

The Occupational Therapy Practice Framework: A Foundation for Documentation

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ABSTRACT

With ongoing changes in health care reimbursement and a new focus on quality versus quantity of intervention, it is becoming more important for occupational therapy (OT) practitioners to provide and document interventions that highlight the distinct value of OT. The importance of such documentation is further underscored by the requirement for completing the occupational profile from the *Occupational Therapy Practice Framework: Domain and Process* (3rd ed.; *Framework*; American Occupational Therapy Association [AOTA], 2014) as part of all OT evaluations per the 2016 CPT® evaluation code descriptions. To ensure that documentation is comprehensive and reflects the tenets of the profession, OT practitioners should look to the *Framework* as a guide for choosing appropriate areas and concepts for inclusion. In addition, organizing evaluations and intervention planning in a way that mirrors the domain and process of the *Framework* will assist practitioners in creating OT-specific fields for use in an electronic medical record system, such as the PERFORM documentation templates created by AOTA.

LEARNING OBJECTIVES

After reading this article, you should be able to:

1. Discuss changes to the reimbursement system that are providing an opportunity for OT practitioners to highlight their distinct value through documentation
2. Discuss the relationship between the process of OT and best practice documentation
3. Identify elements of the occupational profile and their importance in client evaluation
4. Describe the importance of the analysis of occupation, including assessment tool selection
5. Recognize how the structure of the *Framework* translates into an electronic format to streamline the documentation of the client evaluation and treatment plan

INTRODUCTION

Most occupational therapy (OT) practitioners are familiar with the expression, “If it wasn’t documented, it didn’t happen.” Documentation to ensure treatment continuity, establish a basis for billing, and keep a record of change in status are all important reasons for accurately recording evaluation findings, treatment plans, and discharge outcomes. But perhaps the most compelling reasons for accurate and thoughtful documentation in the era of shrinking health care dollars is the need to support the distinct value of what we, as OT practitioners, bring to the system in terms of efficient and excellent client outcomes. Of course the documentation of what we do is important, but the ways in which we measure and understand limits in participation and intervene to improve client participation are equally important; if we do not do it, we cannot document it.

This article will highlight the use of the *Occupational Therapy Practice Framework: Domain and Process* (3rd ed.; *Framework*; American Occupational Therapy Association [AOTA], 2014) as a structure for not only defining elements of the process of OT but also for using these elements and those of the domain of OT practice to guide best practice documentation of assessment, intervention, and outcome planning. In addition, this article will describe the documentation template known as PERFORM, which is based on the *Framework* and can be used to create an OT-specific electronic documentation system or as a concise roadmap for standard documentation.

A New Paradigm in Health Care Reimbursement

In addition to expanding the health care coverage for millions of Americans, the Patient Protection and Affordable Care Act (ACA) of 2010 encouraged reform of the health care delivery system to achieve the Triple Aim, which includes better care, healthy people and communities, and affordable care. The ACA has brought with it an environment of change and improvement, and as a result it has also reinforced the need for OT practitioners to provide services that are cost effective and produce tangible client outcomes that themselves reduce costs and improve the lives of our clients (AOTA, 2013). For example, a top priority is to reduce hospital readmissions, which relates to several of the aims. Keeping people healthy decreases the need for hospital readmissions, and providing treatment outside of the hospital promotes more affordable care. OT services can be the key to reducing readmissions, as was highlighted in a recent study in which increased spending on OT services in acute care was correlated with reduced readmissions for all conditions studied (Rogers et al., 2016)—this is the good news.

Unfortunately, the study does not pinpoint the specific services offered by OT that led to this reduction. We must ensure that we are delivering and documenting OT in a manner that clearly demonstrates our value. We must be sure to intervene and target outcomes in a manner that is cost effective and improves the health and well-being of our clients.

