

# Policy and Payment Changes Create New Opportunities for Occupational Therapy in Acute Care

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**Importance:** Changes in health care policy and payment over the past decade have resulted in a greater emphasis on cost effectiveness, quality outcomes, and the health care consumer's experience. Payers' response to the new policies and their expectations have created expanded opportunities for occupational therapy practitioners in health care overall but particularly in acute care hospitals.

**Objective:** The objective of this article is to empower occupational therapy directors, practitioners, educators, and students to be proactive in a rapidly changing acute care setting.

**Evidence Review:** Research on policy and payment changes since the passage of the Patient Protection and Affordable Care Act (Pub. L. 111-148) was synthesized with evidence related to occupational therapy practice and education.

**Findings:** Occupational therapy practitioners in acute care environments are experiencing expanded roles in optimizing patient readiness for safe community discharge, decreasing lengths of stay, and protecting them from hospital-acquired conditions.

**Conclusions and Relevance:** Policy and payment initiatives reward health care organizations for the added value occupational therapy practitioners bring to acute care teams.

**What This Article Adds:** This article details how occupational therapy practitioners can advance consumer satisfaction, outcomes, and efficiency in acute care, which can lead to increased recognition of the vital role that occupational therapy can play, thus leading to expanded opportunities.

In the past decade, health care has undergone dramatic changes. Articulation of the Triple Aim of the health care system (Berwick et al., 2008) guided the development of the Patient Protection and Affordable Care Act of 2010 (ACA; Pub. L. 111-148). Health care has been transformed by a focus on the aims of cost effectiveness, quality outcomes, and the health care consumer experience. Payers' responses to the new policies and expectations have created expanded opportunities for occupational therapy practitioners in health care overall but particularly in acute care hospitals. The role for occupational therapy in acute care is rapidly changing and has the potential to change even more in ways that may not be apparent to the larger community, including occupational therapy directors, practitioners, educators, and students. This policy framework has set the stage for actions that promote occupational therapy as part of the solution in many settings; in this article, we focus on issues, new opportunities, and recommendations for the acute care hospital setting.

Concerns about rising health care costs, decreased access to care, and suboptimal quality and utilization of care led to the passage of the ACA in 2010. In addition to the more widely recognized insurance provisions of the ACA (often referred to as *Obamacare*), other, less known components sought to change the health care delivery system to provide

more efficient and higher quality care. These ACA initiatives led to changes in Medicare, Medicaid, and private insurance. The Centers for Medicare and Medicaid Services (CMS) was designated to design and implement targeted efforts, including incentive payments and penalties, meant to address concerns about unnecessary expenditures and quality of care in hospitals.

For instance, the ACA directed CMS to implement the Hospital Readmissions Reduction Program. Implemented in 2012, the Hospital Readmissions Reduction Program has reduced Medicare payments to hospitals having a greater than average proportion of Medicare patients readmitted within 30 days of discharge (CMS, 2018d). The program has been successful in reducing readmission of patients with specified cardiopulmonary diagnoses, such as chronic obstructive pulmonary disease and heart failure, as well as planned hip and knee replacements (Zuckerman et al., 2016). Modifications will compare hospitals with a similar proportion of patients who are dually eligible for Medicare and full-benefit Medicaid, addressing concerns that hospitals in underresourced areas that admit patients with greater socioeconomic challenges are unfairly penalized (Hoffman et al., 2018).

In 2014, CMS initiated the Hospital-Acquired Condition Reduction Program, another ACA initiative that resulted in payment penalties to hospitals ranked in the bottom quartile for the proportion of Medicare beneficiaries who experienced a preventable hospital-acquired condition (HAC), such as a fall, decubitus ulcer, or infection (CMS, 2018c). In addition to the penalties for readmissions and acquired conditions, the ACA's Hospital Value-Based Purchasing program provides financial incentives to hospitals that deliver higher quality care (CMS, 2018e). The measures for quality include customer satisfaction, including discharge instructions specifically. This combination of payment penalties and incentives has been designed to make hospitals and clinicians accountable for the cost and quality of care they deliver. However, there is a need for additional research to assess the impact of payment changes on functional recovery (Werner & Konetzka, 2018).

