

Advancing the Value and Quality of Occupational Therapy in Health Service Delivery

Natalie E. Leland, Karen Crum, Shawn Phipps, Pamela Roberts, Barbara Gage

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Natalie E. Leland, PhD, OTR/L, BCG, FAOTA, is Assistant Professor, Mrs. T.H. Chan Division of Occupational Science and Occupational Therapy and Davis School of Gerontology, University of Southern California, Los Angeles; nleland@osot.usc.edu

Karen Crum, MA, OTR/L, is Clinical Doctorate Resident, Rehabilitation Health Services Research Lab, Mrs. T.H. Chan Division of Occupational Science and Occupational Therapy, University of Southern California, Los Angeles.

Shawn Phipps, PhD, MS, OTR/L, FAOTA, is Chief Quality Officer and Associate Hospital Administrator, Rancho Los Amigos National Rehabilitation Center, Los Angeles, and Director, American Occupational Therapy Association Board of Directors, Bethesda, MD.

Pamela Roberts, PhD, OTR/L, SCFES, FAOTA, CPHQ, is Program Director, Physical Medicine and Rehabilitation and Neuropsychology, Cedars-Sinai Medical Center, Los Angeles, and Vice Chair and Chair-Elect, Accreditation Council for Occupational Therapy Education, Bethesda, MD.

Barbara Gage, PhD, MPA, is Senior Vice President, Scientific Research and Evaluation, PAC Center for Research, and Fellow, Brookings Institution, Washington, DC.

The Patient Protection and Affordable Care Act of 2010 (ACA; Pub. L. 111–148) is driving the health care system to shift from a volume-based reimbursement system to one based on value and high quality with an emphasis on evidence-based and patient-centered care. The objective of this new paradigm is to improve patient outcomes by incentivizing providers to deliver scientifically grounded best practices by linking payment to performance. The end goals are to improve population health outcomes, enhance consumer satisfaction, and reduce health care costs—often referred to as the *Triple Aim* (Berwick, Nolan, & Whittington, 2008). In this health care reform context, it is imperative to define and delineate the distinct value and unique role of occupational therapy. Failure of the profession to clearly demarcate what constitutes high-quality occupational therapy and demonstrate its contribution to the broader patient outcomes that value-based care will measure may marginalize occupational therapy in the rapidly changing health care environment.

The objective of this article is to provide a foundation on which to build further dialogue and evidence to highlight the profession's distinctive contribution, significance, and viability as health care policies shift to focus on quality and value. To achieve this goal, we present a framework for examining health care quality and patient outcomes, describe the health care context that is driving the need for quality measurement in occupational therapy, explain the concept of value-based care in the context of occupational therapy, and discuss how occupational therapy can define high-quality care processes to enhance outcomes and ensure a viable future for the profession.

Framework for Examining Health Care Quality

To improve patient outcomes in clinical practice, it is necessary to understand the theory behind health care quality. Donabedian (1966, 2003) proposed a theoretical framework in which health care quality can be evaluated and outcomes targeted for improvement. In his model, Donabedian postulated that outcomes

are the result of the care processes that are provided and the structure in which care is delivered. Donabedian defined *care processes* as actions offered by the health care provider to the patient, whereas *structure* includes the characteristics of the context and environment in which the care is delivered (e.g., physical space, practice culture, policies and procedures, staffing). Guided by this model, the most direct way to improve outcomes is to target the care processes that are delivered (Donabedian, 1966, 2003). Care processes have been identified as the most readily adaptable elements within Donabedian's model, which makes them an ideal target for quality improvement.

Medicare's Physician Quality Reporting System (PQRS) and the American Medical Association's (AMA's) Physician Consortium for Performance Improvement (PCPI), among other bodies, are engaged in the development of both process and outcome measures (Commission on Accreditation of Rehabilitation Facilities, 2014; Joint Commission, 2014; PCPI, 2011). To target outcomes for improvement, it is necessary to identify what care should be provided, document the delivery of that care, and evaluate the outcomes resulting from the delivery of those care processes, also referred to as *care process quality indicators*. These quality indicators are evidence-based and patient-centered clinical action items that reflect critical and prioritized interventions that can be delivered and documented consistently across organizations and by clinicians in pursuit of achieving desired patient outcomes (Mainz, 2003).

