The passage of the Patient Protection and Affordable Care Act of 2010 (ACA; Pub. L. 111–148) represents the largest expansion in government funding of health care since Medicare and Medicaid were established in 1965 (Curfman, Abel, & Landers, 2012). Although the health insurance mandate and Medicaid expansion have received the most attention as a result of legal challenges and the July 2012 Supreme Court ruling on the legality of the ACA (Henry J. Kaiser Family Foundation, 2012), other ACA initiatives may have even greater implications for occupational therapy. The ACA includes sections on improving quality and health systems performance for Medicare recipients, with some sections also applying to Medicaid recipients. Insurance companies commonly follow Medicare rules; therefore, the Medicare reforms are likely to spread across all payers, health care settings, and care recipients.
unnecessary spending. In these areas, occupational therapy practitioners must gather their research, understand the system changes, and reach for the opportunities that will abound.

Value-Based Purchasing

ACA addresses the need for efficiency in health care primarily through value-based purchasing (VBP) proposals. VBP links provider payments to improved performance by health care providers (“Administration Implements,” 2011). VBP is not a new concept for health care providers. Hospitals, insurance companies, and other health care agencies throughout the United States have used pay-for-performance incentives similar to the ones proposed in the ACA, particularly since the Institute of Medicine (IOM) encouraged pilot programs in its 2001 report (Baker, 2003). Baker (2003) investigated the outcome of such programs at various levels of implementation, using the viewpoints of stakeholders of the purchaser (or employer providing health insurance), the health plans themselves, and health care providers (mainly physicians). Although several barriers and concerns were identified, pay-for-performance initiatives were deemed highly useful for controlling costs and reaching quality targets (Baker, 2003).

The ACA establishes VBP programs for Medicare recipients that will gradually be implemented in hospitals and then in SNFs, outpatient surgical centers, and home health agencies (Henry J. Kaiser Family Foundation, 2010). VBP provides payment incentives for health care providers’ desirable behaviors, such as efficient use of resources, provision of high-quality care, and achievement of positive patient outcomes, which means good care organization. In VBP approaches that have been attempted, payment rates have incorporated outcome quality measures and patient satisfaction surveys, rewarding providers who have the highest ratings and who also keep costs down. Allowances can be made to reward deficient hospitals if they improve. Payment penalties for unnecessary costs are assessed to shape behavior and call more attention to outcomes that are valued by the payer.

The ACA uses some of these approaches with Medicare. For example, hospitals will receive a reduced payment if patients with certain conditions are readmitted within 30 days or have high rates of preventable conditions attained during hospitalization, or if hospitals fail to use efficient information technology (Henry J. Kaiser Family Foundation, 2010). More rewards and penalties will be phased in as VBP gradually replaces the current systems of reimbursement for inpatient and outpatient care (“Administration Implements,” 2011).

Implications of Value-Based Purchasing for Occupational Therapy

Although implementing VBP may pose challenges, it also introduces potential avenues for occupational therapy to broaden its scope of influence in physical rehabilitation settings that serve Medicare clients. Using evidence-based practice guidelines, client-centered care, and validated assessments constitutes best practice, and the resulting outcomes can assist a hospital or other provider entity to obtain payment increases for high-quality care. Occupational therapists and occupational therapy assistants can work within a multidisciplinary framework to design facility-specific best-care practice guidelines based on approaches supported by evidence. Although the therapist’s clinical judgment cannot be replaced by a checklist, research has shown that uniform processes can reduce a trial-and-error approach to care, improving efficiency and positive outcomes (Novalis, Messenger, & Morris, 2000).

Coupling clinical pathways with client-centered care can evoke more meaning and more commitment to the therapy regimen on the part of the patient, which is likely to improve functional outcomes and satisfaction surveys, both of which are currently used for payment incentives and will be components of Medicare payment changes. Implementing functional assessments that have been validated as reliable pre- and posttreatment measures, such as the Disabilities of Arm, Shoulder and Hand Questionnaire outcome measure (Institute for Work and Health, 2006) or the Activity Measure for Post-Acute Care™ (2013) will provide data that can be used to prove therapy effectiveness.