Desiring to test additional improvements in care delivery and payment in hospitals and related posthospital services, CMS (2018a) created a bundled payment initiative through the ACA-created Innovation Center, which is charged with developing new care models and payment approaches to implement the ACA directives. The bundled payment approaches provide a prespecified amount to a health care organization based on a Medicare patient's procedure or diagnosis, covering the hospital stay and related services over the next 90 days (CMS, 2018b). This payment for a clinical "episode" results in the hospital receiving shared savings if spending is less than the targeted price and penalties if spending is greater than the target (Finkelstein et al., 2018). Zhu et al. (2018) verified that this payment model incentivizes the hospital to refer the patient to the least expensive type of postacute care (PAC) rehabilitation service, which is home health care, or to no PAC services at all.

An optional bundling pilot implemented in 2014 included 48 diagnoses such as stroke, cardiac conditions, and joint replacement. A mandatory bundling program, Comprehensive Care for Joint Replacement, was added in selected metropolitan areas in 2016 (CMS, 2018b) for lower extremity joint replacements. In the first year of the Comprehensive Care for Joint Replacement program, participating hospitals discharged a significantly lower percentage of patients to institutional PAC (Finkelstein et al., 2018). As is often the case, insurance companies have followed Medicare precedent, and bundling of acute and PAC payments is rapidly expanding. Hospitals that receive bundled payments have a greater incentive to discharge patients home, unless discharge to home is likely to lead to a readmission to the hospital (Zhu et al., 2018).

PAC changes prompted by ACA and other legislation are also offering opportunities for occupational therapy to participate fully in a more effective system. The Improving Medicare Post-Acute Transformation Act of 2014 (IMPACT Act; Pub L. 113-185) was intended to even out the payment for services, especially rehabilitation, across all PAC options (DeJong, 2016). This site-neutral payment would create disincentives for admission to inpatient rehabilitation because it is one of the costliest types of rehabilitative PAC. Initiation of a uniform data collection instrument will allow data analysis across sites and could influence the justification of decisions on discharge

destination after acute care. Data analysis across the continuum of acute to PAC will focus on connecting value to payment.

### Acute Care's Evolving Practices

Combined, the bundled payment approaches and the changes coming from the IMPACT Act may be fostering a health care environment that is increasingly directed at limiting spending on PAC. However, targeting PAC spending has put emphasis on what happens in acute care. This is promoting a dynamic and engaging acute care environment, with opportunities for acute care managers, practitioners, therapists, and students to change practice in this fast-paced setting. The first and third coauthors are acute care administrators and have added positions for occupational therapy practitioners in their acute facilities on the basis of growing need. Occupational therapy's role has expanded in many areas related to the ACA focus on issues such as rehospitalization, PAC placement, and HACs. These opportunities include presurgical instruction, early mobilization, fall prevention, and infection prevention.

In some places, private insurance requires that authorization for admission to inpatient rehabilitation be reviewed 24 hr to 48 hr before a patient's discharge, and occupational therapy documentation of holistic status, potential, and participation in activities is required to make the authorization determination. The mandated need for occupational therapy input throughout admission and specifically before facility discharge can create new demand for additional treatment visits. In our experience, this mandate has resulted in an increased demand for treatment sessions. Without frequent intervention and updated notes, a patient's hospital stay may be extended unnecessarily because of delayed authorization review. Previously, occupational therapy's role in reducing readmissions focused interventions on higher functioning patients discharging home. The growing demand in the discharge process for an updated therapy perspective and documentation supports an increase in therapy frequency for PAC-destined patients to change their trajectory from PAC to home or to help a faster transition to PAC when they still need it.

