Growth, Renewal, and Challenge: An Important Era for Occupational Therapy

(delivery of health care, trends; reimbursement mechanisms; services, occupational therapy)

Carolyn Manville Baum

Occupational therapy is facing some important decisions as it approaches a changing health care system. By understanding the prospective payment system it is possible to promote occupational therapy services to a changing marketplace while avoiding major problems. Specific opportunities and strategies are defined to promote occupational therapy to new markets.

A Revolution in Health Care

"In turbulent times an enterprise has to be managed both to withstand sudden blows and to avail itself of sudden unexpected opportunities" (1). The many changes occurring in health care today may seem like blows, but they actually present great opportunities for the fields of rehabilitation and occupational therapy.

The changes are primarily in the industrialization of health care. By the late 1970s, both hospital beds and certain health professionals were in oversupply, health care costs came under question, and marketing concepts had entered the health care complex. But as long as every health care cost was being reimbursed, the behaviors of medical professionals did not change and many continued to believe that medicine was exempt from industrialization. However, by the fall of 1983, the Prospective Payment System (PPS) was enacted, which literally forced external controls on the health care system. Health care decisions based on cost were beginning to be made.

The industrialization of health care has had an impact on everyone in our profession. We have had to change all our previous principles that govern what health care is, where health care is delivered, who delivers the services, who receives the services, and under what conditions services are provided. Additionally, our researchers are experiencing the reduction of funds for basic and applied research. Our educators are feeling the pressure of decreased applicant pools, decreased monies for educational assistance, increased pressures to meet university criteria for tenure, and greater pressures to modify educational content to produce

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skilled and knowledgeable clinicians for a changing marketplace.

We collectively share these problems and collectively must solve them if we are to move ahead as a profession in a rapidly changing health environment. If we don’t face the revolution in health care, health care education, and health care research, negative consequences or limitations can occur. Luria (2) said “... passivity before an inexorable march of events... can only lead to slavery.”

The 1965 Medicare legislation did not make occupational therapy a covered service under Medicare Part B (the community practice component of the Medicare reimbursement). Because it limits our practice to hospital-based services, this one act enslaved us to an acute medical model. Our services have been reimbursed only under the Medicare program or by insurers who followed the Medicare model. Meanwhile, our colleagues in other rehabilitation fields were not so enslaved. They have been reimbursed for community-based programs, private practice programs, outpatient programs in rehabilitation facilities, programs in skilled nursing facilities, and home health programs. I believe this limitation has compromised us as a profession in our ability to help our patients, in our position in the health care arena, and in our theory development and research of the effect of occupation on health and performance.

Changes in Incentives

The degree of change in health care initiated by the PPS has only two other counterparts in history. The first was the institution of health insurance, which began in the 1920s and was not completed until the late 1950s when federal government employees came under a health insurance program. The second counterpart was the Medicare legislation enacted in 1965, which developed the payment of services in a cost-based model and supported the development of services in acute medical systems.

A change of special note in the PPS is the incentives for hospitals. I will review these incentives because they form the basis of important strategies for delivering occupational therapy services under the new system (see Table 1).

First, the old cost-based system demanded that there be a high volume of patients to cover the costs of the major expansion of hospitals that occurred in the period from 1946 into the early 1980s. Under the new PPS, because of the limited stay, the volume of patients must be higher. This means the hospital must create an image in the community to lure patients to their facilities for services.

Second, under the old system the length of stay was longer because costs were reimbursed based on services provided. Under the new system, the length of stay is shorter because the hospital can make a profit by discharging the patient before the diagnostic-related group (DRG) cut-off date.

