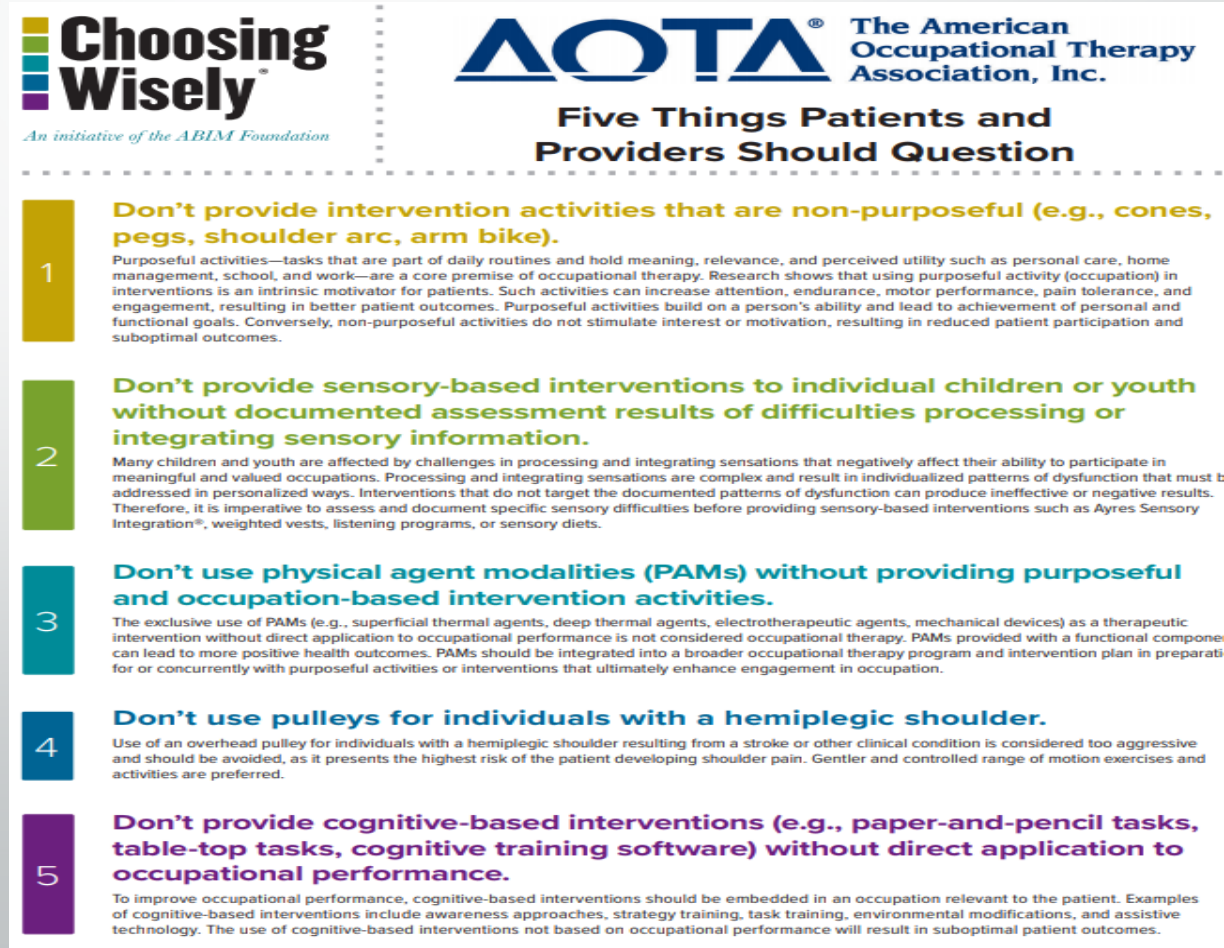
Right Services to the Right People

(Cost)

- It is important that OT provide the right services to the right people
- True client centered, occupation based services are valuable
- Services that do not provide optimal, client-specific outcomes (maintenance or rehabilitative) are not as valuable

Choosing Wisely®

- Link to CW on www.aota.org/value
- "5 Things Patients and Providers Should Question"
- New consumer friendly version is now available
- Review a Q&A with an expert in each area
- More resources are being added regularly including practices
- These services are likely to be low value


Choosing Wisely
An initiative of the ABIM Foundation

AOTA® The American Occupational Therapy Association, Inc.