Although there are many reasons for hospital readmissions, safety issues within the home, including falls and the inability of clients to use medications properly, directly contribute to some unnecessary admissions. Both issues are part of the scope of practice of OT and are identified in the *Framework* as ADLs and IADLs. A recent study demonstrated that OT can have a major impact by addressing the home environment. In fact, implementing home modification interventions by OT could save the health care system more than \$442 million by reducing medically treated falls (Stevens & Lee, 2018). In addition, appropriately understanding and using medication is often necessary for clients to live a quality life and to participate in desired occupations without safety concerns. These and other similar elements that produce effective and efficient outcomes should be considered as a part of the OT intervention plan. Performance patterns—identified in the *Framework* as including habits, routines, roles, and rituals—are key to understanding how the person interacts with their environment and adheres to medication routines. When meaningful to clients, OT practitioners should use contextually appropriate activities and occupations to address the skills and abilities of a client to manage and improve their health and avoid unnecessary health care costs—both key elements of the Triple Aim.

In light of a focus on client outcomes identified by the Centers for Medicare & Medicaid Services (CMS), a concern exists that OT intervention may only be provided to address narrow areas like self-care ADLs, fall risk, and medication management. However, the beauty of OT is that we can see the importance of all factors and occupations by their relationship to common skills. By addressing and documenting performance patterns, the occupational profile, and the interventions around meaningful engagement, OT practitioners demonstrate a distinct value that contributes to achieving the Triple Aim and provides high-quality services to clients. In many cases, outcomes that are important to our clients and the outcomes that are important to the health care system overlap—staying out of the hospital, reducing the need for expensive medical care, and reducing functional limitations because of illness or injury. In addition to addressing these concepts, OT practitioners can and should address other concerns identified by the client's occupational profile through shared skills and client factors.

According to AOTA, as CMS continues to shift priorities from paying for the quantity of services to purchasing high-quality services, OT practitioners must demonstrate the distinct value of OT services for each client encounter and carefully

word all documentation in the medical record to support the skilled therapy being provided (Sandhu, 2015). It is incumbent on OT practitioners to work at the top of their license in providing client-centered care to achieve critical client outcomes and help organizations meet quality and other requirements. A timely example of this transition can be seen in Medicare reimbursement for Part A services for skilled nursing facilities (SNFs). The Patient Driven Payment Model (PDPM) is replacing the Resource Utilization Group (RUG) reimbursement system in October 2019. Under PDPM, SNFs will receive a payment based on the client's characteristics regardless of the services provided, unlike under RUGs, in which more services (such as OT) mean a higher reimbursement rate (AOTA, 2018). PDPM will require OT practitioners to clearly articulate the value of their services.

DOCUMENTING THE DISTINCT VALUE OF OT

Framework

AOTA's Commission on Practice created the first version of the *Framework* in 2001 to provide a common understanding of the areas of human function addressed by the profession (domain) and the manner in which these areas are addressed (process).

Domain of OT

Five areas are outlined in the domain, including: (1) occupations, the areas of daily living in which people participate (ADLs, IADLs, work, leisure, education, play, rest and sleep, and leisure pursuits); (2) client factors, including values, beliefs and spirituality, body functions, and structures; (3) performance patterns, including habits, roles, routines, and rituals; (4) performance skills, including motor, process, and social interaction; and (5) context and environment, including physical and social environment, cultural, temporal, personal, and virtual contexts.

Process of OT

The process of OT includes evaluation, intervention, and targeting of outcomes that occur in the environments and contexts of the client to assist them in achieving health, well-being, and participation in life through engagement in occupation (AOTA, 2014).

Evaluation subcategories include the occupational profile and analysis of occupation, which ensure that the therapist works from a client-based perspective and engages in clinical reasoning to determine how to best assess and analyze the effects of factors, patterns, skills, and the environment/context on the client's desired occupational participation. *Intervention* includes treatment planning, implementation, and review.

Targeting outcomes includes selecting appropriate quality and process measures (administered as part of the analysis of occupation) that will be used to determine outcomes to measure the effect of the intervention. In addition, outcomes are a means of ensuring quality of services and determining changes that may be needed to interventions going forward (AOTA, 2014).

