Opportunities for Occupational Therapy to Serve as a Catalyst for Culture Change in Nursing Facilities

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Ensuring that older adults are receiving quality and effective rehabilitation and skilled nursing services must be a priority to society and to the health care system, but health care policies and systems driving reimbursement continue to challenge the delivery of services. A review of the literature indicates significant problems among residents of skilled nursing facilities (SNFs) that could be alleviated by meaningful occupational therapy. Research and practice in the occupational therapy community should focus on this large area of practice. Advocacy by individual practitioners—challenging themselves and others to provide more patient-centered care—can lead to changes that benefit clients, facilities, and payment systems as well as contribute to career satisfaction of occupational therapy practitioners. Occupational therapy can and should serve as catalyst for culture change in SNFs by providing meaningful interventions and opportunities that support engagement and health.

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With 30% of occupational therapists and 55% of occupational therapy assistants working in skilled nursing facilities (SNFs; American Occupational Therapy Association [AOTA], 2015), the workforce in this setting is larger than that in almost any other practice area, setting the stage for occupational therapy practitioners to serve as catalysts for culture change. Nursing facilities (used interchangeably with *SNFs* in this article, although they may have different definitions in other contexts) are faced with increasing demand for quality of care and increased quality of life (QOL) from both policymakers and consumers. For instance, baby boomers are expected to be more independent than prior generations and want to be empowered to make decisions involving their personal care plans. In nursing homes, privacy, autonomy, psychosocial interaction, communication access (e.g., the Internet), geriatric physical fitness, and meaningful recreational activities have been identified as needs for this population (Siberski & Siberski, 2018).

Because so many occupational therapists and occupational therapy assistants already practice in these settings, the door is open for the profession to take an active role in seeking transformation in these facilities, not only because of the changing desires of older adults but also because of public policy interest in improving quality and cost effectiveness. Occupational therapy practitioners can be a critical component of creating change in nursing facilities by relying on the profession's principles of client-centered care, facilitation of individual choice, and promotion of optimum performance. Occupational therapy practitioners are the experts at supporting society's older adults in maximizing QOL; however, it will take considerable change in practice patterns in settings such as SNFs to implement these changes. We believe that if the profession engages in the pursuit of culture change and client-centered service provision in

these facilities, occupational therapy can lead the charge to positively influence both this population of clients and the health care providers and systems of care to whom these individuals' lives are entrusted.

Indeed, our profession's vision for the future compels us to take action. In 2016, AOTA announced its *Vision 2025:* "Occupational therapy maximizes health, well-being, and quality of life for all people, populations, and communities through effective solutions that facilitate participation in everyday living" (AOTA, 2017b, para. 1). Challenges may be considerable, but if the profession hopes to fulfill *Vision 2025* and meet the needs of the ever-growing older adult population, the entire profession must take action. Research must be undertaken to support models of change in which occupational therapy can be a leading authority. Evidence must be translated to optimize practice and outcomes, and the courage must be found to speak out and take action to improve care in SNF settings. Occupational therapy's distinct contributions in this practice setting must be written into the care plan not only for individual residents but also for the nursing facilities themselves. Occupational therapy, through the change agency of every SNF practitioner, can serve as a catalyst to remodel the culture of SNFs. This process may require changing administrative thinking; restructuring organizational silos; and providing individualized, meaningful, and empowering services. The evidence is that change is needed.

Challenges of Past and Current Payment Systems

In April 1995, AOTA published a response to a U.S. General Accounting Office (1995) report on Medicare payment for therapy services provided in nursing facilities. The report cited "widespread examples of overcharges to Medicare" by contract companies and nursing facilities and pointed to "weaknesses in Medicare's payment rules" (p. 2). AOTA also supported its members who had raised concerns about such problems and expressed that "[t]he Association has a compelling interest in the delivery of appropriate, high-quality occupational therapy services" and condemned "exploitation of the Medicare program" (AOTA, 1995, p. 1).

Through the Balanced Budget Act of 1997 (Pub. L. 105-133), Congress attempted to address some of the weaknesses by instituting the SNF prospective payment system. Implementation began in 1999 and, virtually from the beginning, criticism was directed toward therapy and therapy payment amounts (Garrett et al., 2007, p. 3).

