March 25, 2016


Dear Clinical Episodes Payment Work Group:

The American Occupational Therapy Association (AOTA) is the national professional association representing the interests of more than 213,000 occupational therapists, occupational therapy assistants, and students of occupational therapy. The science-driven, evidence-based practice of occupational therapy enables people of all ages to live life to its fullest by promoting health and minimizing the functional effects of illness, injury, and disability. Occupational therapy practitioners serve beneficiaries in all inpatient and outpatient settings, including but not limited to inpatient acute care hospitals, home health agencies, skilled nursing facilities (SNF), long-term care hospitals, inpatient rehabilitation facilities (IRF), hospice, outpatient hospitals, and independent occupational therapy private practices. For the purposes of this comment, we find it important to note that occupational therapy practitioners have an especially significant role in the post-discharge phase of an elective joint replacement procedure and as a result, the significant value of having an occupational therapy practitioner working in collaboration with the acute and post-acute care (PAC) team should be recognized. We appreciate the opportunity to comment on the Clinical Episodes Payment (CEP) Work Group’s Elective Joint Replacement draft White Paper.

The Health Care Payment Learning & Action Network (LAN) is proposing 10 recommendations that consist of both design elements and operational considerations based on the experience and the analysis of existing episode payment initiatives. The occupational therapy profession has an important stake with regard to recognition in recommendations 1, 4, 5, 6, and 10, and thus the focus of this comment will be on those particular recommendations with the ultimate goals of providing both evidence asserting that occupational therapy practitioners should be included as part of the team in the post-discharge phase of the episode model, and illustrating the significant impact the services OTs provide in order to move and keep post-discharge individuals well-functioning and out of acute and post-acute care facilities so they can successfully integrate back into the community.

1. Inclusion of an Occupational Therapy Practitioner in the Elective Joint Replacement Model

The CEP Work Group notes that a significant component of an “accountable entity” is the ability it has to engineer change and that, while it is important that one entity be the primary accountable party, it is also important that care is provided using a team-based approach.

1“Episode Definition”, “Services,” “Patient Engagement,” “Accountable Entity,” and “Quality Metrics”
AOTA believes that the provider responsible for the episode of care should have appropriate knowledge of the clinical needs of beneficiaries who require outpatient rehabilitation and PAC services. They should understand the differences among PAC settings or risk jeopardizing beneficiary access to the right care in the right setting at the right time.

AOTA believes that the provider responsible for the episode of care:

- Must have the necessary clinical staff, including occupational therapy practitioners, with appropriate expertise in a range of patient needs depending on condition and medical complexity;
- Must include rehabilitation staff, like occupational therapy practitioners, in discharge planning to ensure patients are discharged to the most appropriate setting;
- Must be able to monitor patient status and track quality indicators and patient outcomes; and
- Must coordinate with other settings and providers to focus on patient-centered care that promotes the patient’s independence.

AOTA asserts that explicit recognition of how the profession of occupational therapy interacts with other disciplines involved in care (e.g., physicians, nurses, physical therapists, speech-language pathologists, social workers) is necessary in the White Paper to facilitate better collaboration and thus more coordinated care. This consideration is especially significant for patients who, although they may be appropriate for the model, may also come with complex rehabilitation needs and/or multiple chronic conditions requiring more intensive occupational therapy to develop their activities of daily living and other skills for a full return to the community/home setting.

Further, the patient-centered focus of the care plan and discharge planning processes discussed in the White Paper are part of the foundation of occupational therapy practice and how occupational therapists assess, treat, and consider discharge and transitions as part of the assessment of a patient’s functional and cognitive status on an ongoing basis. AOTA strongly supports the involvement of the patient in determining their goals of care and discharge planning, as well as taking into account realistic caregiver support after discharge. We believe this recommended step would result in appropriate and more informed choices that meet the patient’s needs. In this instance, the presence of an occupational therapy practitioner is not only suggested, but should be deemed necessary in the White Paper to fully achieve the most optimal patient outcome.

II. Episode Definition – Functional Status Assessment Tools and “Episode end point”

In defining whether an episode is “appropriate” for the purposes of this Model, the Work Group recommends that “in addition to a clinical assessment, a provider used a standardized, validated functional status assessment tool to determine that the patient is an appropriate candidate for surgical procedure, as opposed to being a candidate for less invasive care.”

