Using the New Postacute Care Quality Measures to Demonstrate the Value of Occupational Therapy

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As the health care system continues to evolve toward one based on quality not quantity, demonstrating the value of occupational therapy has never been more important. Providing high-quality services, achieving optimal outcomes, and identifying and promoting occupational therapy's distinct value are the responsibilities of all practitioners. In relation to the Improving Medicare Post-Acute Care Transformation (IMPACT) Act of 2014, the Centers for Medicare and Medicaid Services (CMS) is implementing new functional items and related outcome performance measures across postacute care (PAC) settings. Practitioners can demonstrate the role and value of occupational therapy services through their participation in data collection and the interpretation of the resulting performance measures. In this column, we review the objectives of the IMPACT Act, introduce the new self-care and mobility items and outcome performance measures being implemented in PAC settings, and describe ways to use these new data to advocate for occupational therapy. We also discuss American Occupational Therapy Association initiatives to provide materials and guidance for occupational therapy practitioners to contribute to PAC data collection.

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Occupational therapy is a prominent service in Medicare, particularly in postacute care (PAC) settings, which include skilled nursing facilities (SNFs), home health agencies (HHAs), inpatient rehabilitation facilities (IRFs), and long-term care hospitals. Among members of the American Occupational Therapy Association (AOTA), SNFs are the main work site of 34% of occupational therapists and 55% of occupational therapy assistants (AOTA, 2015). IRFs and HHAs are also prominent workplaces for occupational therapy practitioners. The Medicare Payment Advisory Commission (MedPAC; 2017) reported that in 2015, $60 billion was spent in Part A fee-for-service payments for all therapy in PAC settings. In light of the significant Medicare program spending on therapy services, Congress, MedPAC, and the Centers for Medicare and Medicaid Services (CMS) have been scrutinizing Medicare PAC costs and services for more than a decade. The occupational therapy profession must therefore ensure that the services it provides are clearly identified, valued, and maintained in the long term (Leland, Crum, Phipps, Roberts, & Gage, 2015).

Recent research has shown that occupational therapy professionals can help achieve desired outcomes such as reductions in rehospitalizations (Rogers, Bai, Lavin, & Anderson, 2017). As CMS collects more data to judge the effectiveness and results of its programs, occupational therapy practitioners must ensure that information is properly collected and analyzed at the facility level. Performance measures are critical for the profession because, in the current health care climate, any services that do not contribute to the measured outcomes risk losing reimbursement. AOTA has advocated on behalf of the profession, but individual practitioners must understand that their participation in data collection—as well as the quality of their clinical interventions—will determine the future of the profession.

IMPACT Act Background and Objectives in Postacute Care

Legislation passed by Congress put the gears in motion for CMS to develop the procedures now being implemented to measure and improve the quality of services provided. As discussed by Kroll and Fisher (2018) and Giles, Edwards, Morrison, Baum, and Wolf (2017), the purpose of the Improving Medicare Post-Acute Care Transformation (IMPACT) Act of 2014 (Pub. L. 113-185) was to evaluate and better align the incentives and payment for PAC services provided under Medicare and to optimize the quality of services in PAC settings.

Enactment of the law was driven in part by a series of recommendations from MedPAC (2016) over several years that urged CMS to collect data to recommend a PAC payment system and "begin to base payments for PAC on patient characteristics, not the site of service" (p. 57). The IMPACT Act, which will be fully implemented in 2019, is also bringing attention to issues that are critically related to quality of care, such as improving resource utilization, ensuring patient safety, reducing caregiver burden, and enhancing discharge planning and care transitions.

The use of uniform data items allows Medicare to collect standardized data across PAC settings and evaluate the effects of health care services on patients' overall health and functional status over time. The IMPACT Act initiated the reporting of standardized quality measures across PAC settings that focus on key clinical areas, including medical conditions, functional status, cognitive function, and social supports, among others. The specification of these areas, which are all highly relevant to occupational therapy process and outcomes, has created opportunities to promote the role of occupational therapy in achieving client-centered and client-meaningful outcomes.