Five Things Patients and Providers Should Question

1 **Don't provide intervention activities that are non-purposeful (e.g., cones, pegs, shoulder arc, arm bike).**

Purposeful activities—tasks that are part of daily routines and hold meaning, relevance, and perceived utility such as personal care, home management, school, and work—are a core premise of occupational therapy. Research shows that using purposeful activity (occupation) in interventions is an intrinsic motivator for patients. Such activities can increase attention, endurance, motor performance, pain tolerance, and engagement, resulting in better patient outcomes. Purposeful activities build on a person's ability and lead to achievement of personal and functional goals. Conversely, non-purposeful activities do not stimulate interest or motivation, resulting in reduced patient participation and suboptimal outcomes.

2 **Don't provide sensory-based interventions to individual children or youth without documented assessment results of difficulties processing or integrating sensory information.**

Many children and youth are affected by challenges in processing and integrating sensations that negatively affect their ability to participate in meaningful and valued occupations. Processing and integrating sensations are complex and result in individualized patterns of dysfunction that must b addressed in personalized ways. Interventions that do not target the documented patterns of dysfunction can produce ineffective or negative results. Therefore, it is imperative to assess and document specific sensory difficulties before providing sensory-based interventions such as Ayres Sensory Integration®, weighted vests, listening programs, or sensory diets.

3 **Don't use physical agent modalities (PAMs) without providing purposeful and occupation-based intervention activities.**

The exclusive use of PAMs (e.g., superficial thermal agents, deep thermal agents, electrotherapeutic agents, mechanical devices) as a therapeutic intervention without direct application to occupational performance is not considered occupational therapy. PAMs provided with a functional compone can lead to more positive health outcomes. PAMs should be integrated into a broader occupational therapy program and intervention plan in preparati for or concurrently with purposeful activities or interventions that ultimately enhance engagement in occupation.

4 **Don't use pulleys for individuals with a hemiplegic shoulder.**

Use of an overhead pulley for individuals with a hemiplegic shoulder resulting from a stroke or other clinical condition is considered too aggressive and should be avoided, as it presents the highest risk of the patient developing shoulder pain. Gentler and controlled range of motion exercises and activities are preferred.

5 **Don't provide cognitive-based interventions (e.g., paper-and-pencil tasks, table-top tasks, cognitive training software) without direct application to occupational performance.**

To improve occupational performance, cognitive-based interventions should be embedded in an occupation relevant to the patient. Examples of cognitive-based interventions include awareness approaches, strategy training, task training, environmental modifications, and assistive technology. The use of cognitive-based interventions not based on occupational performance will result in suboptimal patient outcomes.

Delivering authentic, high quality occupational therapy services demonstrates our services are critical to patients and facilities achieving desired outcomes