The Medicare Payment Advisory Commission (MedPAC), providing insight to Congress on the implementation of the Medicare program, has repeatedly criticized SNF payment and continues to express concern about SNF payment and therapy. In 2016, a heading in one of the two published MedPAC reports stated emphatically that "No improvement in managing patients' functional status" had been observed (MedPAC, 2016, p. 186). MedPAC put forward data that showed that even when risk was adjusted for patient characteristics, the average rates of functional change were essentially unchanged between 2011 and 2014, even though the program paid for more therapy during this period.

Consumer groups are still expressing concern: According to the Center for Medicare Advocacy (2017), this reimbursement system "encourages overutilization of therapy services, insufficient payment for nursing services, and inaccurate payment for non-therapy ancillary services" (p. 1).

In the 2000s, as they did in response to the concerns of 1995, AOTA members complained to AOTA about unreasonable demands for provision of therapy. In 2017, noting that the issue of high productivity requirements could put practitioners in difficult situations, AOTA responded that occupational therapy practitioners should be aware of and alert to inappropriate and potentially unethical practices in SNFs that "are used to achieve the highest Medicare reimbursement levels rather than meet appropriate patient/client needs" (AOTA, 2017a, para. 1).

Do the continuing flaws in the payment system contribute to pressures on practitioners? Do these pressures relate to the lack of functional improvement cited by MedPAC? Are the larger size and distant ownership of SNFs having an impact? More research must be done to examine why significant provision of therapy does not seem to be associated with improved QOL for SNF residents.

Challenges to Quality of Life in the Traditional Nursing Home

Life in nursing homes is less than optimal. For residents, the routines are predictable, and there is a lack of autonomy, personal decisions, privacy, and dignity (Ragsdale & McDougall, 2008). Moreover, "in traditional long-term care settings, QOL interventions that address dignity, freedom of choice, and individuality are not always a priority" (Ragsdale & McDougall, 2008, p. 992).

Kane (2003) pointed to the lack of interventions to improve QOL in traditional nursing homes. Loneliness, which can contribute to depression and social isolation, has reached critical rates in nursing facilities (Bekhet & Zauszniewski, 2012; Brownie & Horstmanshof, 2011; Tremethick, 2001). According to Theurer et al. (2015), "Loneliness and depression are serious mental health concerns across the spectrum of residential care, from nursing homes to assisted retirement living" (p. 201). Yet the methods for addressing loneliness and depression appear to include only social events, such as games and social gatherings, that are implemented by nursing facility staff, even though there is little evidence of their effectiveness (Cruwys et al., 2014; Victor, 2012).

Occupational therapy has much to offer in addressing these concerns; however, organizational—including financial—structures may limit the profession's impact. Theurer et al. (2015) further examined the operational approaches that do not allow for attention to these needs and highlighted the lack of resident choice and input that "further perpetuates the stereotype of residents as passive recipients of care" (p. 201). Residents' lives appear to lack meaning, they are not involved in decision making, and there are limited opportunities to feel productive and engaged. Why is this the case when so much occupational therapy is provided in SNFs? Are the payment or organizational structures restricting practice?

Current Practice in Nursing Facilities

From 2014 to 2016, the code for therapeutic exercise was billed under occupational therapy 9,594,480 times; therapeutic activities were billed even more, at 13,020,360 times; and self-care or activities of daily living (ADLs) was billed 8,311,520 times (Centers for Medicare and Medicaid Services [CMS], 2016). Do these statistics reflect the distinct value of occupational therapy? We are concerned that evidence may not legitimize interventions (e.g., "Move this yellow bar over your head 10 times and repeat 3 sets," "Move this ring from this side of the arc to the other side of the arc 25 times," or "Get on this arm bike for about 20 minutes") as addressing improved occupational performance. Moreover, are those prescriptive exercises motivating and meaningful to the residents? The referenced data concerning the high use of the exercise code over ADLs or instrumental activities of daily living (IADLs) codes provide a glaring light for the profession to face and not ignore.

CMS (2015) indicated that cognitive and functional impairments, as well as pain, falls, bowel and bladder incontinence, and pressure ulcers, are common among nursing home residents. Every one of these areas can and should be addressed by occupational therapy practitioners through interventions that address performance and occupation. However, a review of the *Occupational Therapy Practice Guidelines for Adults With Stroke* (Wolf & Nilsen, 2015), *Occupational Therapy Practice Guidelines for Productive Aging for Community-Dwelling Older Adults* (Leland, Elliott, & Johnson, 2012), and *Occupational Therapy Practice Guidelines for Adults With Neurodegenerative Diseases* (Preissner, 2014) resulted in identification of only 4 articles that were in any way concerned with adults in SNFs.