The IMPACT Act requires attention to these clinical areas for the purposes of predicting PAC resource needs, promoting continuity of care, avoiding preventable hospital readmissions, and achieving positive outcomes for Medicare beneficiaries. These objectives are clearly aligned with other legislative and regulatory efforts in Medicare payment policy over recent years to reimburse health care practitioners and facilities for the value rather than the volume of health care services provided to beneficiaries. Such efforts include the Triple Aim highlighted by the Patient Protection and Affordable Care Act (2010; Pub. L. 111-48), the creation of the Center for Medicare and Medicaid Innovation and resulting alternative payment models and, more recently, quality programs being implemented under the Medicare Access and CHIP Reauthorization Act (Pub. L. 114-10).

The objectives of Congress in passing the IMPACT Act were to capture more thorough and consistent data; to carefully and specifically document outcomes related to function and cognition; and to rethink how services in PAC settings are provided, evaluated, and reimbursed. Ultimately, the goal was to ensure that appropriate, quality care is provided at equitable costs across these settings.

The underlying message of the IMPACT Act is that PAC settings must look more at the whole patient across the episode of care. This message aligns perfectly with occupational therapy practitioners' consideration of all of the activities of daily living (ADLs) their clients need to function and remain healthy (i.e., independent, productive, healthy, not rehospitalized) when they move from PAC to the community or other outpatient care. AOTA believes that the IMPACT Act presents a wide-open door to prove the profession's distinct value for the whole client.

Critical Data: Section GG

IMPACT Act implementation started with data collection. The CMS standardized data elements provide a significant opportunity for occupational therapy. Building on the profession's foundation in functional performance, with a focus on self-care, cognition, and community mobility, the IMPACT Act offers the field of occupational therapy a platform to demonstrate the profession's distinct value in PAC.

IMPACT Act efforts have built on a particular set of assessment items, the Continuity Assessment Record and Evaluation (CARE) Item Set, that was originally developed as part of the Post-Acute Care Payment Reform Demonstration project (Gage, Constantine, et al., 2012; Gage, Deutsch, et al., 2012; Gage, Smith, et al., 2012). The CARE Item Set measures the health and functional status of Medicare beneficiaries on admission to PAC and measures changes in function between PAC admission and discharge. The CARE Item Set provided a framework for a subset of items now being implemented. Most items in CARE Item Set are typically recorded in patients' medical records, although the format or formality of the medical record, location of the data in the record, and individuals or clinicians designated to collect the data may vary. Items in the CARE Item Set were selected to maximize reliability, validity, and breadth of application (to minimize floor and ceiling effects) and to minimize incentives that might encourage provider behavior inconsistent with best practices for care.