Identifying new ways of using occupational therapy in acute settings, such as in PAC decision making, support the overall premise that occupational therapy improves outcomes and efficiency in the acute care setting and will be critical to the future expansion of opportunities for occupational therapy. The occupational therapy profession has the research to demonstrate its distinct value, which supports the goals of acute care organizations and health care consumers (Rogers et al., 2017). Ability to meet goals around increasing safe discharges into the community, promoting appropriate transitions to other PAC settings, decreasing length of stay (LOS), and ensuring quality of care will favor organizations with a robust occupational therapy presence.

### Increasing Discharges to Home

As a result of the CMS payment and other policies described earlier, we believe that the acute care setting will continue to see an increase in patients being discharged home in lieu of typical PAC settings, creating opportunities for acute care occupational therapy practitioners to provide increasing proportions of a patient's rehabilitation throughout a care episode. Acute care occupational therapy practitioners can ensure a safe discharge home through emphasizing evaluation within 24 hr of admission, caregiver education, and wellness initiatives in addition to discharge planning recommendations and caregiver training (Fisher & Friesema, 2013; Rogers et al., 2017). In addition, the best opportunity to reduce readmissions and drive down expenses is with adults who have four or more medical comorbidities, because they have longer LOS and occupational therapy has unique perspectives on these patients (Steiner & Friedman, 2013).

Occupational therapy practitioners' education and skills emphasize the interconnection of diagnoses and their effect on performance and participation. Addressing the complexities of these patients' abilities to remain healthy after an acute episode can be improved using the holistic approach of occupational therapy and can also provide invaluable insights to the multidisciplinary care team. In rethinking acute care as a preparation for the next juncture of recovery,

occupational therapy practitioners can contribute to reducing LOS and readmissions if they emphasize treatments targeting prevention, wellness, patient and caregiver education, safety, self-management, and quality of life for all patients, especially those with multiple medical comorbidities or who are critically ill.

Another area for expansion for occupational therapy is in presurgical intervention. The bundling and site neutral payment initiatives are resulting in a rapid decrease in LOS for postsurgical patients, which may shift occupational therapy staffing (DeJong, 2016). The decreased LOS for total joint replacement (TJR), the most common inpatient surgery for Medicare beneficiaries (CMS, 2018b), results in occupational therapy practitioners having fewer days to intervene postoperatively and potentially a lower volume of inpatient treatment units. However, the shorter LOS for TJR surgery, which is now an outpatient procedure in some facilities, creates new opportunities for the hospital in using occupational therapy practitioners in preoperative TJR classes. Preliminary evidence points to the effectiveness of presurgical group or individualized classes that focus on performing activities of daily living with newfound precautions, home and environmental modifications, equipment recommendations, realistic patient or caregiver expectations, and initial compensatory techniques before rehabilitative outpatient intervention (Crowe & Henderson, 2003).

Occupational therapy's presence in the care plan for these surgeries is reinforced by the Joint Commission's (2018) Certification for Total Hip and Total Knee Replacement, which identifies high-level, quality facilities. The certification requires a preoperative functional status assessment (in combination with other patient education). A preoperative occupational therapy–led functional assessment can provide important information: preemptively flag patients at high risk for issues such as an LOS greater than the expected, readmission, or potential need for PAC. After high-risk patients are flagged, staffing hours may need to be shifted to address needs. For instance, provision of postoperative evaluation on the day of surgery and two separate treatment sessions in a day may maximize a patient's ability to return safely to the community faster and instead of to a PAC setting; in some cases, this method can result in condensing the typical postoperative treatment volume into fewer days to achieve the needed therapy outcomes for discharge with a shorter LOS. In this context, an occupational therapy practitioner can bring value and efficiency to a preoperative evaluation and education program when planning for varying postsurgical needs sooner, and later adapting treatment timing and frequency after surgery in response to these identified needs.

### Moving Beyond Early Mobilization for Other Diagnoses

Hospitals attempt to find a balance between decreasing LOS and reducing readmission. If a hospital's actual LOS is higher than what is predicted on the basis of the Diagnosis-Related Group, its ability to efficiently and effectively treat patients may be compromised. If a hospital's LOS is too short, leading to a greater than average number of readmissions, that will also have a negative impact on resources. Occupational therapy practitioners can find opportunities to meet these quality outcomes with new roles on the critical care team.