Table 1

<table>
<thead>
<tr>
<th>Incentives for Hospitals</th>
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<tbody>
<tr>
<td>Cost-Based (old system)</td>
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<tr>
<td>No. treated</td>
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<tr>
<td>Length of stay</td>
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<tr>
<td>Services performed</td>
</tr>
<tr>
<td>Quality</td>
</tr>
<tr>
<td>Efficiency</td>
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<tr>
<td>Investment in resources (equipment and staff)</td>
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<tr>
<td>Referral programs (vertical systems)</td>
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</tbody>
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Third, under the old system, more services were provided the more costs were reimbursed. Under the new system, the incentive is to perform the fewest number of services possible in the stay so that the facility does not have to incur the costs of additional services.

The fourth incentive is quality. Under the old system, a high quality of service was important and meant more services. Under the new system, quality, although talked about as being at a very high level, has not yet been clearly defined. The professional review organizations are looking at this issue, and a national commission has been established to oversee the quality issues. Under the old system, efficiency, although stated as important, was not important. Often, instead of being discharged, patients were permitted to stay in the hospital over the weekend to get specific services, because these services would be reimbursed. Now high productivity is a critical issue. Under the old system, investment in resources (e.g., equipment and staff) was possible because it was reimbursed. Under the new system, the patient-to-staff ratio is increasing and there are fewer pieces of equipment, particularly of those that are labor-intensive.

Even the referral program is an
Incentive. Under the old system, it was not important for the hospitals to have referral programs because revenues were generated out of patients’ inpatient stays. Under the new system, a referral network, usually a vertical system, is critical for the hospital to have in place. The vertical referral system can include such programs and services as surgery centers, nursing homes, home health, hospice, emergency care centers, wellness programs, fitness programs, industrial services, rehabilitation services, and psychiatric services. A vertical system is important because each of its independent services linked with the hospital is a referral source for filling hospital beds. Not only can the hospital place a patient into one of its vertical services before the DRG cut-off date, but it can also readmit that patient to a hospital bed if that is what the patient needs. The vertical system also provides a community base for that hospital, which both stimulates referrals to the hospital bed and gives the hospital wider visibility.

Health Care Delivery Systems

There are several different types of health service delivery systems. In the nonprofit, multihospital systems, hospitals link with each other for the purpose of sharing human resources, facilities, and administrative resources (e.g., management and purchasing contracts). This provides all linked hospitals with a larger corporate structure (a means to reduce costs) and with a referral network among themselves. Also, primary hospitals in rural areas or smaller communities combine to form a referral base and linkage with a larger diagnostic center.

A second type of system is the for-profit hospital system, such as the Hospital Corporation of America and Humana. These are projected to control nearly 50% of the hospital beds in the country by the end of the decade. Organized around a profit motive, they not only are designing acute hospital systems with vertical referral systems but also are moving into the business of health insurance to profit from the wellness component of the health care system.

The third type of health delivery system is physician controlled. These are the health maintenance organizations, the preferred provider organizations, and the physician group practices. The technological advances that have occurred as a result of basic research in the medical fields have made it possible for much of health care to be delivered outside of the acute hospital. Physician group practices are setting up miniature “Mayo Clinics” in which patients referred to the practice stay in hotels that are under contract to the physicians to support their ambulatory surgery centers and diagnostic systems.

The fourth type of health delivery system, industry, is going to develop rapidly this next decade as it strives to prevent work accidents, maintain a higher level of productivity and fitness in their employees, and decrease the health care costs within industry itself.

The fifth major health delivery system is the public health system. With nearly 13% of the population not covered by health insurance, it is critical for public hospitals and public agencies to continue to provide both preventive care and health service for this population.

We need to develop occupational therapy services in a vertical model not only to support the hospitals where nearly 50% of us have practiced for the past 15 years but also to broaden our community involvement. Table 2 offers a list of potential occupational therapy services.