The Occupational Profile

In 2016, the new CPT evaluation codes released for OT included the use of the occupational profile as a necessary part of the OT evaluation process (AOTA, 2017). The requirement for this important aspect of the *Framework* underscores its importance as a guide for intervention and documentation. The Occupational Profile Template, a formalized profile document that should become a standard component of OT evaluations across all areas of practice, is available through AOTA at www.aota.org/profile. The profile provides a structured means for asking the client to provide their goals for intervention; their occupational history; and information about their life contexts and environments, performance skills, performance patterns, and client factors that present as either supports or barriers to occupational participation.

Analysis of Occupation

Following administration of the occupational profile, the therapist determines those aspects of the domain requiring more in-depth assessment using standardized measurement tools. Those client factors, performance skills, performance patterns, and contexts and environments identified as barriers to occupational participation are targeted. Because the specific barriers are not always obvious to the client, the therapists should assess those that are likely contributors. For example, in the case of a client unable to feed her pet after sustaining a radial fracture of the wrist 8 weeks previously, the client should undergo assessment of strength, range of motion, performance patterns, and her home environment to determine whether limitations exist that may contribute to the occupational deficit. This top-down approach is a more efficient manner of evaluation because it can limit specific assessment to those underlying areas contributing to the occupational deficit.

To ensure that clients in post-acute care facilities can be safely discharged to home, the OT should assess process skills of health literacy and medication management, as well as the home environment, to rule out limitations that could lead to difficulties with home safety and health management after discharge. In addition, AOTA provides self-care and mobility templates of the CMS Section GG data elements that can be used as outcome measurement tools (Kroll & Fisher, 2017). The information gleaned from targeted assessments informs the intervention plan and assists therapists in selecting appropriate interventions that address the performance and underlying area deficits. The analysis of occupational performance is a critical section of the evaluation that not only informs the distinct plan of the OT but also provides an opportunity for practitioners to educate others about their level of knowledge and detail regarding the health and well-being of the client.

Intervention

Following assessment and analysis, the therapist determines the intervention approach and creates the intervention plan. The

plan identifies the areas of occupation, underlying client factors, performance patterns, performance skills, and contexts that will be targeted by OT to enhance occupational participation. The intervention plan involves documenting the specific problem areas, creating and documenting short- and long-term goals, selecting appropriate frames of reference or treatment models, and implementing specific treatment interventions. Careful and comprehensive documentation of the intervention plan provides practitioners with a solid resource for measuring progress and documenting the approach and interventions used to treat their clients.

Intervention Plan

Problem statements serve as the backbone of the intervention plan because it is the identified problems that are remediated through OT intervention. By definition, both the targeted problems and the outcomes of intervention are occupations (AOTA, 2014). Problems are identified during the process of the occupational profile and the analysis of occupation in which an outcome assessment, such as the Canadian Occupational Performance Measure (Law et al. 2015), may be used to identify problems and describe their level of importance to the client. For example, if a client is unable to prepare herself breakfast and dinner, and this is an important and necessary area of occupational performance, the inability to prepare meals is a problem targeted in the intervention plan.

Because the *Framework* has both categories and subcategories of occupations, problems and long-term goals, are written as a category (if several deficits within the category exist), or as subcategories (for single deficits). For example, if a client has difficulty with dressing, hygiene, bathing, and medication management, the problem is that the client is unable to complete desired ADLs. If only one or a few subcategories are deficient, the problem(s) could be that the client cannot dress independently, and/or that the client is unable to engage in bathing without assistance.

Long-term goals, also known as treatment goals, are the realistic and measurable outcomes that indicate the problems no longer present barriers. As previously stated, problems identified by occupational therapists are occupational deficits; therefore, the long-term goals of intervention target occupational participation. For example, if an inability to complete meal preparation is the identified problem, the long-term goal will be for the client to be able to engage in meal preparation within specified conditions. Often, practitioners write long-term goals to target performance skills, client factors, or the environment. However, these underlying factors, although identified through targeted assessments and addressed during intervention, are component parts of participation and not the goals of intervention. Factors, skills, patterns, and the context and environment that underlie occupational performance are addressed through occupations, activities, preparatory methods and tasks, educa-

tion, and advocacy, and progress reports and daily notations will reflect how they change and affect participation.