Regarding increased early use of occupational therapy in the acute episode, more than a decade of literature demonstrates the clear benefit of early mobility in the intensive care unit (ICU), which is out-of-bed activity as soon as medically appropriate. The literature supports occupational therapy playing a key role (Corcoran et al., 2017; Schweickert et al., 2009). Successful early mobility hinges on the interdisciplinary nature of the critical care team and optimal communication. Occupational therapy consultation as soon as possible after admission is key; this can be achieved through standardized diagnosis-specific order sets, advocacy during interdisciplinary rounds, and promotion of mobility as early as medically feasible as part of the facility's protocols for all critical or ICU patients. Collaborative early mobility decreases LOS by helping to improve function, mitigate narcotic or sedative use, and improve respiratory status in patients who are critically ill (Needham et al., 2010). The financial feasibility and cost-effective nature of early mobility in the ICU is becoming apparent to hospital leadership and interdisciplinary teams (Lord et al., 2013).

Examples of early mobility becoming commonplace can be seen in the development of entire mobility departments or through comprehensive mobility training for all nurses and technicians. Occupational therapy having a role on the

critical care team in early mobility or activity is a departure from working as a consultative service to facilitate discharge planning after assessing a patient only once. The expanding value of occupational therapy's role is evidenced by [Corcoran et al.'s \(2017\)](#) study, in which occupational therapy practitioners provided daily 29-min interventions in the ICU after an initial evaluation, leading to a decrease in ICU and general floor LOS by 1 day and 2.6 days, respectively. This study also showed a doubling of the number of patients who were able to be discharged home without needing facility-based PAC services. Nonetheless, lack of time and interdisciplinary factors are the most prevalent barriers to successful early mobilization despite obvious benefit. Occupational therapy practitioners must research and define their collaborative role in skilled intervention and quality outcomes. Otherwise, organizations may implement strict early mobility practices but provide them through the use of less expensive rehabilitation aides, nurse technicians, nurses, and even entire mobility departments. Consideration in the profession must be given to how occupational therapy practitioners can clearly define their role in improving quality outcomes to integrate occupational therapy effectively in these programs.

Occupational therapy is poised to expand its focus beyond early mobility to providing services that can effectively decrease LOS. Occupational therapy practitioners could provide interventions addressing valued occupations and performance patterns to speed recovery and improve quality of life after discharge. For example, an occupational therapy practitioner working with an adolescent patient in the ICU may use putting on makeup as a means to address strength and balance. The practitioner should be intentional about choosing supported or unsupported sitting, followed by standing positions, to progress physical challenge. However, concurrently, in using the underlying important activity of makeup application, the occupational therapy practitioner is mitigating role loss, supporting self-identity, and promoting physical demand necessary for typical routine tasks.

Occupational therapy practitioners can also collaborate with family and the interdisciplinary teams to minimize gaps in meaningful routines to speed a patient's ability to leave acute care more ready and confident to go home. Another occupation-based example could be an occupational therapy practitioner addressing functional cognition while a patient ambulates through a hospital gift shop to purchase a meaningful gift for a family member instead of simulating a money management activity. These kinds of occupation-based interventions go beyond simply helping a patient move out of bed to a chair but address the more skilled and potentially effective issues of daily life for recovery for the whole person. Occupational therapy practitioners must continue to research the impact of these approaches on quality of recovery and successful transition.