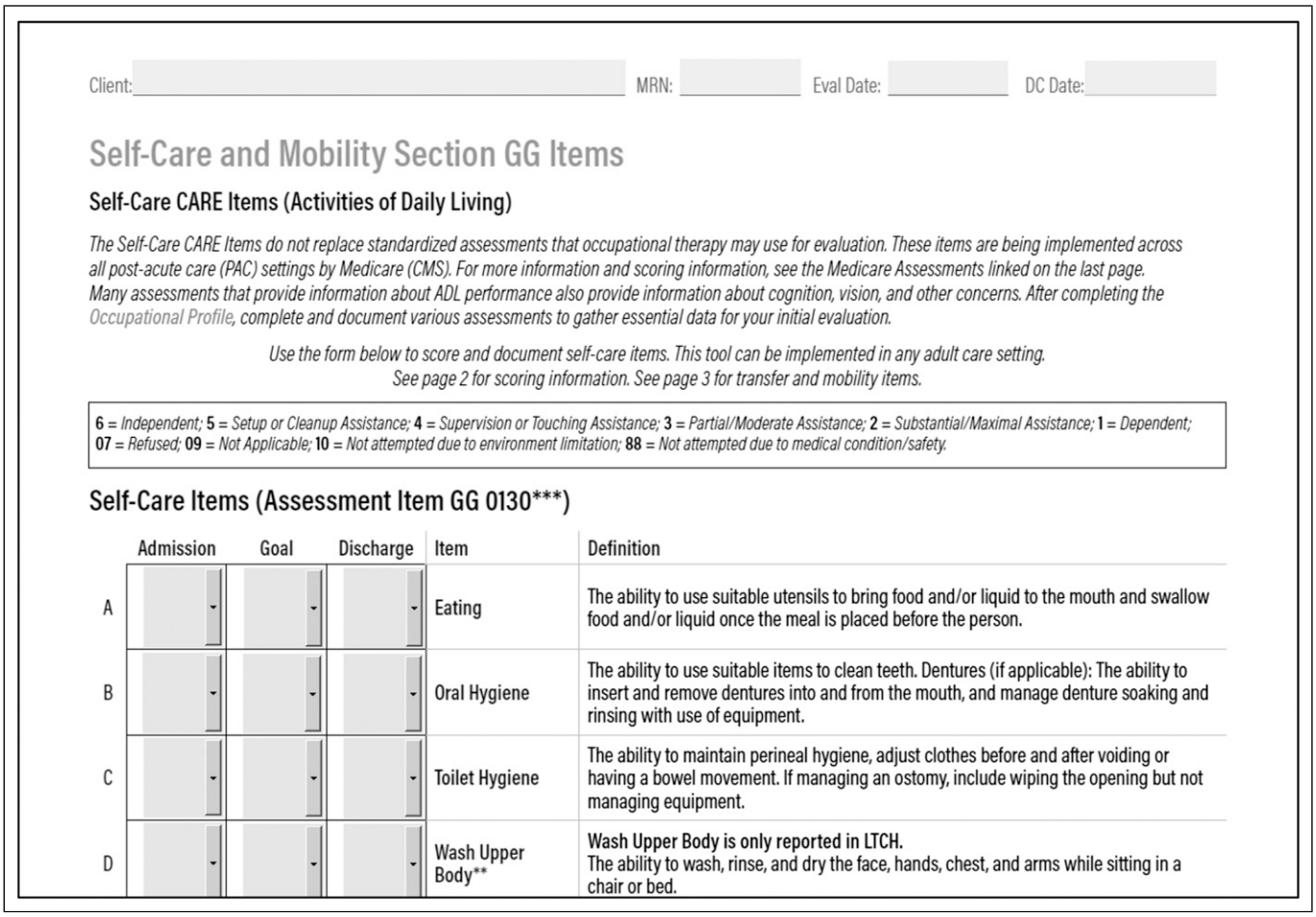
CMS is implementing select functional CARE items with minor adjustments in Section GG of the four Medicare PAC assessments:

- Inpatient Rehabilitation Facility Patient Assessment Instrument (CMS, 2017b)
- Minimum Data Set in SNFs (CMS, 2017c)
- Outcome and Assessment Information Set (OASIS) in HHAs (CMS, 2017d)
- Long-Term Care Hospital Continuity Assessment Record and Evaluation (CMS, 2017a).

In addition, several new outcome performance measures focus on function and are based on the new items in Section GG. AOTA (2018a) has created a resource to assist in scoring and tracking these items (Figure 1); practitioners should also consult the CMS training and instruction materials for their site. The functional items and performance measures are described in more detail in the sections that follow.

Functional Items

One of the key purposes of IMPACT Act data collection efforts is to synthesize the data collected on clients. For the first time ever, all PAC settings will score self-care and mobility function with the same item definitions using the same scale (see AOTA, 2018c, for a full description of these items and their scoring). Because the results of data collection will affect care delivery and payment in PAC settings, it is important that occupational therapy practitioners understand the items and scale and know how to effectively participate in data collection. In fact, all practitioners,



Client: MRN: Eval Date: DC Date:

Self-Care and Mobility Section GG Items

Self-Care CARE Items (Activities of Daily Living)

The Self-Care CARE Items do not replace standardized assessments that occupational therapy may use for evaluation. These items are being implemented across all post-acute care (PAC) settings by Medicare (CMS). For more information and scoring information, see the Medicare Assessments linked on the last page. Many assessments that provide information about ADL performance also provide information about cognition, vision, and other concerns. After completing the Occupational Profile, complete and document various assessments to gather essential data for your initial evaluation.

Use the form below to score and document self-care items. This tool can be implemented in any adult care setting. See page 2 for scoring information. See page 3 for transfer and mobility items.