Short-term goals are the components of long-term goals that are not required by all payers. Regardless of payer requirement, short-term goals are very useful to document, as they lay out the steps required for reaching the long-term goal and set shorter time lines, which can be useful in documenting gains in participation leading to problem resolution. For example, if a goal is to improve independence with cooking a light meal, a series of short-term goals may lay steps that start with gaining independence in preparing a cold sandwich, to heating selected canned foods in a microwave, to following a recipe for creating a three-ingredient meal using the stove. As with long-term goals, short-term goals are sometimes written to target underlying factors, such as strength, range of motion, or cognition. As mentioned previously, although important components of participation that will be addressed in the intervention plan, factors, skills, patterns, and context environment should not be the sole focus of short-term goals.

Both long- and short-term goals should be written according to a goal-writing system that includes a client focus, safe participation in the occupation as the outcome, conditions of the outcome, criteria for success, and a timeline (e.g., “Client will demonstrate independence with medication routine, including consistent correct dosage and frequency, within 2 weeks”).

Intervention Implementation

Perhaps one of the most distinct aspects of OT practice is the type of clinical reasoning in which practitioners engage that includes analysis of the client, the desired outcomes of treatment, and the activities and occupations that are used as interventions. The selection of the interventions to be provided by the practitioner must be evidence based, chosen to address the targeted goals, address concerns of the payer, and representative of best practice. Several types of interventions are identified by the *Framework* and are within the scope of OT. These include occupations such as those targeted in the goals; activities such as components of occupations or distinct engagements that are not considered occupations; preparatory methods administered in preparation for occupations and activities, such as ultrasound, hot packs, and splints; preparatory tasks, which are interventions that require participation of the client and resemble activities but lack relevance or meaning to the client, such as pulling and placing pegs in a pegboard or squeezing a hand gripper; education and training to improve the ability of the client to participate in occupations; advocacy and self-advocacy; and/or group interventions.

In addition to their ability to target goals, interventions should be selected based on their ability to target client factors, performance patterns, and skills as well as the context and environment, if identified during the evaluation to be contributors to deficient occupational performance. When documenting interventions, an explicit connection must be made to what

participation outcome the intervention will target. For example, if a client factor of finger range of motion is to be addressed during intervention and the client will be instructed in using a hand gripper to address this area, the therapist should document how addressing finger range of motion in this manner will enhance occupational participation. This information will help payers understand the connection of specific tasks, methods, activities, and occupations to the short- and long-term goals of intervention.

It should be noted, however, that some classifications of interventions described in the *Framework*, such as preparatory tasks, are not always considered to be best practice or distinct to occupational therapy. For example, according to the Choosing Wisely® campaign—an initiative of the ABIM Foundation that the American Occupational Therapy Association joined to advance a national dialogue on avoiding unnecessary medical tests, treatments, and procedures—preparatory tasks, such as placing a client on an arm bike or a shoulder arc, often appear to target client factors that may eventually enhance a component of occupational participation. However, there is little empirical evidence to show that there is a direct connection between preparatory activities and ultimate client safety, participation in occupations, or development of healthful habits and routines (Richardson, 2018). Therefore, the use of these types of interventions must be carefully considered in the context of how they work to improve the status of the client upon discharge from the facility. These tasks are not inherently meaningful or relevant, do not have utility or produce a tangible output, and do not provide the client with the rich experiences found in actual occupations and activities. OT practitioners understand that engagement in occupations and activities in context and with purpose supports the creation of habits and routines and enhances cognition and motor learning that endure (AOTA, 2014).

Intervention Review

According to the *Framework*, the intervention review involves revisiting the intervention plan and documenting progress toward targeted outcomes. For the purposes of this article, the review will describe the process of daily documentation in which practitioners must describe the occupations and activities provided as interventions; the targeted goals of treatment; daily progress toward the goals; and, most importantly, how advancement toward the goals is going to provide the client with performance skills, habits, and routines, and improved client factors to ensure long term-safety and compliance with medical instructions within their natural context on discharge to ensure that chances of readmission to a facility are minimized. OT practitioners must be certain to execute and document interventions that relate to participation outcomes and address underlying component factors, skills, patterns, and the context and environment. Documentation should indicate that the OT practitioner does not simply present solutions and activities to clients, but

understands the interaction of the occupations and activities with the client's mind (cognition and learning), physical body, and spirit (motivation and purpose).