### Reducing Hospital-Acquired Conditions

Occupational therapy practitioners can also assert an expanded role in reducing HACs that can result in an increased LOS, unnecessary expenses, and worse patient outcomes ([Agency for Healthcare Research and Quality, 2018](#)). The highest opportunity HACs—adverse drug events, catheter-associated urinary tract infection, falls, and pressure ulcers ([Agency for Healthcare Research and Quality, 2018](#))—are objectively within the occupational therapy scope of practice and suggest interdisciplinary collaboration to expand teams to include occupational therapy. For example, in a nursing study of fall prevention strategies in hospitalized adults, [Titler et al. \(2016\)](#) recommended low vision aids, delirium and cognitive screening, and changing toileting habits to reduce falls in the hospital. Although the study did not reference occupational therapy, opportunity still exists to move onto the hospital teams to promote use of occupational therapy.

Evidence-based therapeutic interventions to prevent hospital-acquired pneumonia have been described in the literature, but this fundamental care is often missed or omitted in U.S. hospitals ([Baker & Quinn, 2018](#)). Occupational therapy practitioners can advocate for the incorporation of basic ADLs and routines that are often omitted in acute settings. They can also champion movement and activities such as tooth brushing to decrease hospital-acquired pneumonia. The standard of care consists of tooth brushing, elevating the head of bed, mobility, and breathing exercises. A nurse can complete these interventions; however, the occupational therapy practitioner's role is to assess

a patient and prescribe a routine for the nurse or family member to help a patient reliably implement the oral care routine throughout admission. This situation provides an opportunity for the practitioner to evaluate what may be interfering with independent oral hygiene and to modify the environment, tools, visual supports, or instructions to facilitate success in accomplishing this self-care task. This process empowers the patient and builds collaboration among occupational therapy practitioners, patients, and nurses.

These areas build on the known scope of practice of occupational therapy. Occupational therapy practitioners should be prepared to promote or lead other interdisciplinary quality improvement projects, perhaps including students and universities as collaborators, to further demonstrate that occupational therapy can contribute to implementing known protocols and thus contribute to cost savings and patient health.

### Recommendations to Expand Occupational Therapy's Contributions in Acute Care

Hospital administrators and occupational therapy managers will benefit from identifying the value that occupational therapy practitioners bring to their bottom line, customer satisfaction, and quality metrics (Roberts & Robinson, 2014). The following recommendations promote understanding of the potential of occupational therapy contributions in acute care:

- Include occupational therapy practitioners in organizational committees addressing HACs, patient satisfaction, safe patient handling, and patient education.
- Leverage current research demonstrating that occupational therapy reduces LOS or reduces readmissions as justification for staffing.
- Move away from evaluating occupational therapy productivity solely on the basis of billable units by incorporating the following value-based metrics:
  - Response time for new patient evaluation to proactively decrease LOS;
  - Adherence to planned treatment frequency to improve patient satisfaction, outcomes, and LOS; and
  - Appropriate treatment dosage to support discharge destination and optimum throughput timing.

### Recommendations for Academic Fieldwork Coordinators, Fieldwork Educators, and Faculty

Ongoing practice changes have created challenges and opportunities for multiple fieldwork stakeholders; these possibilities are especially important to address given the growing need for placements (Evenson et al., 2015). With increased employment opportunities and expanded roles in acute care, ensuring adequate student preparation is essential:

- Academic fieldwork coordinators can promote optimal student matching with acute care sites by means of student self-selection on the basis of understanding acute care demands.
- Fieldwork educators can orient students to the broader context regarding the changing role and value of occupational therapy in acute care.
- Faculty can better prepare students for the changing acute care environment by incorporating case scenarios, site visits to ICUs and acute care settings, acute care occupational therapy practitioners as guest lecturers, and hands-on lab experiences that mimic acute care demands.