V

Occupational Therapy
An Investment Worth Making

Flip the Script

Occupational Therapy Professionals' Opportunity to Improve Quality of Care

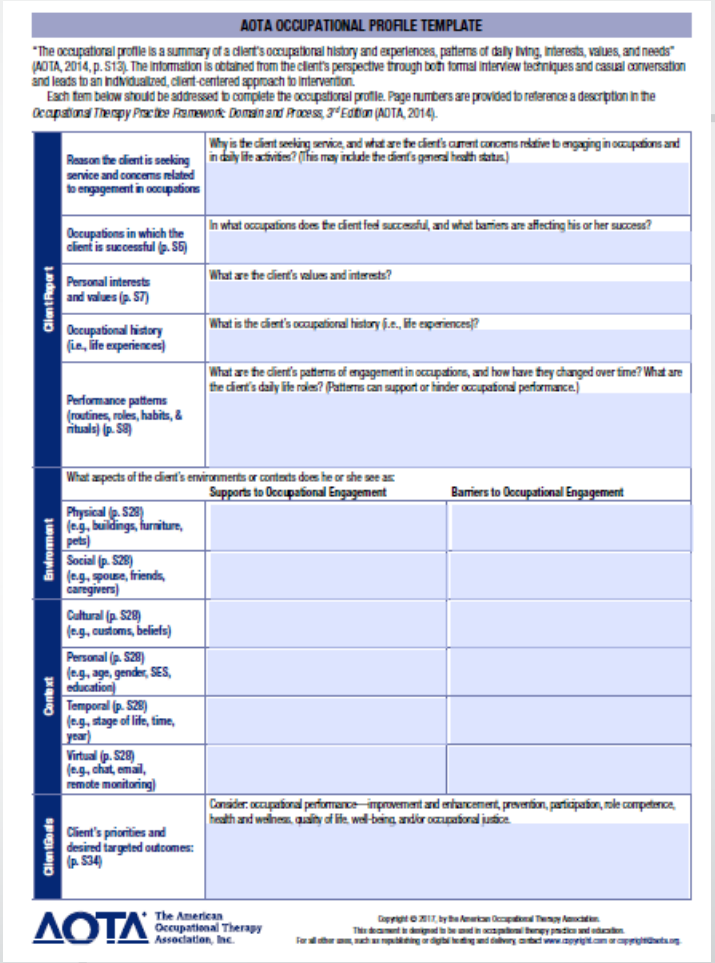
AOTA Resources for Occupational Therapy Professionals #MembershipWorks

- **All information can be accessed on our Volume to Value at www.aota.org/value**
  - Quality Toolkit for practitioners
  - AOTA Occupational Profile Template
  - Self-Care and Mobility Items from Section GG
  - Choosing Wisely – Consumer list & Clinician Materials
- **Click on "Skilled Nursing Facilities" at www.aota.org/value**
  - AOTA SNF Evaluation Checklist
  - PDPM Part 1 Webinar* (30 minutes) – Policy changes & quality measures in PDPM
  - PDPM Part 2 Webinar* (45 minutes) – Applying the value proposition to practice
  - Additional overview & topic specific webinars are also available.

Stay focused on the patient.

Authentic Occupational Therapy

- Distinct value of occupational therapy;
- Utilizing the occupational profile to individualize care and identify the supports and barriers to successful occupational engagement.



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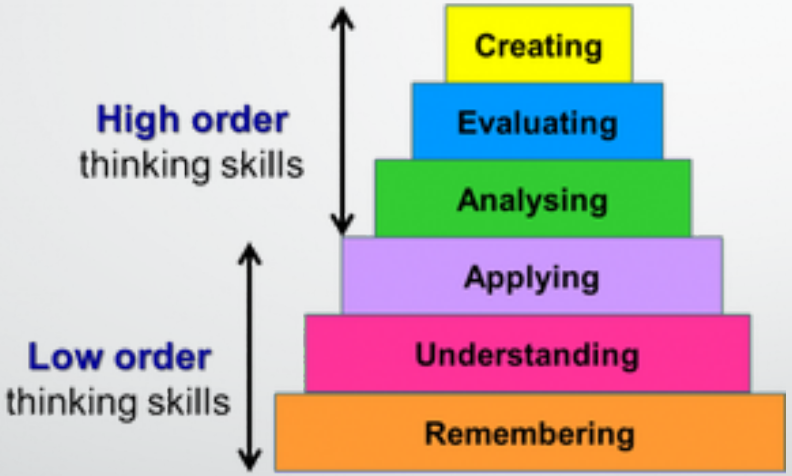
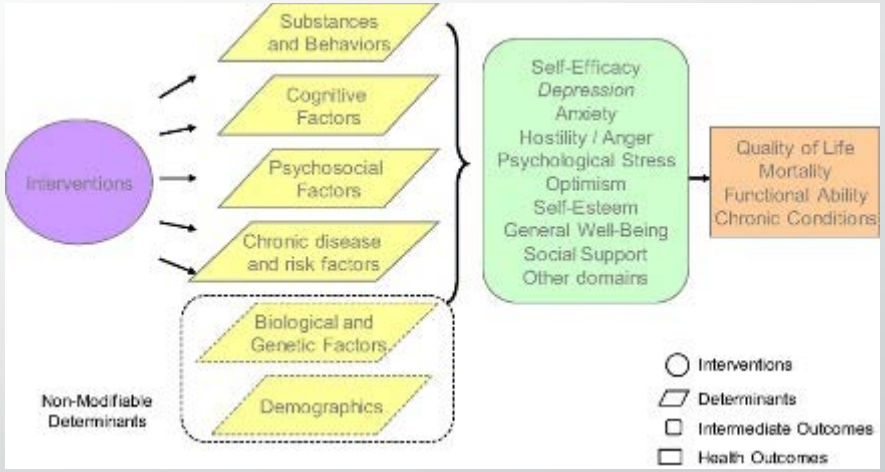
AOTA The American Occupational Therapy Association, Inc.