6 = *Independent;* **5** = *Setup or Cleanup Assistance;* **4** = *Supervision or Touching Assistance;* **3** = *Partial/Moderate Assistance;* **2** = *Substantial/Maximal Assistance;* **1** = *Dependent;* **07** = *Refused;* **09** = *Not Applicable;* **10** = *Not attempted due to environment limitation;* **88** = *Not attempted due to medical condition/safety.*

Self-Care Items (Assessment Item GG 0130***)

	Admission	Goal	Discharge	Item	Definition
A				Eating	The ability to use suitable utensils to bring food and/or liquid to the mouth and swallow food and/or liquid once the meal is placed before the person.
B				Oral Hygiene	The ability to use suitable items to clean teeth. Dentures (if applicable): The ability to insert and remove dentures into and from the mouth, and manage denture soaking and rinsing with use of equipment.
C				Toilet Hygiene	The ability to maintain perineal hygiene, adjust clothes before and after voiding or having a bowel movement. If managing an ostomy, include wiping the opening but not managing equipment.
D				Wash Upper Body**	**Wash Upper Body is only reported in LTCH.** The ability to wash, rinse, and dry the face, hands, chest, and arms while sitting in a chair or bed.

Figure 1. AOTA's tool to assist with tracking items related to function.

Note. DC = discharge; MRN = medical record number; LTCH = long-term care hospital. From "Self-Care and Mobility Section GG Items," by the American Occupational Therapy Association, 2018, Bethesda, MD. Retrieved from http://www.aota.org/~/media/Corporate/Files/Practice/Manage/Documentation/Self-Care-Mobility-Section-GG-Items-Assessment-Template.pdf. Copyright © 2018 by the American Occupational Therapy Association. Adapted with permission.

including those who do not work in PAC, would benefit from familiarity with the items as they may become more common in other Medicare and Medicaid health care settings. Furthermore, these data will be used to generate new quality measures.

The new functional items do not replace the standardized assessments and instruments that occupational therapy practitioners use to evaluate clients and create a plan of care, and scoring them does not have to interfere with parallel occupational therapy evaluation activities. The information needed to score the items can easily be collected along with the other assessment data occupational therapists use as part of a comprehensive evaluation.

Outcome Measures

Four new outcome performance measures specifically relate to function and are based on the self-care and mobility items in Section GG. CMS will calculate the performance measures using national data to statistically adjust facility results by several factors, including beneficiary characteristics and conditions. These outcome performance measures were endorsed by the National Quality Forum (NQF) initially for use in IRFs. NQF is a not-for-profit, member-based organization that reviews quality measures for use in federal programs and for endorsement. NQF-endorsed measures have gone through a highly rigorous review and have been found to be scientifically sound, important, useable, and feasible.

CMS is implementing applications of the NQF measures in other settings. CMS used setting-specific risk-adjustment models to make the applications appropriate for specific settings. The original NQF outcome measures are as follows:

1. Change in self-care score (NQF #2633): risk-adjusted change in self-care function between admission and discharge
2. Change in mobility score (NQF #2634): risk-adjusted change in mobility function between admission and discharge
3. Discharge self-care score (NQF #2635): percentage of discharged beneficiaries who meet or exceed Medicare's expected discharge self-care score
4. Discharge mobility score (NQF #2636): percentage of discharged beneficiaries who meet or exceed Medicare's expected discharge mobility score.

These outcome performance measures are being implemented in stages and are already in place for IRFs. Applications of these measures will be calculated for SNFs starting with 2019 data ("Medicare Program," 2018).

In addition to these outcome performance measures, CMS has implemented a process performance measure related to a subset of the self-care and mobility items. This measure, percentage of patients with an admission and discharge functional

assessment and a care plan that addresses function, is calculated on the basis of whether a subset of Section GG items have both admission and discharge scores and at least one goal score (RTI International, 2014). This measure is currently implemented in all PAC settings.

Occupational Therapy Process and the New Measures

Since the implementation of the IMPACT Act in 2014, AOTA has been providing feedback to CMS as measures are developed and implemented across PAC settings. AOTA will continue to advocate for occupational therapy with CMS, including for the use of new measures that capture the value that occupational therapy brings to clients.

The introduction of a standardized method of measuring facility performance across PAC settings presents an opportunity for the field of occupational therapy to quantifiably articulate a piece of occupational therapy's distinct value to clients, administrators, and payers. The critical activity is at the daily, practical, client level. Even as this new data collection process is implemented, the occupational therapy process will continue to have its own trajectory and unique view of the client (AOTA, 2014). The occupational therapy evaluation begins with the occupational profile and analysis of occupational performance (AOTA, 2014). The AOTA Occupational Profile Template is designed to guide the development of a profile and can be downloaded at www.aota.org/profile. On the basis of the information from the profile, practitioners select and administer the appropriate standardized assessments to complete the analysis of occupational performance. Throughout the occupational therapy process (AOTA, 2014, 2017), it is important that practitioners incorporate the functional items that CMS has selected. Practitioners should implement evidence-based practice to maximize the effect of treatment on functional status. Although the new measures focus on basic ADLs, this focus is not meant to diminish the role of occupational therapy in instrumental activities of daily living, which are critical for a safe transition into the community and living life to its fullest.