### Conclusion

Acute care settings may become a central hub for health care services of all types. We are in the midst of a great transition period to integrate occupational therapy into patient care over the long term. Occupational therapy must seize opportunities—in policy, in education, in research, and in individual practice at the facility and patient levels—to

demonstrate the potential for contributing to quality and patient outcomes. We can and must enhance our position in this arena by building on our scope, our knowledge and our personal abilities. ■

## References

- Agency for Healthcare Research and Quality. (2018, June). *AHRQ national scorecard on hospital-acquired conditions: Updated baseline rates and preliminary results 2014–2016*. Retrieved from [https://www.ahrq.gov/sites/default/files/wysiwyg/professionals/quality-patient-safety/pfp/natlhacratereport-rebaselining2014-2016\\_0.pdf](https://www.ahrq.gov/sites/default/files/wysiwyg/professionals/quality-patient-safety/pfp/natlhacratereport-rebaselining2014-2016_0.pdf)
- Baker, D., & Quinn, B. (2018). Hospital Acquired Pneumonia Prevention Initiative–2: Incidence of nonventilator hospital-acquired pneumonia in the United States. *American Journal of Infection Control*, *46*, 2–7. <https://doi.org/10.1016/j.ajic.2017.08.036>
- Berwick, D. M., Nolan, T. W., & Whittington, J. (2008). The Triple Aim: Care, health, and cost. *Health Affairs*, *27*, 759–769.
- Centers for Medicare and Medicaid Services. (2018a). *Bundled Payments for Care Improvement (BPCI) initiative: General information*. Retrieved from <https://innovation.cms.gov/initiatives/bundled-payments/>
- Centers for Medicare and Medicaid Services. (2018b). *Comprehensive Care for Joint Replacement model*. Retrieved from <https://innovation.cms.gov/initiatives/cjr>
- Centers for Medicare and Medicaid Services. (2018c). *Hospital-Acquired Condition Reduction Program*. Retrieved from <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/HAC-Reduction-Program.html>
- Centers for Medicare and Medicaid Services. (2018d). *Hospital Readmissions Reduction Program*. Retrieved from <https://www.cms.gov/medicare/medicare-fee-for-service-payment/acuteinpatientpps/readmissions-reduction-program.html>
- Centers for Medicare and Medicaid Services. (2018e). *Hospital Value-Based Purchasing*. Retrieved from <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HospitalQualityInits/Hospital-Value-Based-Purchasing-.html>
- Corcoran, J. R., Herbsman, J. M., Bushnik, T., Van Lew, S., Stolfi, A., Parkin, K., . . . Flanagan, S. R. (2017). Early rehabilitation in the medical and surgical intensive care units for patients with and without mechanical ventilation: An interprofessional performance improvement project. *PM and R*, *9*, 113–119. <https://doi.org/10.1016/j.pmrj.2016.06.015>
- Crowe, J., & Henderson, J. (2003). Pre-arthroplasty rehabilitation is effective in reducing hospital stay. *Canadian Journal of Occupational Therapy*, *70*, 88–96. <https://doi.org/10.1177/000841740307000204>
- DeJong, G. (2016). Coming to terms with the IMPACT Act of 2014. *American Journal of Occupational Therapy*, *70*, 7003090010. <https://doi.org/10.5014/ajot.2016.703003>
- Evenson, M. E., Roberts, M., Kaldenberg, J., Barnes, M. A., & Ozelie, R. (2015). National survey of fieldwork educators: Implications for occupational therapy education. *American Journal of Occupational Therapy*, *69*(Suppl. 2), 6912350020. <https://doi.org/10.5014/ajot.2015.019265>
- Finkelstein, A., Ji, Y., Mahoney, N., & Skinner, J. (2018). Mandatory Medicare bundled payment program for lower extremity joint replacement and discharge to institutional postacute care: Interim analysis of the first year of a 5-year randomized trial. *JAMA*, *320*, 892–900. <https://doi.org/10.1001/jama.2018.12346>
- Fisher, G., & Friesema, J. (2013). Implications of the Affordable Care Act for occupational therapy practitioners providing services to Medicare recipients. *American Journal of Occupational Therapy*, *67*, 502–506. <https://doi.org/10.5014/ajot.2013.675002>
- Hoffman, G. J., Hsuan, C., Braun, T., & Ponce, N. (2018, August 24). Health equity and hospital readmissions: Does inclusion of patient functional and social complexity improve predictiveness? *Journal of General Internal Medicine*. Advance online publication. <https://doi.org/10.1007/s11606-018-4635-z>
- Improving Medicare Post-Acute Transformation Act, Pub. L. 113-185, 128 Stat. 1952, 1801 U.S.C. 6001 et seq. (2014).
- Joint Commission. (2018, January). *Total hip and total knee replacement inpatient: Performance measurement implementation guide*. Retrieved from [https://www.jointcommission.org/assets/1/6/THKRIP\\_Manual2018January\\_New.pdf](https://www.jointcommission.org/assets/1/6/THKRIP_Manual2018January_New.pdf)
- Lord, R. K., Mayhew, C. R., Korupolu, R., Manthey, E. C., Friedman, M. A., Palmer, J. B., & Needham, D. M. (2013). ICU early physical rehabilitation programs: Financial modeling of cost savings. *Critical Care Medicine*, *41*, 717–724. <https://doi.org/10.1097/CCM.0b013e3182711de2>
- Needham, D. M., Korupolu, R., Zanni, J. M., Pradhan, P., Colantuoni, E., Palmer, J. B., . . . Fan, E. (2010). Early physical medicine and rehabilitation for patients with acute respiratory failure: A quality improvement project. *Archives of Physical Medicine and Rehabilitation*, *91*, 536–542. <https://doi.org/10.1016/j.apmr.2010.01.002>
- Patient Protection and Affordable Care Act, Pub. L. 111-148, 42 U.S.C. §§ 18001–18121 (2010).
- Roberts, P. S., & Robinson, M. R. (2014). Occupational therapy's role in preventing acute readmissions. *American Journal of Occupational Therapy*, *68*, 254–259. <https://doi.org/10.5014/ajot.2014.683001>
- Rogers, A. T., Bai, G., Lavin, R. A., & Anderson, G. F. (2017). Higher hospital spending on occupational therapy is associated with lower readmission rates. *Medical Care Research and Review*, *74*, 668–686. <https://doi.org/10.1177/1077558716666981>
- Schweickert, W. D., Pohlman, M. C., Pohlman, A. S., Nigos, C., Pawlik, A. J., Esbrook, C. L., . . . Kress, J. P. (2009). Early physical and occupational therapy in mechanically ventilated, critically ill patients: A randomised controlled trial. *Lancet*, *373*, 1874–1882. [https://doi.org/10.1016/S0140-6736\(09\)60658-9](https://doi.org/10.1016/S0140-6736(09)60658-9)
- Steiner, C. A., & Friedman, B. (2013). Hospital utilization, costs, and mortality for adults with multiple chronic conditions, nationwide inpatient sample, 2009. *Preventing Chronic Disease*, *10*, E62. <https://doi.org/10.5888/pcd10.120292>