One in 7 Medicare patients experiences an adverse event such as a preventable illness or injury while in the hospital. One in 3 Medicare beneficiaries who leave the hospital is readmitted within a month (“Administration Implements,” 2011). The VBP initiatives of reducing hospital-acquired conditions and preventing unnecessary hospital readmission provide opportunities for occupational therapy personnel to demonstrate their important role in meeting the ACA objectives.

Preventing Hospital-Acquired Conditions

The ACA seeks to put pressure on hospitals to reduce avoidable hospital-acquired conditions. Under this legislation, several conditions will be monitored, such as catheter-associated urinary tract infections and foreign objects retained after surgery; however, occupational therapists have specific expertise in preventing injuries resulting from falls (and fall prevention), preventing pressure ulcers (Stages 3 and 4), and preventing deep vein thrombosis (DVT) after orthopedic surgeries (Centers for Medicare and Medicaid Services [CMS], 2012). Under the ACA, beginning in 2015 hospitals that rank in the top 25% of prevalence of patients with these hospital-acquired conditions will be subject to 1% loss of Medicare diagnosis-related group (DRG) payment for each patient that has these conditions (Bricker & Eckler, LLC, 2010). Several hospital types are currently exempt from this aspect of the ACA, such as psychiatric hospitals, rehabilitation hospitals, children’s hospitals, long-term care hospitals, and certain cancer treatment and research facilities (CMS, 2012).

Falls are one of the hospital-acquired conditions that will be reported under the ACA, and occupational therapy practitioners working in the hospital setting can play a key role in falls prevention management. Clyburn and Heydemann (2011) found that estimations of falls for inpatients in acute care hospitals ranged from 3% to 20% of all those admitted, and Shorr et al. (2002) found that 78% of these falls occurred in general medical or surgical care units. Additionally, nearly half of the patients who fell did so on or before the 4th day of hospitalization, with 31% sustaining injury (Shorr et al., 2002). The Institute for Clinical Systems Improvement...
(ICSI) determined that falls are the leading cause of injuries sustained in the hospital, with 30% resulting from patients’ attempts to use the bathroom (Degelau et al., 2012).

Although fall prevention may require multidisciplinary action, occupational therapists have a unique skill set to analyze patients’ abilities, the environmental risk, and the complexity of the desired task in relation to the person and the environment that plays a key role in developing a sustainable program in any hospital as well as postdischarge. This skill set can be vital in the early stages of ACA implementation to deter hospitals from using unnecessary restraint interventions to avoid financial penalties based on patient falls. Occupational therapists can play an important role in educating staff about the literature associated with restraint use and about how studies have indicated that restraints actually increase the risk of falls due to deconditioning and increased agitation, among other factors (Shorr et al., 2002).

In addition, Degelau et al. (2012) reported that physical and behavioral interventions are key components of a sustainable falls program. Occupational therapists are uniquely trained in evaluating how mobility deficits and cognitive deficits interplay and affect fall risk. ICSI recommended several measures for minimizing fall risk, including consultation with physical therapy and occupational therapy (Degelau et al., 2012). Occupational therapists working in the acute care setting should be front and center on their hospital’s falls prevention committee.

Moreover, occupational therapy can play an important role in establishing appropriate early mobilization programs in their hospitals to lessen key fall risk factors. Needham (2008) critiqued the treatment of bed rest for intensive care unit (ICU) patients and supported rehabilitation for early mobilization. According to early proponents of occupational therapy’s involvement in early mobilization programs with ICU patients (Affleck, Lieberman, Polon, & Rohrkelmer, 1986), ICU patients can experience stress pattern cycles: The patient in ICU becomes sensory deprived and immobile, has limited meaningful social interactions, and has frequent sleep disruptions, leading to neurological disorganization, which promotes depression, decreased motivation, and disorientation. While in this state, the hospitalized patient will be less likely to participate in health-promoting activities. If this neurological disorganization is unnoticed or left untreated, the patient will have a greater likelihood of falls from the weakness resulting from immobilization, as well as the accompanying confusion and disorientation. In our experience, occupational therapy personnel can intervene at any stage of the ICU stress pattern cycle by providing meaningful sensory stimulation, activity programming, activities of daily living (ADL) habit retraining, relaxation strategies, and other stress-relieving activities.