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2 Accelerating and Aligning Clinical Episode Payment Models: Elective Joint Replacement Draft White Paper, Episode Definition, p. 11
AOTA recommends that the following tools that apply to occupational therapy and other therapy disciplines be utilized in the assessment for determining whether an episode is “appropriate” for the purposes of the Model. We feel that the following assessment instruments3 more fully reflect the scope of a patient’s severity level and functional status prior to an elective procedure, and reflect the needs of the full range of providers who could be performing this assessment:

- Activity Measure for Post-Acute Care (AM-PAC): Daily Activity and Basic Mobility sections
- Activity Daily Living Index
- Berg Balance Scale
- Assessment Motor and Process Skills (AMPS)
- Functional Assessment Scale
- Performance Assessment of Self-Care Skills (PASS)

These assessments are standardized, validated functional status measures of variables that focus on mobility, activities of daily living (ADLs), cognitive status; static and dynamic balance abilities using functional tasks commonly performed in everyday life; various motor and process skills; self-care function for institutionalized individuals and; ADL function in the clinic or at home.

With regard to the “episode end point,” AOTA supports the principle that the episode design should be patient-centered, and acknowledge the challenges patients experience in the recovery period post-operatively. The Work Group proposes the episode should end 90 days post-discharge and while that may seem like a reasonable timeline following an elective procedure, the discussion does not actually go into further detail on what should be taken into consideration when assessing whether the Model actually delivers on its ultimate purpose by the end of the episode.

Existing evidence strongly emphasizes that appropriate and effective discharge planning should help reduce readmissions and address a patient’s functional and cognitive status needs so he or she can reside as independently as possible. Of note with respect to potentially preventable readmissions and a patient’s occupational therapy needs, several recent studies consider whether returning to the community from a recent hospitalization with unmet ADL need was associated with probability of readmission. The findings from these studies indicate that unmet ADL needs is indeed a considerable risk factor.

The studies reveal that many older patients are discharged from the hospital with ADL disability. Those who report unmet need for new ADL disabilities after they return home from the hospital are particularly vulnerable to readmission. This area is not typically addressed in a thorough manner through current discharge practices. This needs to change. Patients' functional needs after

discharge should be carefully evaluated and addressed. Factors such as enabling self-management and ensuring appropriate medication management and ADLs, such as cooking and eating are addressed, can have a direct effect on readmissions. Self-management is a key element in successful post-acute care, and occupational therapists are experts in motivation, task analysis, and psychosocial contexts, which all contribute to enabling positive outcomes.

With that in mind, AOTA poses the question of whether 90 days is enough time to sincerely conclude whether the patient was actually better off after the episode of elective joint replacement — i.e. are they functioning adequately in the community, and does his/her outcome match or come close to the goals they set prior to the episode’s commencement? Furthermore, who is monitoring the patient’s status after the 90 days is complete to see if the discharge plan was completed and additionally, adequately followed-up? Ultimately, how do we measure a threshold or standard to say whether the episode was a success upon the Model’s intended “end point”? AOTA requests that the Work Group consider each of the above questions and concerns when developing language in the White Paper to address the episode timeline/definition and the long-term functional status needs of recipients of elective joint replacement to assure the most appropriate and high quality services are provided under this Model to keep patients functioning as independently as possible post-surgery and rehabilitation. This would likely need to be a concern of the accountable entity.

III. Services

AOTA believes that the Work Group’s recommendation that “all services needed by the patient that are related to (emphasis added) the joint replacement procedure should be covered by the episode price,” is too broad and may exclude important and medically necessary services depending on who is interpreting the phrase “related to.” Additionally, the Work Group directs readers to Appendix C, however from those initiatives, it is still not entirely clear on what services are “related to” the joint replacement procedure. Considering the complexity of certain patients, an excluded services list would likely run into issues if it did not take into consideration the patients with complex rehabilitation needs or those with multiple chronic conditions. AOTA supports the idea of an included services list as being a more effective alternative to an excluded services list. An included services list would be easier to manage without being overly broad or overly restrictive, and would be better suited for patients with conditions that may be reasonably tied to an elective joint procedure that may not have been identified at the onset of the episode. Finally, AOTA respectfully requests that occupational therapy services be added to that included services list.