As an example of documentation that not only meets the basic CMS requirements but also ties interventions to targeted outcomes, consider the case example of Martha. Martha was an 80-year-old female who sustained a fracture to her left hip when she fell in her home. Martha lived alone with her small, aging dog that she needed to carry up the stairs of her two-story home when preparing for bed. Prior to her fall, Martha was independent in all ADLs, IADLs, community mobility, leisure activities, and social pursuits. At the time of OT, Martha was living in a skilled nursing facility until her hip healed and she could return home to her previous lifestyle. The occupational profile indicated that Martha cared deeply for her pet and her independence. She was a well-educated individual who worked as a nurse for 40 years before retiring 15 years ago. Martha reported that she had no cognitive limitations but was concerned about returning to her house because of the residual pain and weakness of her injured hip. She had several grown children and grandchildren, but they lived out of town; her husband had passed away 3 years earlier. Targeted assessments confirmed that Martha was able to complete self-care ADLs with increased time and adaptive equipment for bathing and toileting, but that her pain level and limited endurance were affecting her ability to cook meals; complete laundry tasks; feed and walk her dog, Spunky; and reach her second story bedroom. She was considered at risk for a fall if she were to return to her home without OT services.

The OT plan of care, created in conjunction with Martha, used a rehabilitative and occupation-based approach. It identified Martha's problems as (1) an impaired ability to care for Spunky, (2) an inability to safely complete desired IADL tasks, and (3) an inability to reach her bedroom to sleep. Her strengths included intact cognition and health literacy, an understanding of medication management, safety awareness, and independence in dressing and bathing using a shower chair. Components of function addressed during OT included pain, limited endurance and strength, the questionable safety of her home, and balance concerns on uneven surfaces.

During one particular day of treatment, the OT worked with Martha on her IADL pet care goal of walking Spunky. The short-term goal was to ensure that Spunky was able to go outdoors first thing in the morning to relieve himself without being walked by Martha until she was able to walk safely on uneven surfaces. Interventions include discussing techniques to reduce pain on rising and determining methods for letting Spunky outside in a manner that ensured his safety and Martha's piece of mind.

The following treatment note was created to document Martha's second treatment session using the SOAP (subjective-objective, assessment, and plan) method of documentation.

S: "I am still nervous that if I go home I may lose my balance and fall in my house from the pain in my hip, especially when caring for Spunky."

O: Martha continues to report pain and weakness in her hip but has a strong desire to return home to her dog and her independence. Today's treatment session required the skilled services of an occupational therapist and included activities to improve ADL functioning, reduce fall risk, improve balance, and set supportive habits and routines.

Martha has indicated that her hip pain is worse in the morning after rising and that she is concerned she will not be able to ambulate safely to the back porch or within her kitchen to take her dog for a walk.

Discussed physician-ordered medication plan of non-opioid pain meds to be taken every 4 to 6 hours. Martha stated that she was not asking nurse for medication through the night so she had none in her system when she woke. Practitioners recommended that Martha request her first dose of pain medication in the morning prior to leaving the bed to control pain. Martha agreed that this idea might help alleviate her fear of falling because of pain. She stated that following confirmation with her physician and upon discharge to home, she could routinely place her medication and a glass of water on her bedside table before retiring.

Martha engaged in a discussion and simulated activity to let her dog out of the house in the morning. She stated that her typical morning routine involves taking her dog for a short walk around the yard to allow him to relieve himself and get fresh air. Because Martha is not sure whether she will feel confident walking outside with her dog while using a cane when she first returns home, the therapist suggested an adaptation that involves having a long leash placed outside her door that she can connect to her dog while she is safely inside the house that allows the dog free and safe access to a grassy area. Martha and the OT simulated this activity with a 30-foot walk through the OT clinic and simulated placement of the leash; she demonstrated good attention to safety while ambulating with her cane and was successful with all elements of the activity. Ideas for a new pain medication routine and method for letting her dog out of house were documented for Martha, with a copy placed in chart.