American Occupational Therapy Association. (2014). Occupational therapy practice framework: Domain and process (3rd ed.). *American Journal of Occupational Therapy, 68*(Suppl. 1), S1–S48. https://doi.org/10.5014/ajot.2014.682006

Physical, Cognitive, and Psychosocial Components Impacting Occupational Engagement





Functional Assessments and treatments

- Performance-based assessments to measure independence and safety – beyond MIN, MOD, MAX
- Using functional assessments to perform a task analysis, recognize where occupational deficits exist, and then analyze occupational engagement and performance using our distinct language.
  - Occupations
  - Client factors
  - Performance skills
  - Performance patterns
  - Context and environment

Example of Functional Assessment Utilization

- Example – Functional Reach Tool in-conjunction with observation based tasks of reaching into the shower to transfer, obtaining objects like gathering clothes from a closet – how far off the norm is the patient for their age and sex and what is their current fall risk.

Normative Data

Adults aged: 20 to 87

Duncan, P.W., Weiner, D.K., Chandler, J., Studenski, F. Functional Reach: a new clinical measure of balance. J. Gerontology 1990 Nov; 45(6) : M192-7

Age	Men	Women
20 to 40	16.73 ± 1.94 inches	14.64 ± 2.18 inches
41 to 69	14.98 ± 2.21 inches	13.81 ± 2.20 inches
70 to 87	13.16 ± 1.55 inches	10.47 ± 3.53 inches

Predictive Data

- Predictive Data
  - Fall risk w/ in next 6 months

Unable to reach 8 times normal risk

Reach <= 6 inches 4 times normal risk

Reach >= 6 inches <10 inches 2 times normal risk

Reach >=10 inches normal risk

Duncan, P, Studenski, S, Chandler, J, Prescott, B. Functional Reach: predictive validity in a sample of elderly male veterans, J of Gerontology, 1992 May; 47 (3): M93-98

Occupation-based Treatments

- Do you practice along the continuum of occupational therapy?
- What is the difference between the various parts of the continuum?

Practice Analysis Exercise

Preparatory	Purposeful	Occupation-based

A Comparison of Performance in Added-Purpose Occupations and Rote Exercise for Dynamic Standing Balance in Persons With Hemiplegia

Ching-Lin Hsieh, David L. Nelson, Doris A. Smith, Cindee Q. Peterson

Key Words: human activities and occupations • motivation

Objectives. *Adding purpose to daily occupations to promote performance is a basic premise of occupational therapy. This study investigated the hypothesis that in persons with hemiplegia, two added-purpose occupations would elicit more exercise repetitions than a rote exercise.*

Method. *In a counterbalanced order, 21 subjects with hemiplegia, aged 51 to 78 years, experienced all three conditions of a dynamic standing balance exercise that involved bending down, reaching, standing up, and extending the arm. One condition of added purpose involved the use of materials (small balls and target); a second added-purpose condition involved the subjects' imagination of the small balls. The third condition was the rote exercise without added purpose.*