In the hospital, we must see our role as triage, making the necessary plans for individuals in their acute stage of hospitalization to receive their rehabilitation, particularly their occupational therapy services, in other systems. We then must follow this hospital-based occupa-

### Table 2

<table>
<thead>
<tr>
<th>Occupational Therapy</th>
<th>Hospital</th>
<th>Physician Practice</th>
<th>Industry</th>
<th>Public System</th>
<th>Public</th>
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</thead>
<tbody>
<tr>
<td>Inpatient triage</td>
<td>X</td>
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<tr>
<td>Home health</td>
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<tr>
<td>Skilled nursing</td>
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<td>Hospice</td>
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<tr>
<td>Wellness programs</td>
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<td>X</td>
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<td>X</td>
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<tr>
<td>Designated beds</td>
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<tr>
<td>Rehabilitation facilities</td>
<td>X</td>
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<td>X</td>
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<td>Life skills evaluation/training</td>
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<td>Work evaluation/training</td>
<td>X</td>
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<tr>
<td>Industrial consultation</td>
<td>X</td>
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<tr>
<td>Driving evaluation/training</td>
<td>X</td>
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<td>Technology services</td>
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<td>Community services</td>
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<td>Public school services</td>
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ional therapy program with the appropriate outpatient occupational therapy program, whether it be in home health, skilled nursing, hospice, wellness, or designated rehabilitation beds in our acute facilities, psychiatric facilities, or rehabilitation facilities.

Additionally, our outpatient programs could be designed around specific occupational therapy products, such as life skills evaluation and training, work evaluation and training, industrial consultation, driving evaluations and training, and technological services (e.g., using computers and advanced technology to allow an individual to function or to support higher levels of human potential).

Also, we could design specialty clinical programs to relate to people with head trauma, arthritis, movement disorders, and severe disabilities. Another major area for services is in the community. Finally, our programs could be associated with the public health system (via headstart programs), with developmental disability centers, with community-based wellness programs, and with state-regulated programs for the elderly.

In the public schools, our services are defined by Public Law No. 94-142. Many states have implemented a full scope of services to handicapped children in the schools, whereas others are still struggling to implement the law. It is possible for occupational therapy departments to provide contractual services to the school systems.

The matrix in Table 2 shows that an occupational therapy department that develops a full scope of services has the potential to market those services across different delivery systems to operate a community-based program, either in the context of a private practice or in a hospital that serves a community.

Sources of Payment

To pay for these occupational therapy services we need to explore sources other than third-party payment, which is primarily medical insurance and not geared to support long-term disability, occupational therapy’s major focus.

Self-payment from people who have discretionary income is a potential source of funds for occupational therapy services, particularly if we produce a definable product that is important to those individuals. Certain people who want to return to the work force will pay for work-related programs. For example, people who want to drive will pay for driving evaluations. People who want to become functional will pay for life skills training.

Another source of payment is workers compensation. All but three states in the nation have mandatory rehabilitation requirements for people injured on the job. This is a major source of payment in our acute care systems and could be extended to occupational therapy services in outpatient programs, particularly in work-evaluation and work-hardening programs.

Liability insurance is another payment source. Most people in accidents are injured in cars, on the job, at home, or on some form of public transportation and thus are compensated by liability insurance. We can tap this resource if we build the kinds of programs that fully rehabilitate our patients. For example, a recent release issued by a major liability insurance corporation described an individualized claims management program for catastrophic conditions requiring acute continuing care. The company, in its “Alternatives to Prolonged Hospital Stays” program, saved $1.8 million on 23 cases in 18 months by purchasing aggressive rehabilitation services and equipment for the patients. This case illustrates that if we don’t do a comprehensive job, others will.

Another source of payment is corporate funds. Corporations may well be willing to pay a fee for our programs that directly relate to industry. Some corporations hire occupational therapists to provide services to work-related accident cases and to support accident prevention in their settings.

Another source of payment is tapped through a business arrangement (known as capitation) with health maintenance organizations (HMOs). This source is particularly important as HMO services expand to the Medicare population. (The HMO is required to provide occupational therapy services.) In capitation, a rehabilitation services fee is determined per HMO enrollee. In turn, rehabilitation agencies provide a full scope of rehabilitation services to the HMO, including skilled nursing, home health, and in- and out-patient services.