- Titler, M. G., Conlon, P., Reynolds, M. A., Ripley, R., Tsodikov, A., Wilson, D. S., & Montie, M. (2016). The effect of a translating research into practice intervention to promote use of evidence-based fall prevention interventions in hospitalized adults: A prospective pre–post implementation study in the U.S. *Applied Nursing Research*, *31*, 52–59. <https://doi.org/10.1016/j.apnr.2015.12.004>
- Werner, R. M., & Konezka, R. T. (2018). Trends in post-acute care use among Medicare beneficiaries: 2000 to 2015. *JAMA*, *319*, 1616–1617. <https://doi.org/10.1001/jama.2018.2408>
- Zhu, J. M., Patel, V., Shea, J. A., Neuman, M. D., & Werner, R. M. (2018). Hospitals using bundled payment report reducing skilled nursing facility use and improving care integration. *Health Affairs*, *37*, 1282–1289. <https://doi.org/10.1377/hlthaff.2018.0257>
- Zuckerman, R. B., Sheingold, S. H., Orav, E. J., Ruhter, J., & Epstein, A. M. (2016). Readmissions, observation, and the Hospital Readmissions Reduction Program. *New England Journal of Medicine*, *374*, 1543–1551. <https://doi.org/10.1056/NEJMsa1513024>

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