Results. *A one-way analysis of variance for related measures indicated that the subjects performed significantly differently in each of the three conditions (p < .001). A Tukey multiple com that the subjects did significantly tions in the added-materials con agery-based condition than in th tion (p < .05).*

Conclusion. *This study demo*

Added-Purpose Versus Rote Exercise in Female Nursing Home Residents

Rita M. Yoder, David L. Nelson, Doris A. Smith

Key Words: activity analysis • aged • purposeful activities • therapeutic exercise

Occupationally Embedded Exercise Versus Rote Exercise: A Choice Between Occupational Forms by Elderly Nursing Home Residents

Sheri Zimmerer-Branum, David L. Nelson

Key Words: aging • motivation • therapeutic exercise

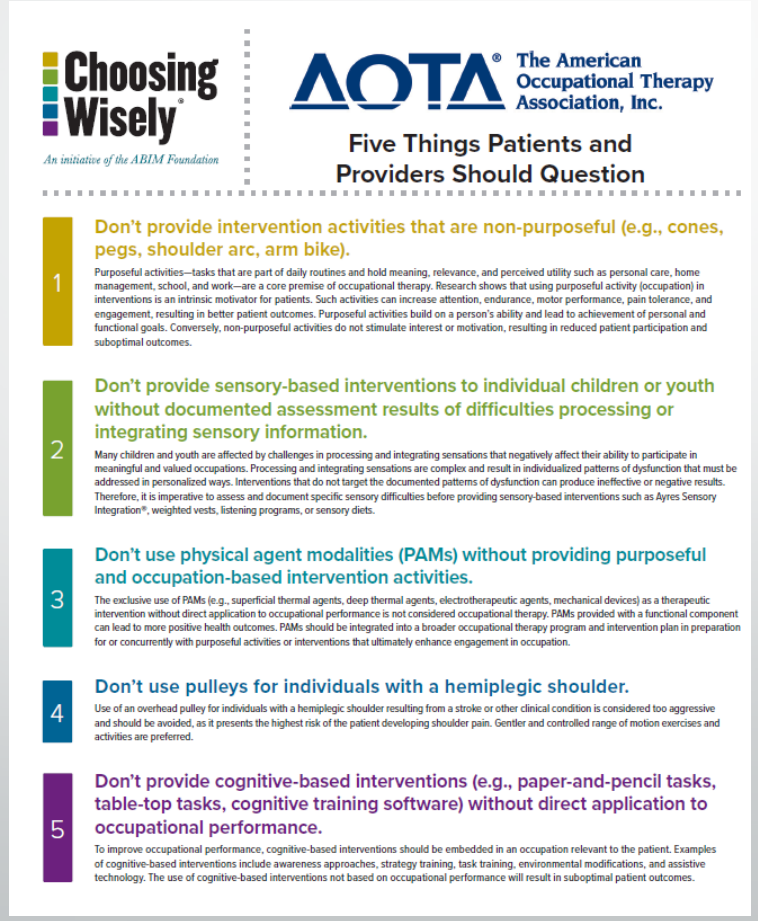
Objectives. *The provision of options in the occupational form that encourages meaningful choices and subsequent purposeful occupational performances is a basic premise of occupational therapy. This study examines the preferences of elderly nursing home residents when presented with an occupationally embedded exercise versus a rote exercise and addresses the methodological problems identified in similar past research.*

Method. *Fifty-two elderly nursing home residents were presented with a choice between an occupationally embedded exercise that involved unilateral dunking of a small, spongy ball into a basketball hoop and a rote exercise that involved moving the arm above the head in a simulation of the dunking exercise. Both exercises required flexion of the shoulder joint. Random assignment of the 52 subjects into one of four groups controlled for the order of the presentation of the exercises and the order of the choice statements.*

Results. *Sixty-nine percent of the subjects chose the occupationally embedded exercise. Analysis with the significance of a proportion statistic revealed a statistically significant difference (z = 2.77; p (one-tailed) = .003).*

Conclusion. *Results were consistent with the hypothesis that elderly nursing home residents would tend to choose the occupationally embedded exercise. To further confirm this basic premise of occupational therapy, future studies that investigate therapeutic patterns of movement embedded in common occupations are recommended.*

Are you…..Choosing Wisely?