The resources in Table 1 can be used throughout the analysis of occupational performance to facilitate item scoring and can be downloaded at www.aota.org/CARE. AOTA also provides evidence-based practice resources to identify standardized assessments and implement best practice interventions to achieve the best possible outcomes. See the links in Table 1 to access AOTA's evidence-based practice guidance.

Table 1. Resources on Medicare Quality Measures for Occupational Therapists

Topic	Source	Links
Background information		
Evidence-based practice resources	AOTA	https://www.aota.org/Practice/Productive-Aging/Evidence-based.aspx https://www.aota.org/Practice/Health-Wellness/Evidence-Based.aspx http://www.aota.org/Practice/Rehabilitation-Disability/Evidence-Based.aspx
Medicare and occupational therapy	AOTA (2018c)	https://www.aota.org/Advocacy-Policy/Federal-Reg-Affairs/Medicare.aspx
IMPACT Act and occupational therapy	AOTA (2018b)	https://www.aota.org/Advocacy-Policy/Federal-Reg-Affairs/Medicare/Improving-Medicare-Post-Acute-Care-Transformation.aspx
AOTA quality resources		
Occupational Profile Template	AOTA (2017)	https://www.aota.org/profile
Self-Care and Mobility Section GG Items form	AOTA (2018a)	http://www.aota.org/~/media/Corporate/Files/Practice/Manage/Documentation/Self-Care-Mobility-Section-GG-Items-Assessment-Template.pdf
CARE item set	CMS	https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Post-Acute-Care-Quality-Initiatives/CARE-Item-Set-and-B-CARE.html
Medicare PAC assessments		
Inpatient Rehabilitation Facility Resident Assessment Instrument	CMS (2017a)	https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/InpatientRehabFacPPS/IRFPAI.html
Minimum Data Set used in skilled nursing facilities	CMS (2017c)	https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/MDS30RAIManual.html
Outcome and Assessment Instrument Set (OASIS) used in home health agencies	CMS (2017d)	https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/OASIS/index.html
Long-Term Care Hospital Continuity Assessment Record	CMS (2017b)	https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/LTCH-Quality-Reporting/LTCH-CARE-Data-Set-and-LTCH-QRP-Manual.html

Note. AOTA = American Occupational Therapy Association; CARE = Continuity Assessment Record and Evaluation; CMS = Centers for Medicare and Medicaid Services IMPACT = Improving Medicare Post-Acute Care Transformation (IMPACT) Act of 2014; PAC = postacute care.

Advocating for the Profession in Everyday Practice

Occupational therapy practitioners in PAC settings are called on to advocate for the profession using the new functional items and outcome performance measures using two steps. First, practitioners should score the self-care and mobility items in Section GG for all patients at evaluation and at discharge from occupational therapy. Even if facility personnel other than occupational therapy practitioners collect Section GG data, practitioners should incorporate the data into their evaluations, documentation, and interventions. Scoring and documenting the items as a part of the occupational therapy evaluation and discharge processes can provide practitioners with critical information that other providers involved in the clients' care are reviewing and can facilitate a common language across PAC providers.

Second, occupational therapy practitioners can advocate with administration and management at their facilities to score the Section GG functional items during evaluations and discharges to help create the new data set. These items and the related outcome performance measures are new concepts to many professionals, but not to occupational therapy practitioners. Occupational therapy practitioners have a unique skill set that can have a great impact on the facility scores on these performance measures, and every practitioner can influence the IMPACT Act results. Medicare will be publicly reporting the performance measures and may use the information to describe the quality of care provided at each facility. If occupational therapy practitioners can take ownership of the functional items, it may affect how well the information demonstrates that occupational therapy interventions improve the well-being of clients and help maximize the outcome measures for their settings.

AOTA wants to hear the challenges and successes from providers as they implement these two steps. Email quality@aota.org to share your stories. ▲

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