Public health funds can also be explored as a source of payment. Municipalities’ block grants can be tapped for community-based services. State funds, which are designated for specialized programs such as those for the elderly, can also be tapped.

Social Security funds, another potential source of payment, will probably decline or become more limited. Only 10% of Social Security recipients spend over $2,000 a year on health care, so cuts in those payments can be expected; and, those same 10% include most occupational therapy patients.

So far I have identified areas
where occupational therapy can expand services so that the field not only continues to meet the needs of hospitals but also branches out to other service delivery systems in the community. Additionally, I have shown that we must expand our sources of payment. While we do these things, we must address some major impending changes in the health care system by developing or expanding our models of practice. This series of changes can be seen as either blows to or opportunities for occupational therapy.

**Impending Changes: Our Complement Strategies**

The first impending change is copayment. With this system, patients make out-of-pocket payments for a portion of their health expenditures. The strategy for occupational therapy with copayment will be to have a well-defined product at a level that consumers will accept and with a definable outcome. This means we must present our objectives to the patients in achievable, short-term goals so that from session to session and week to week the patient understands what has been achieved and what comes next. If we proceed in this way, the patient will be motivated to stay with the program as well as pay for it. This requires us to sell occupational therapy to consumers.

The second impending change is further cuts in federal programs. Our strategy should be to create new markets for our products; we should not limit our products or programs to a Medicare or acute care program but design products that people are willing to pay for. To obtain other funding, we must diversify our programs to provide services to industry, communities, and the public. This means keeping our skills and knowledge as generalists so that we can shift easily from providing nonviable to viable programs. We must offer a full scope of services to patients because some programs will fail and other programs will be assumed by other health providers.

Another major strategy for dealing with this impending change is to inform legislators of issues affecting their constituents at the national, state, and local levels. Recently, we received information that the Missouri Crippled Children’s Funds had been depleted and that services would not be paid for the period of March through July. We found that our state legislators did not know that this decision had been made, and when properly informed, they were able to appropriate more funds, which temporarily resolved the issue. This could have been a serious blow to our programming (especially at a community-based children’s hospital), for had we accepted it the patients we served and our own facilities would have been placed in serious jeopardy.

Another strategy for coping with cuts in federal programs is to work as a team to achieve outcomes. By collaborating with the members of the health care team to get the most appropriate response as quickly as possible and without duplication of services, we won’t waste any funds by isolating our services.

The next impending change is an oversupply of physicians, in some groups at the level of 190%. Some physicians will take over the services we have traditionally provided, particularly those in our specialty areas. To avoid this, it is critical that we maintain consultative relationships with physicians. We must refer patients to physicians.

We must orient our programs to returning patients to work or at least to a functional level that is cost-effective. We also must maintain communication between the physician and his or her patient.

Not only physicians but also nurses will be in oversupply. With the implementation of the PPS, nurses are bearing the brunt of the health care cost cutbacks and they are trying to redefine their roles in medicine. They are getting involved in many activities of daily living. We must actively assume and communicate occupational therapy’s role in supporting human function in daily living skills, a role which is much broader than activities of daily living, and we must demonstrate performance at that level. We also must use standard measures of function that reflect changes in our patients’ levels of performance. For example, AOTA’s uniform occupational therapy checklist looks at a whole complement of life skills instead of focusing narrowly on limited aspects of a person’s performance. We must speak openly about occupational therapy in functional terms while delivering a full complement of occupational therapy services.