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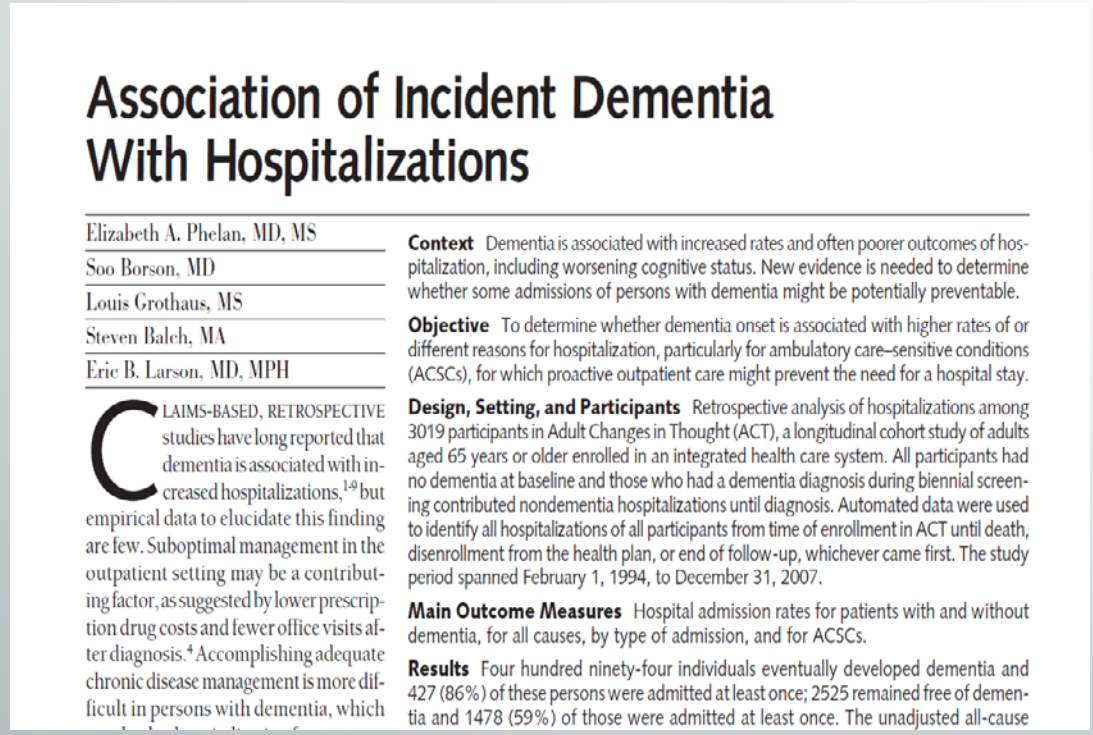
Connect the dots with function and cognition

- Definition of functional cognition – "Cognition in Action"
- Cognition – the ability to learn, retain, and use new information to enable occupational performance across the lifespan (AOTA 2019 Statement: Cognition, Cognitive Rehabilitation and Occupational Performance).
- Are you deferring cognitive interventions to remediate or manage decline to other disciplines? If so, are you demonstrating your distinct value?
- What cognitive screens are you using? What cognitive assessments do you incorporate into your practice?

Incidence of Dementia with Hospitalizations



Association of Incident Dementia With Hospitalizations

Elizabeth A. Phelan, MD, MS
Soo Borson, MD
Louis Grothaus, MS
Steven Balch, MA
Eric B. Larson, MD, MPH

Context Dementia is associated with increased rates and often poorer outcomes of hospitalization, including worsening cognitive status. New evidence is needed to determine whether some admissions of persons with dementia might be potentially preventable.

Objective To determine whether dementia onset is associated with higher rates of or different reasons for hospitalization, particularly for ambulatory care–sensitive conditions (ACSCs), for which proactive outpatient care might prevent the need for a hospital stay.