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IV. Patient Engagement

AOTA supports and applauds the Work Group’s strong recommendation on the required use of shared decision-making and patient engagement tools in order to maximize opportunities to engage patients and families in advancing high-value care. The experience of a patient and his or her caregiver/family following a procedure such as elective joint replacement that spans over a course of an episode is undoubtedly impacted by a variety of factors, both having to do with the intensive therapy provided in the phase following the event, as well as the health care team’s involvement in the patient’s personal treatment aims from the beginning of the intervention until discharge. Supported care planning should not be something taken halfheartedly.

AOTA believes that occupational therapy’s “client-centered” approach to treating patients directly aligns with the overarching purpose of the recommendation of supported care planning and ultimately seeks to get to the core of what is important and meaningful to the individual patient. Using a client-centered approach, the practitioner gathers information to understand what is currently important and meaningful to the client (i.e., what he or she wants to do) and to identify past experiences and interests that may assist in the current understanding of current issues and problems. During the process of collecting this information, the client, with the assistance of the occupational therapy practitioner, identifies priorities and desired target outcomes that will lead to the client’s engagement in occupations that support participation in life. Only clients can identify the occupations that give meaning to their lives and select the goals and priorities that are important to them. By valuing and respecting clients’ input, practitioners, help foster their involvement and can more efficiently guide interventions.

Moreover, coordination and collaboration on the patient’s medical and functional goals of care are critical since many patients have both a personal and rehabilitation goal of returning to their home or a community-based setting. It is part of the AOTA Practice Framework’s teachings to consider what the patient wants to achieve from rehabilitation to ultimately achieve his or her long term living objectives. Aspects of patient-centeredness, such as acknowledging the importance of the patient’s perspectives in treatment planning have been present in occupational therapy practice values since the very beginning of the profession.

V. Accountable Entity and Quality Metrics

AOTA believes that these recommendations leave a lot of considerations unanswered, making it difficult to take a fully informed position. The Work Group provides an example in the form of a “Joint Replacement Care Team” that divides the phases of the episode into pre-procedure, event, and post-discharge. Those phases then include within them, a minimum of two providers. One concern that we would raise would pertain to what is an appropriate way to measure the quality of the entire model’s outcome when the quality and inclusiveness within the care team may vary in and of itself? This next raises a concern from AOTA about quality measurement

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7 Accountable Entity, supra., n. 2, p. 17
once the patient reaches the end of an episode. The Work Group must consider and address in the White Paper which professional service will be measured and the issue of attribution, i.e., how any one profession can be assessed in affecting patient outcomes when the joint replacement model, by its very nature, requires bundling of discreet services to best treat patients. If accountability is delegated to each provider who essentially touches the patient at one phase or another during the episode, is it the amount of time spent with that provider that goes into consideration when factoring out risk and reward? Or, rather, will the quality of the services delivered within the bundle as a whole be measured for quality? If so, how will that quality measure be developed?

AOTA would further suggest that measures be developed to take into consideration the events following the end of the post-discharge phase of the episode that are critical yet often ignored, when patients are trying to integrate back into the community. These considerations would include but are not limited to follow-up that may be required given the patient’s age, socioeconomic status, mental health, family/caregiver support, and outside persistent health problems. With regard to these considerations, AOTA believes there needs to be some level of clarity on how the “accountable entity” would be responsible for the risks or rewards associated with the outcomes, both long and short term, if those were added considerations to the model’s overall effectiveness.

AOTA finds that there is a lack of clarity of what the quality metrics in this Model actually signify. For OT, quality measurement at the conclusion of the episode, or even at a later point after that time, would not truly encapsulate the value of what OTs strive for with regard to helping patients achieve their goals related to functioning in occupations that give their lives meaning.

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Thank you for the opportunity to comment on the Elective Joint Replacement draft White Paper. AOTA looks forward to a continuing dialogue with the Health Care Payment Learning & Action Network on the prospective future of payment policies that may affect the ability of occupational therapy practitioners to provide quality care to beneficiaries in settings that implement these models.

Sincerely,

[Signature]

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