Defining High-Quality Care: Developing Care Process Quality Indicators

Many health care professions have developed care process quality indicators to improve outcomes, demonstrate their unique value, and enhance service delivery (Min et al., 2011; Rubenstein et al., 2004; Wenger et al., 2010). Although the emphasis has been on the development of care process measures, outcome measures (e.g., 30-day readmissions) and composite measures, which combine information on more than one performance measure, are also being developed. PCPI, the National Quality Forum (NQF), and the Agency for Healthcare Research and Quality (AHRQ) have standardized protocols for developing both process and outcome quality measures (Battelle, 2011; NQF, 2011; PCPI, 2011). The protocol comprises six phases, the first of which is *measure development*. During this initial phase, an expert panel is convened to prioritize a set of measures drawn from the existing evidence base and stakeholder priorities using the RAND Appropriateness Model (Battelle, 2011; NQF, 2011). The panel is made up of a broad group of stakeholders relevant to the measure development topic

area and includes, but is not limited to, providers, topical experts, researchers, payers, administrators, and informatics specialists.

The protocol requires that the identified measures then go through five additional phases: *measure specification, evaluation, implementation, maintenance, and enhancement*. Measures are currently being developed by a variety of health care stakeholder groups, including national organizations, the federal government, consumer advocates, professional societies, and researchers.

Improving Outcomes: Integrating Quality Measures Into Practice

The objective of developing care process quality measures is to define minimum standards of care. Guided by the standardized six-phase protocol described in the preceding section, physicians have been actively engaged in defining care process quality measures and integrating those measures into clinical practice in an effort to improve patient outcomes (Wenger, Shekelle, & ACOVE Investigators, 2001). For example, a group of physician researchers were acutely aware of the devastating impact accidental falls had on the health and quality of life of community-dwelling older adults. In an effort to prevent this undesirable outcome and enhance care delivery, they developed a series of care process quality measures for fall prevention in primary care (Rubenstein et al., 2004). The objective was to decrease the likelihood of falling, and the associated subsequent poor outcomes, for older adult patients.

Using the standardized six-phase protocol, physician groups have defined fall prevention care processes, operationalized them as quality measures, and then integrated these measures into clinical documentation to support clinical decision making (Min et al., 2011; Rubenstein et al., 2004). The essential quality measures include improving screening rates, enhancing fall risk factor identification, and facilitating necessary referrals to other disciplines targeting the identified risk factors. A controlled trial found that primary care facilities that integrated the quality measures into clinical practice had a higher rate of delivering and documenting the care process quality measures and improving patient outcomes than facilities that did not use the measures in their practice (Wenger et al., 2009, 2010).

Although physicians have been at the forefront of quality measure development through the AMA's leadership and the establishment of the PCPI, this example of quality improvement can also be applied and implemented by occupational therapy practitioners. Indeed, occupational therapy practitioners in private practice who bill Medicare are able to report these three items as part of the PQRS (Hitchon, 2014). Furthermore, occupational

therapy practitioners have participated in the fall prevention measure development process as integral stakeholders, have attended the AMA's PCPI biannual meetings, and have advocated for the linkage of process measures to occupational therapy.

To align with the priorities of health care reform, occupational therapy practitioners can use the six-phase measure development methodology to define and evaluate the value of occupational therapy services in other areas of health care delivery. To this end, we must define our evidence-based and patient-centered care processes to enhance the delivery of occupational therapy services and improve patient outcomes, thereby demonstrating the value that the profession contributes to patient care.

Context of Health Care Reform: Attention to Acute and Postacute Care

The United States spends more than any other developed country on health care. Unfortunately, despite outspending other developed countries, patient outcomes in the United States are worse than those of other countries, indicating a need to improve the quality and efficiency of our health care system (Davis, Schoen, & Stremikis, 2010; Honoré et al., 2011). Further, rising health care costs are exacerbated by an aging population that is relying on Medicare in growing numbers, placing further financial strain on the fee-for-service system in which volume is the key driver instead of outcomes. For example, Medicare spending for postacute care has more than doubled over the past 10 years, with expenditures increasing from \$26.6 billion to \$63.6 billion, yet patient outcomes are sub-optimal, resulting in Medicare's growing scrutiny of rehabilitation quality in postacute care (Medicare Payment Advisory Commission, 2010, 2012). Cumulatively, escalating health care expenditures, gaps in quality of care, and the exponential growth of the older adult population served as drivers of reform in the U.S. health care system, facilitating the passage of the ACA.