Occupational therapists can work with other disciplines to help prevent other hospital-acquired conditions. A comprehensive early mobilization program for ICU patients can significantly decrease the risk for DVT and decubitus ulcers. One of the earliest studies on the benefits of early mobilization and occupational therapy found that patients involved with these interventions make faster improvements in endurance, cardiovascular health, muscle strength, and functional abilities (Affleck et al., 1986), all of which also influence falls (Degelau et al., 2012). In addition, occupational therapists are trained to properly educate patients, their families, and staff members on pressure-relieving strategies and functional positions that have proven to be effective in minimizing risk for decubitus ulcers as well as with the critical component of integrating these strategies into daily life. Cutajar and Roberts (2005) found that pressure sores in people with spinal cord injuries are significantly reduced with increased engagement in ADLs. Patients with any debilitating illness would likely have similar results.

Finally, movement has been proven to reduce the risk of DVT. Occupational therapy intervention is poised to reintroduce activity after surgical procedures to reduce the risk for this life-threatening condition.

**Preventing Hospital Readmission**

To improve efficiency, responsible use of Medicare funds, and quality of hospital care, the ACA has made reducing hospital readmissions a priority. The ACA includes the Hospital Readmission Reduction Program, which became effective October 1, 2012 (ACA, 2010). Patients targeted in the first round of ACA payment penalties are those who are readmitted within 30 days of their original hospitalization for acute myocardial infarction (AMI), congestive heart failure, and pneumonia (ACA, 2010). In addition, CMS proposes to expand the applicable conditions for 2015 to include patients admitted for an acute exacerbation of chronic obstructive pulmonary disease and patients admitted for elective total hip arthroplasty and total knee arthroplasty (CMS, 2013). This program will assess penalties on hospitals that have readmission rates higher than the national average. The CMS has reported that the median prevalence of readmission in 2009 was 19.7% for patients with AMI, 24.7% for those with heart failure, and 18.4% for those with pneumonia, adjusting for risk factors such as demographics and comorbidities. Similar figures were found for the 2 years prior (Yale New Haven Health System Corporation, 2011).

Penalties for readmission of people with these conditions range from 0.01% to 1% of the DRG payment rate and will increase to a maximum penalty of 3% by 2015 (McKinney, 2012). CMS will work with these hospitals via quality improvement organizations to assist with long-term planning to reduce preventable readmissions (CMS, n.d.).

Occupational therapy practitioners have an opportunity to be a critical part of the care team to prevent hospital readmissions. They can take a leadership role and assist in screening for and addressing subsequent readmission risk before discharge from the acute setting. Using a self-management approach (Lorig et al., 1999), occupational therapy personnel can assist the patient and family in identifying realistic goals and action plans to manage the patient’s health condition. Using occupation-focused assessments and models, they can identify potential risks associated with discharge and recommend supports and education related to physical and cognitive cues that may be suitable for a patient as well as environmental adaptations to prevent an unnecessary return to the hospital.

Outside of acute care, hospitals will be looking for therapy providers in home
health, outpatient settings, and SNFs who are successful in preventing unnecessary hospital readmission. Therapists and businesses that demonstrate that they have protocols in place to prevent return to the hospital will be sought after. Protocols may include the following:

- Education of clients and family members regarding warning signs that warrant a hospital visit, and those that do not, in the context of performing occupations
- Reviewing which level of care is recommended on the basis of symptoms and making sure the patient and family have a realistic plan for determining what type of consultation is needed before going to the hospital
- Self-management of symptoms, including medication management with accommodations for cognitive, sensory, and physical limitations
- Use of evidence-based assessments and interventions to address fall risk in the home or residential facility, a frequent trigger for a readmission
- Engaging the client in carefully selected physical and cognitive therapeutic activities that will build functional capacity as well as strength and endurance.