Design, Setting, and Participants Retrospective analysis of hospitalizations among 3019 participants in Adult Changes in Thought (ACT), a longitudinal cohort study of adults aged 65 years or older enrolled in an integrated health care system. All participants had no dementia at baseline and those who had a dementia diagnosis during biennial screening contributed nondementia hospitalizations until diagnosis. Automated data were used to identify all hospitalizations of all participants from time of enrollment in ACT until death, disenrollment from the health plan, or end of follow-up, whichever came first. The study period spanned February 1, 1994, to December 31, 2007.

Main Outcome Measures Hospital admission rates for patients with and without dementia, for all causes, by type of admission, and for ACSCs.

Results Four hundred ninety-four individuals eventually developed dementia and 427 (86%) of these persons were admitted at least once; 2525 remained free of dementia and 1478 (59%) of those were admitted at least once. The unadjusted all-cause

CLAIMS-BASED, RETROSPECTIVE studies have long reported that dementia is associated with increased hospitalizations,[1-9] but empirical data to elucidate this finding are few. Suboptimal management in the outpatient setting may be a contributing factor, as suggested by lower prescription drug costs and fewer office visits after diagnosis.[4] Accomplishing adequate chronic disease management is more difficult in persons with dementia, which

- Patients with dementia may end up at hospitals more frequently because they have difficulty with managing their medical conditions, managing their medication, and alerting family, caregivers, or physicians to new symptoms.

Empirical Research

Higher Hospital Spending on Occupational Therapy Is Associated With Lower Readmission Rates

Medical Care Research and Review
1–19
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DOI: 10.1177/1077558716666981
mcr.sagepub.com
SAGE

2017 Vol 74(6) IP 668 688

Andrew T. Rogers[1], Ge Bai[1], Robert A. Lavin[2], and Gerard F. Anderson[1]

Abstract

Hospital executives are under continual pressure to control spending and improve quality. While prior studies have focused on the relationship between overall hospital spending and quality, the relationship between spending on specific services and quality has received minimal attention. The literature thus provides executives limited guidance regarding how they should allocate scarce resources. Using Medicare claims and cost report data, we examined the association between hospital spending for specific services and 30-day readmission rates for heart failure, pneumonia, and acute myocardial infarction. We found that occupational therapy is the only spending category where additional spending has a statistically significant association with lower readmission rates for all three medical conditions. One possible explanation is that occupational therapy places a unique and immediate focus on patients' functional and social needs, which can be important drivers of readmission if left unaddressed.

Keywords

hospital spending, quality, readmissions, hospital management, occupational therapy

AOTA Continuing Education Article

Earn .1 AOTA CEU (one contact hour and 1.25 NBCOT PDU). See page CE-7 for details.

The Role of Occupational Therapy in Reducing Hospital Readmissions

Marnie Renda, MEd, OTR/L, CAPS, ECHM
Occupational Therapists and Founder/Owner, Rebuild Independence LLC, Cincinnati, OH, and Adjunct Faculty Member, Xavier University, Norwood, OH

Susan Lee, MS, OTR/L
Occupational Therapist and Research Scientist, Center for Assistive Technology and Environmental Access, Atlanta, GA

Marian Keglovits, OTD, MSCI, OTR/L
Occupational Therapist, Washington University in St. Louis, School of Medicine, Program in Occupational Therapy

Emily Somerville, MS, OTR/L
Occupational Therapist, Washington University in St. Louis, School of Medicine, Program in Occupational Therapy

This CE Article was developed in collaboration with **AOTA's Home & Community Health Special Interest Section.**

ABSTRACT

The implementation of the Affordable Care Act led to the Centers for Medicare & Medicaid Services mandate to reduce costly unplanned hospital readmissions. As a result, hospitals are actively seeking solutions to reduce readmissions, which now have financial penalties. This provides occupational therapy professionals the opportunity to demonstrate their expertise and knowledge in contributing to a reduction in readmissions. The role of occupational therapy in reduction can include care coordination, fall prevention, medication management, assistive technology acquisition, and community re-integration.

Reducing hospital readmissions is one such area where occupational therapy can demonstrate the value of its services, improving the health and wellness of clients while reducing health care costs.