The transition to value-based reimbursement is an ACA initiative designed to achieve the Triple Aim. The traditional fee-for-service model, in which payment is based on the volume of services provided, has been associated with a financial incentive to provide more care without improving outcomes (Schroeder & Frist, 2013). The ACA's emphasis on quality is facilitating a paradigm shift that aims to incentivize the achievement of desired outcomes by rewarding the provision of high-quality care. Although most of the ACA's proposals are linked to Medicare, some efforts it fosters address multiple types of payers. Furthermore, because Medicare is the major payer

of health care in the United States, using Medicare to test innovations will have an impact on the larger U.S. health care system (Boccuti & Moon, 2003; Finkelstein, 2007).

Initial value-based payment initiatives that have been rolled out focus on reducing negative outcomes that research has demonstrated are preventable, are associated with high health care costs, and should not occur (e.g., hospital readmissions, hospital-acquired conditions). The initiatives also have focused on promoting consumer satisfaction and improving health overall. In any value-based payment model, facility or provider payments are tied to performance on outcomes, and the unit of analysis is the provider (e.g., acute care hospital, individual occupational therapy practitioner). In such a model, poor performance is tied to financial penalties. For example, in fiscal year 2013, 2,200 acute care hospitals with excessive 30-day readmission rates incurred a total of \$280 million in penalty payments to Medicare (Centers for Medicare & Medicaid Services, 2013; James, 2013). Thus, this reimbursement structure provides a strong financial incentive for providers to deliver high-quality care, accompanied by the corresponding preferred patient outcomes, to avoid such penalties.

Value-Based Care in the Context of Occupational Therapy

To be responsive to the current health care reform initiatives, the field of occupational therapy needs measures that can reliably and validly assess the quality and value of its services across practice settings. Also, because occupational therapy is now included in lump-sum facility payments, as value-based purchasing becomes more sophisticated it will be important to identify, protect, and recognize the specific contribution of occupational therapy to facility or system outcomes (Lamb & Metzler, 2014). Roberts and Robinson (2014) discussed the important role occupational therapy practitioners can play in addressing readmissions and hospital-acquired conditions to improve provider performance on these outcome measures; the authors specifically addressed the role occupational therapy has in improving outcomes in the area of accidental falls. We must push forward the identity and utility of occupational therapy in all settings, however, to make sure a link is understood and validated. One critical aspect of ensuring the value of occupational therapy's contribution to optimizing outcomes is to encourage practitioners to use evidence to inform clinical interventions. Some estimates indicate that use of evidence in occupational therapy fall prevention interventions is limited and that quality improvement initiatives are needed (Philibert, Snyder, Judd, & Windsor, 2003; Thomas, Saroyan, & Lajoie, 2012).

As an example of quality measure development, fall prevention is useful. Improvement initiatives addressing falls must be multidimensional. First, we must clearly define occupational therapy care processes in the area of fall prevention, and then these processes must be widely disseminated to influence practice. For instance, protocols for patients seen in certain settings (e.g., hospital emergency rooms) must be developed to enable application of the processes identified in the evidence. Follow-up on longer-term outcomes, such as monitoring patients who experience a fall and receive preventive interventions, will also be necessary to determine effectiveness. Further, documentation and reporting systems must be transformed to ensure that clinicians consistently provide and document their delivery of appropriate, evidence-validated fall prevention care processes. These systems may then be used to create a robust data set that can be examined to demonstrate occupational therapy's distinct value in preventing falls to inform the broader context of health care reform.

Defining High-Quality Occupational Therapy

A growing knowledge base of clinical research trials is providing evidence of occupational therapy's efficacy, but the translation of that evidence into practice must be amplified. To align with the priorities of the ACA, we need to ensure that the care occupational therapy practitioners provide and document is grounded in evidence and is patient centered. Moreover, we need to demonstrate our efficacy across settings, geographic regions, and subpopulations to establish care processes for the specific patient populations we serve (e.g., patients with stroke, brain injury, spinal cord injury, orthopedics). As a profession, we need to ask, What are the essential care processes that every occupational therapy practitioner should provide for each patient population we serve?

For example, what are the core interventions that constitute high-quality care to be provided across the continuum for all patients who have experienced a hip fracture, regardless of the setting in which they are receiving care? This is a population at high risk for subsequent falls, both while in rehabilitation and during the initial transition back to the community, which can increase the risk of hospital readmissions and long-term institutionalization (Mahoney et al., 2000). A recent study found that occupational therapy home safety assessments before community discharge decreased 30-day hospital readmissions (Johnston, Barras, & Grimmer-Somers, 2010). Home safety assessments are an efficacious care process that occupational therapy practitioners identify as being within

our scope of practice, particularly in the area of fall prevention (Gillespie et al., 2012; Leland, Elliott, O'Malley, & Murphy, 2012). An occupational therapy care process such as "an environmental safety assessment is provided and documented prior to community discharge" could be proposed as a process indicator for quality measure development using the standardized measure protocol (Min et al., 2011; Rubenstein et al., 2004; Wenger et al., 2010). If this process is validated as a quality measure, clinicians could then provide and document the care process, which would serve as a means of validating the quality of occupational therapy. Longitudinal data would optimally show that patients who received the assessment from an occupational therapy practitioner did better (e.g., experienced fewer injuries from falls), thus improving the facility's overall care rating and further validating occupational therapy's distinct value in home safety and fall prevention.