Meanwhile occupational therapists will be in undersupply. We cannot possibly have enough manpower to provide all those programs for the vertical health care services being developed in the community and do it at the full scope that occupational therapy is able to provide. We clinicians must help recruit occupational therapy students for the schools and retrain nonpracticing therapists for community-based positions (e.g., in home health). We should also provide positions that are as flexible as possible for those therapists who
wish to work while they raise their families. We clinicians must make it our responsibility to prepare students to work in programs other than acute care. Acute care positions are becoming quite limited (only 9.4 days are allowed to rehabilitate a stroke patient in a hospital), and the full scope of occupational therapy can only occur in community-based programs.

We must integrate certified occupational therapy assistants (COTAs) into our clinical programs. If they are not integrated and able to find jobs in this way, other health professionals will take over the positions traditionally held by occupational therapists, and that would be a strategy for disaster. We must explore innovative ways to provide the supervision that certified occupational therapy assistants need to integrate them into a full scope of occupational therapy programs. Additionally, we must educate the individuals in the patient’s rehabilitation program to support his or her functional performance.

The next impending change is an increase in the number and distribution of elderly persons with limitations in activities of daily living, according to the American Hospital Association’s annual report. If this population is a critical market for hospitals, then we must also see it as a critical market for occupational therapists and help hospitals design the programs that will support this population of individuals as they grow older. Additionally, we must link our services with others (e.g., social psychologists, industrial psychologists, gerontologists, engineers, and computer scientists) to meet the functional needs of the elderly or to manage people with limited function. Our role is to provide the interface between the skills and knowledge of these professionals with the human potential of individuals with limitations.

There will be decreased dollars for health care. One strategy for dealing with this impending change is to determine the efficacy of our services and the impact of occupation on function. We can no longer just talk about our impact but must design programs that allow us to measure it.

It is essential that we create the image of cost-effectiveness by referring patients to the most cost-effective systems. Trying to rehabilitate patients or achieve a long-term outcome of functional performance in three to five days of hospitalization is not the way to be cost-effective. Services must produce functional outcomes; we can no longer afford to provide programs that do not. Program outcomes must be recorded in functional terms so that people understand that this is our orientation.

Occupational therapists must become recognized as the experts in function. Additionally, as individual professionals we must have a knowledge of health policies and health economics so that we know how to build programs to address broad health issues and know how to be cost-effective.

As clinicians, we must have the skills to anticipate change; for no longer will systems remain static. Students must be educated to a changing health environment. We must direct our learning and maintain our knowledge of four important areas: a) the human being—his or her structure, function, and motivation; b) occupational therapy—its history, values, philosophy, product, techniques, and efficacy; c) the marketplace—its environment, characters, conflicts, and issues; and d) ourselves—our commitment, imagination, and strength to promote and achieve growth. In addition to this knowledge we also need the technical skills to apply our principles in a changing marketplace.

These many opportunities require that we discipline ourselves to create a strong force for the profession—one that has recognized expertise in the evaluation, treatment, and prevention of performance dysfunction. We use occupation and activity as our media. Let us not confuse the public and ourselves by talking about the effect of occupation. Let us instead talk about the effect that occupation has on performance. At this time we cannot afford to have the public misunderstand our role in helping people achieve a functional status. The entire health system is currently organized around the outcome of care. That outcome is function.

Conclusion

There seem to be three options for us as individuals. Our first option is to continue on our present course, primarily in acute care. But
with the medical technology today, I believe this option is aimless. As we weave in and out of the existing system, we will have growth without direction.

Our second option is to move on the periphery of our interchange—watching what others are doing in these turbulent times. Initially, this will prove to be a fast track because we can move in circles around the periphery of our interchange. However, eventually this option will become dangerous as we will have order but no growth.

Our third option is to use this interchange as a process of learning and direct our growth so that we as a profession take the responsibility for fully designing our services to support the individual’s need to acquire the skills, attitudes, and knowledge to achieve a functional status in all aspects of human performance. As we individually take on this challenge, I believe that we will balance our profession and our role as a profession and will achieve directed growth.

REFERENCES

RELATED READINGS
Kassorla IC: Go For It. New York: Delacorte Press, 1984