In addition, occupational therapists can lead the team with an understanding of how health literacy affects outcomes. The complexity of the U.S. health care system requires a keen set of health literacy skills, defined by the IOM as the “degree to which individuals have the capacity to obtain, process and understand basic health information and services needed to make appropriate health decisions” (Kutner, Greenburg, Jin, Paulsen, & White, 2006, p. iii). These skills will be even more critical as tenets of the ACA unfold, and people will need to learn how this legislation affects their specific health needs. The negative consequences of a mismatch on health literacy skills between practitioners and patients are numerous but include noncompliance with recommendations, underutilization of services, and increased hospitalizations (Levasseur & Carrier, 2010; Smith, Hedrick, Earhart, Galloway, & Arndt, 2010).

The profession of occupational therapy is exceptionally well positioned to address health literacy issues because practitioners are trained to analyze activity demands and adapt them for increased participation. Smith and Gutman (2011) advised practitioners to evaluate the literacy of their own workplace, making adaptations as needed, including material revisions and training staff in improved oral communication as well as on how to further globalize education of patients on topics when they may be embarrassed about their lack of skill. Griffin, McKenna, and Tooth (2003) offered strategies for assessing and modifying documents to be more congruent with a variety of health literacy needs.

Opportunities, Challenges, and Actions

The ACA provides opportunities for occupational therapists and occupational therapy assistants to play an active role in the transformation of the U.S. health care system. In addition to the VBP initiatives, the ACA encourages new, more efficient models for service delivery through the Center for Medicare and Medicaid Innovation (n.d.), which has 36 funded projects. One is the establishment of accountable care organizations, which would tie improved patient outcomes to payment. Another is the Independence at Home program, which will test the cost-effectiveness of providing comprehensive primary care services in the home for people with multiple chronic conditions (Center for Medicare and Medicaid Innovation, 2012). These projects could have dramatic implications for the delivery of acute and postacute care.

The opportunities provided by the ACA are accompanied by challenges. Occupational therapists may not be perceived as key personnel to include in VBP initiatives and innovation grants. Home health agencies, SNFs, and hospitals will be developing new relationships that will focus on preventing hospitalizations, patient satisfaction, and functional outcomes. Do we have the quality measures, assessments, and outcome measures we need to demonstrate our effectiveness? Can we articulate how occupational therapy is an efficient use of limited resources? Demonstrating a positive cost–benefit ratio will be essential.

Occupational therapy could take the lead on fall prevention and self-management. If other professionals position themselves as the most qualified to address these key domains, occupational therapy practitioners will be left out. Practitioners need to do their homework to learn about the latest evidence-based fall prevention and self-management programs. Grassroots advocacy will be needed as the ACA is implemented and revised—in the halls of Congress, regulatory agencies, and state capitols and in research projects and every care setting. The American Occupational Therapy Association (AOTA) needs practitioners and students to develop ongoing relationships with legislators, policymakers, and health care systems to educate them about the value of occupational therapy. Legislators will be more likely to sponsor or support laws and amendments that will ensure access to occupational therapy if they have heard from their constituents. Encouraging colleagues to join AOTA will assist in funding these lobbying initiatives. Contributing to the American Occupational Therapy Political Action Committee (AOTPAC) will enable the profession to elect and reelect key legislators who share its priorities and sponsor its bills and amendments.

The profession has a long road ahead in transforming occupational therapy practice to thrive in the changing health care environment. Through individual and collective efforts, occupational therapy practitioners may be recognized as an integral part of improving the health care system and client outcomes. To get there, however, we must move toward the 2017 Centennial Vision (AOTA, 2007) to be a “powerful, widely recognized, science-driven, and evidence-based profession . . . meeting society’s occupational needs” (p. 613), or the value we create for our clients and the system will never be realized. The profession’s Centennial Vision coincides with the health care system’s movement toward outcomes, evidence, and science and will guide us on the journey toward the future. ▲

References