Implications for Occupational Therapy Practitioners, Educators, and Researchers

The transition to value-based care will require the participation of occupational therapy practitioners, educators, and researchers to develop strategies that will align the practice of occupational therapy with the Triple Aim of health care reform. Occupational therapy researchers working together with clinicians can enhance the translation of evidence into practice. Furthermore, as a team, researchers and clinicians can integrate current evidence with the pragmatics of clinical practice to define high-quality occupational therapy practice using the standardized quality measure development methods of the PCPI, AHRQ, and NQF (Min et al., 2011; Rubenstein et al., 2004; Wenger et al., 2010).

In the context of the ACA's "meaningful use" mandate (i.e., the "use of certified electronic health record [EHR] technology to improve quality, safety, efficiency, and reduce health disparities" to improve clinical outcomes; healthIT.gov, 2014) and the emergence of EHRs, clinicians need documentation platforms that reflect the clinical reasoning and decision-making processes of occupational therapy practitioners. Additionally, these systems must promote documentation of the actual care provided and the outcomes achieved. For institutions to develop documentation systems that capture the quality care occupational therapy practitioners define as *value*, we must come to consensus as a profession and communicate those care processes and critical elements to the developers of the EHR platforms. Accurate documentation reflecting high-quality occupational therapy serves as the foundation for validating the value of our services.

In the context of value-based care, clinicians need to ensure that their documentation reflects the care they provide, that the care is grounded in evidence, and that they use their own data to assess the quality of their care processes. Quality improvement in the clinical setting is a continuous process. Clinicians and administrators need to work collaboratively, examining practice patterns and establishing minimum standards of practice. The ongoing use of clinical data can identify areas in which the facility exceeds expectations and reveal areas of care delivery that would benefit from improvement. By taking action and engaging in self-appraisal, we can enhance our practice, thereby improving patient outcomes.

The demand is growing for health services research in occupational therapy. The profession needs researchers to use new and emerging EHR data sources to examine the impact of occupational therapy services and build the evidence that measures the value of our contributions within the context of the broader health care community. The use of Medicare administrative data, registries, and EHRs provides opportunities for the assessment of service delivery in the clinical setting for populations of patients, thereby allowing us to move beyond clinical trials to demonstrate the value of occupational therapy services on a broader scale. For example, data from fall prevention care process measures may demonstrate that patients who received the fall prevention care processes during rehabilitation across all postacute care settings while recovering from hip fracture had lower rates of falls and hospital readmissions after discharge back to the community compared with those who did not receive high-quality care. For the profession to have the evidence base needed to advocate for high-quality occupational therapy in the era of value-based reimbursement, we need not only to produce more research, but also to develop a critical mass of trained researchers who can evaluate the quality, access, timing, and utilization of occupational therapy services.

Each occupational therapy practitioner needs to be accountable for the type and value of services he or she provides to ensure optimal outcomes. Measuring and improving the value of occupational therapy remains a central priority of the profession (Porter, 2010). Value-based payment has significant implications for the education of occupational therapy practitioners. Health care is changing so rapidly that educational programs are challenged to prepare their students for the ever-changing health care environment. In addition to being prepared to engage in the evolving practice environment, students need the skills to appraise evidence, articulate the care they provide, document evidence-based care processes, and examine data from clinical practice. Furthermore,

academic programs can team up with health information technology programs to expose students to the emerging area of electronic health and health information systems. It will be critical to have occupational therapy-trained people on the front lines of health information technology, developing EHR systems that capture the quality and value of occupational therapy.

Conclusion

As the focus in health care shifts toward supporting higher quality, the occupational therapy profession needs to develop quality measures that will allow practitioners to provide, document, and evaluate our valuable contribution to optimal patient outcomes. This paradigm shift presents an opportunity for clinicians, researchers, and educators to collaboratively contribute to defining quality care measures, promote the adoption of these standards of service, and evaluate the delivery of care that occupational therapy provides. By using data to reflect our contribution to improved patient outcomes and recognizing areas for future progress, the profession will be strengthened. ▲

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