The ACA was designed to facilitate changes in our health care system by linking quality of care to reimbursement. In doing so, health care providers are encouraged to discover and use best practices to create optimal outcomes while reducing cost. The Medicare Payment Advisory Commission (n.d.) in June 2011 identified hospital readmissions as a critical area to be addressed.

Hospital readmission is defined as a repeated hospitalization within a defined period of time. CMS defines a readmission as a hospitalization occurring within 30 days of discharge. This includes readmissions to any hospital, not just the hospital at which the patient was originally hospitalized (Boccuti & Casillas, 2015).

CMS spends an estimated $26 billion annually on hospital readmissions for Medicare recipients (Rau, 2014). Of those readmissions costs, about $17 billion has been identified as preventable, stemming largely from substandard care, including poor resolution of the cause for hospitalization and inadequate post-discharge care (Benbassat, 2000).

CMS began measuring and reporting the incidence of hospital readmissions for particular medical conditions in 2007. In an effort to create transparency, this information is available on the Hospital Compare website (www.medicare.gov/hospitalcompare). CMS reports each hospital readmission rate compared with hospitals nationally to determine each hospital's Excess Readmissions Ratios for specific medical conditions. Hospitals with readmission ratios above the national average are issued financial penalties of between 0.01% and 3% of total revenue (CMS, 2014a). Currently, CMS measures readmission rates related to the following medical conditions: acute myocardial infarction

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Reducing Hospital Readmission: Current Strategies and Future Directions

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Abstract

New financial penalties for institutions with high readmission rates have intensified efforts to reduce rehospitalization. Several interventions that involve multiple components (e.g., patient needs assessment, medication reconciliation, patient education, arranging timely outpatient appointments, and providing telephone follow-up), have successfully reduced readmission rates for patients discharged to home. The effect of interventions on readmission rates is related to the number of components implemented, whereas single-component interventions are unlikely to reduce readmissions significantly. For patients discharged to post-acute care facilities, multicomponent interventions have reduced readmissions through enhanced communication, medication safety, advanced care planning, and enhanced training to manage common medical conditions that commonly precipitate readmission. To help hospitals direct resources and services to patients with greater likelihood of readmission, a number of risk stratification methods are available. Future work should better define the role of home-based services, information technology, mental health care, caregiver support, community partnerships, and new transitional care personnel.

Keywords: Transitions of care, Hospital discharge, Readmission risk, Post-acute care

Areas at risk for re-hospitalization

- Occupational therapy reduces incidence of re-hospitalization
  - Medication management
  - Person, environment and occupation fit
  - Managing one's state from a physiological perspective through incorporating behaviors within habits and routines
  - Falls prevention and management

Benefits of Group Therapy

- Benefits of Group Therapy
- Irvin Yalom
  - Persistence of Hope
  - Being One
  - Imparting Information
  - Altruism
  - Corrective Behavioral Commentary
  - Remaining Social while Healing
  - Imitation
  - Interpersonal Learning
  - Catharsis
  - Existential Factors

Group Treatment Sessions

- Do you have a group "class" ideas for short-term patients?
  - Problem-focused training
  - Discharge planning classes
  - Diagnostic specific training classes
  - Patient and family education classes
  - Health management and maintenance

Put your foot in the door

- Embrace change
- Analyze your practice
- Are you exuding the distinct value of OT?
- Maximize your capacities to support optimal outcomes, successful transitions, and reducing re-hospitalizations

Significance of Documentation during Medicare Reform

Best Case Scenario

- Data-driven documentation for Medicare shows value and increases reimbursement for OT, increases OT job and fieldwork opportunities

Worst Case Scenario

- OT documentation does not show value; reimbursement from Medicare decreases
- OT positions are eliminated: decreased availability of FW spots and job opportunities for new graduates

Potential
Student Projects:
Data-Driven Documentation for Value

In-services for staff on outcome measures

Develop toolkit for documentation

Journal Club series: Volume to Value Literature

Critical appraisal reports of articles related to outcome measures

DISCUSSION

Sharing Resources