Research in other occupation-based areas has examined related issues. Kuk et al. (2017) found that IADLs are not encouraged as often as basic ADLs; moreover, when residents are engaged in ADLs, they typically include only functional mobility, eating, and drinking (den Ouden et al., 2015). Research has also indicated that residents of nursing homes are largely sedentary and inactive. The consequences of inactivity, which are especially critical for older adults who are frail, have been described by den Ouden et al. (2015). Completion of important occupations, such as ADLs, is a major component of independent living for older adults. Older adults' continued participation in basic self-care tasks and routines is viewed as critical in avoiding disability (Raia, 1999). According to Keeler, Guralnik, Tian, Wallace, & Reuben (2010), functional status has a considerable effect on QOL, with declines in both ADL and mobility resulting in disability and decreased life expectancy.

Promotion of occupation-based models already in use, as well as additional research on effective interventions for older and, possibly, frail and lonely adults in SNFs, must be added to the profession's education and research agendas if occupational therapy practitioners are to fulfill their vision to maximize QOL and outcomes for this population.

Related Factor: Caregiver Burnout

Perhaps some of the limited achievement of functional outcomes is related to how occupational therapy practitioners experience practice in SNFs. After reviewing nursing and staff perceptions and feelings about their work, Ragsdale and McDougall (2008) described the lack of stability of the nursing workforce as problematic and detrimental to the well-being of nursing facility residents. Caregiver workload and emotional exhaustion are topics frequently addressed in the literature. Similar issues likely exist among the occupational therapy workforce in nursing facilities and should be examined.

Caregiver burnout is defined as a "negative psychological experience of an individual, linked to emotional and chronic stress and caused by work aimed at helping people" (Kandelman, Mazars, & Levy, 2018, p. e147). Kandelman et al. (2018) described the prevalence of caregiver burnout as high, with up to half of caregivers in geriatric settings suffering from the emotional exhaustion, depersonalization, and reduced personal accomplishment that come with burnout. Burnout not only has a negative impact on care providers, including occupational therapy practitioners, but also negatively affects the residents, with reports of decreased quality of care affecting patient mortality (Wallace, Lemaire, & Ghali, 2009) as well as neglect and abuse (McDonald et al., 2012).

A decade ago, researchers at the Institute for Healthcare Improvement proposed the Triple Aim, with the intention of enhancing patient experience, improving population health, and reducing costs (Berwick, Nolan, & Whittington, 2008). In 2010, the Triple Aim became part of the national glossary on health care reform and was an underpinning of the Patient Protection and Affordable Care Act of 2010 (Pub. L. 111-148; see Whittington, Nolan, Lewis, & Torres, 2015). The Triple Aim posited that to reform health care effectively, there had to be balance in patient experience, population health outcomes, and cost control. In 2014, Bodenheimer and Sinsky introduced and recommended a fourth aim of addressing widespread burnout and dissatisfaction of health care providers, because improving their work life is just as critical as the original three aims and should be identified as a prerequisite to the Triple Aim.

The interrelatedness of quality care and practitioner satisfaction is undeniable; however, how can occupational therapy be a catalyst for addressing all these issues in SNFs? Occupational therapy can build on the past 30 years of consumer advocacy and policy initiatives to improve care for these vulnerable clients.

The Move to Culture Change

In the early 1980s, the National Citizens' Coalition for Nursing Home Reform (now the National Consumer Voice for Quality Long-Term Care) issued a consumer statement of principles that emphasized the rights of nursing home residents (Holder, 1983). The National Citizens' Coalition for Nursing Home Reform (1985) then issued a consumer perspective on quality care that informed the work of the Institute of Medicine (IOM) Committee on Nursing Home Regulation (Zimmerman, Shier, &

Saliba, 2014). In 1986, the IOM focused on the "home" aspect of nursing home care versus the more medical and institutionalized "nursing" aspect of care (Vladeck, 2003).

Shortly after the publication of the IOM's (1986) report, the Nursing Home Reform Act was incorporated into the Omnibus Budget Reconciliation Act of 1987 (Pub. L. 100-203), "creating an explicit statutory requirement that residents be provided services to attain and maintain their highest practicable well-being" (Zimmerman et al., 2014, p. S2). This movement gained support in the early 2000s, because CMS directed Quality Improvement Organizations to partner with nursing homes to improve the organizational culture of nursing homes (CMS, 2005). The call for culture change in nursing facilities is evident in studies by professionals in gerontology, physical therapy, medicine, and nursing (den Ouden et al., 2015; Kuk et al., 2017; Ragsdale & McDougall, 2008; Zimmerman et al., 2014). Occupational therapy's literature must follow suit.

In 2017, the Peterson Center on Healthcare published a report with a goal, "to improve the quality and lower the cost of care for high-need patients" (para. 1). To address this goal, this center identified three areas of focus: finding the right approach for each patient and adapting the care plan to meet the specific needs and goals, advancing the field's knowledge of how to implement many promising models of health care delivery for patients with complex needs, and addressing challenges through a collaborative approach. The care approaches reviewed by this center also included intervention based on multidisciplinary care teams, individualized care plans, behavioral health integration, and enhanced care team availability.

Recommendations for continued research include promoting person-centered care and optimal psychosocial and medical outcomes (Shier, Khodyakov, Cohen, Zimmerman, & Saliba, 2014). A commitment to client-centered care and research is needed to collect data on how occupational therapy is—and can be more—effective in improving care and clinical outcomes. None of these concepts is new or unfamiliar to occupational therapy. Occupational therapy practitioners must renew their commitment to principles of patient centeredness and focus on occupation to establish their distinct value and, more important, to enhance the lives of people who reside and work in these facilities. Occupational therapy practitioners should play an integral role in culture change models, because the field thrives on empowering clients through meaningful occupations and because "engagement in enjoyable and productive activity is paramount to productive aging" (Robnett & O'Sullivan, 2015, p. 263).

Evidence exists that the goals of occupational therapy directly link to QOL and positive effects on health and well-being. Specific areas in which occupational therapy interventions facilitate these positive outcomes include engaging in meaningful activities related to social and leisure participation (Matuska, Giles-Heinz, Flinn, Neighbor, & Bass-Haugen, 2003; Stav, Hallenen, Lane, & Arbesman, 2012), addressing IADLs (Golisz, 2014; Orellano, Colón, & Arbesman, 2012; Spillman, 2004), and supporting community mobility (Gill & Kurland, 2003). As these new cultural models expand, the profession has an opportunity to assess and intervene in the areas of habits, roles, and routines as well as to increase participation in basic ADLs and IADLs, which in turn can improve nursing home outcomes. Occupational therapy practitioners are fueled to power this vessel with their priorities on improving and sustaining quality of care, patient safety, work process, clinical outcomes, and contributions to policy and procedures as leaders in health care (K. Jordan, personal communication, April 2, 2016). Although many practitioners are contributing in these ways, and making these areas a priority in their work, the profession must engage the SNF population using optimal models of care to achieve change in a broad way.

Conclusion: A Call to Action

Wong and Fisher (2015) stated, "In the last 50 years, the profession's focus on occupation has waxed and waned with socio-political movements and shifting professional priorities" (p. 297). Moreover, they warned, "If occupational therapy is to stay at the forefront of its unique knowledge, evidence-based theories and models of practice" (p. 298), occupational therapy practitioners must continue to be experts on occupation. Occupational therapy's distinct value shines when practitioners focus on occupation and the many ways in which it influences a person's health and well-being. Furthermore, the payment structures and physical structures of separate rehabilitation gyms or activity rooms may further isolate the potential of occupational therapy to promote facilitywide improvement for residents. However, these factors can be changed.

Given the dynamism in health care payment policies, including a transition to value-based care, it is critical that occupational therapy practitioners become proactive in identifying, implementing, documenting, and measuring the distinct value of services provided so as to ensure that the profession is relevant in the eyes of CMS and other third-party payers. Occupational therapy practitioners must reclaim their roots, especially in this setting, where vulnerable people could be supported in living more meaningful and empowered lives. Occupational therapy's scope of practice, if fully utilized and effectively implemented, can be the solution to the challenges described in today's nursing facilities. If occupational therapy practitioners believe in occupation as an area of expertise, the profession can lead the charge in flipping the SNF culture and serving as a catalyst for change. ▲

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