A: Martha has articulated her interest and plan to create a medication routine that reduces her morning hip pain and her fear of falling because of pain and morning stiffness. She has demonstrated an adaptive strategy to care for her dog's early morning need to go outdoors that will reduce her need to walk on an uneven surface. Martha's safety continues to improve during functional mobility with cane and in balance maintenance while manipulating items required for IADL independence.

P: To continue skilled service of OT to address safety during IADL tasks, such as cooking and dog care using functional activities. To schedule home visit following client discharge from facility to ensure no trip or fall hazards and consider use of the downstairs bedroom.

As OT practitioners, we must be sure to let others, who may not understand our profession and who may view interventions as pastimes or frivolous engagements, know that OT facilitates therapeutic interactions among the client, their environments and contexts, and the occupations in which they engage. OT practitioners recognize that human function is much more than a sum of the parts, and that without authentic attention and engagement in context with those things that are important to a client, routinized change leading to compliance and safety will not occur.

PERFORM Documentation Templates


As outlined in this article, practitioners must have a common understanding of the domain and process of occupational therapy as well as the ability to document in a manner that highlights the distinct contribution and value of the profession in an era of health care change. The PERFORM documentation templates were created by AOTA to support occupation-based and client-centered documentation using the *Framework* as a foundation. The templates provide a roadmap to guide traditional written documentation and include instructions throughout for creating a custom addition to an existing electronic medical record system.

PERFORM is a detailed deconstruction of the three-part evaluation section of the OT process as described in this article. Each section (Occupational Profile, Analysis of Occupation, and Intervention/Plan of Care), provides the details of the subcategories and subcomponents that are important to consider and address during the evaluation process. To improve efficiency in both traditional and EMR documentation, the templates lay out the relationships that the assessment elements have to each other.

To facilitate creation of an OT documentation system within an EMR, suggestions are included to assist IT staff to create interactive tables and pre-filled fields. In addition, suggestions for cross populating content to avoid duplication are included. It is suggested that when the PERFORM template is integrated into an existing EMR that existing system data, such as medical history, is used to avoid duplication of effort; it is also recommended that a daily treatment note be created that allows inclusion of the occupation-centered problem and goals and OT interventions, including ICD codes that demonstrate the distinct value of the profession.

The Intervention/Plan of Care section of the templates include instructions for creating problem statement and occupation-centered goal writing tools. These tools provide structure and terminology to assist practitioners with focused and efficient documentation. This section also contains additional

elements that should be included in summary documentation, such as strengths and weaknesses, statement of skilled service, and prognosis. When needed, practitioners can refer to the *Framework* for detailed descriptions of various treatment approaches and interventions that support the established goals and address the identified problems.

For practitioners, OT program staff, rehabilitation department managers, or health care system administrators interested in integrating the templates into an existing or new electronic medical record system, the templates are available from AOTA at <https://bit.ly/2OSOF31>. 

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The Occupational Therapy Practice Framework: A Foundation for Documentation

October 2018

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Learning Level: Introductory

Target Audience: Occupational Therapy Practitioners

Content Focus: Domain of Occupational Therapy; Occupational Therapy Process; Professional Skills: Documentation

1. **The Patient Protection and Affordable Care Act (ACA) of 2010 introduced health care providers to the Triple Aim. The Triple Aim includes which one of the following sets of improvements?**
 - A. Better care, affordable care, healthy people/healthy communities
 - B. Free care, annual physicals, educational subsidies for physicians
 - C. Improved care, community health services, focus on primary care
 - D. Healthy people and communities, affordable health care, and primary care
2. **Which priority listed below positively affects at least two of the aims of the Triple Aim of health care that is part of the ACA?**
 - A. Ensure that all Americans have a yearly check up to prevent disease.
 - B. Provide free vaccinations to children under the age of 3 years to reduce epidemics.
 - C. Pre-schedule physician follow-up appointments with hospitalized individuals to ensure compliance with recommendations.
 - D. Reduce the number of hospital re-admissions as a cost saving measure.
3. **What intervention provided by an OT practitioner can save the health care system more than \$442 million, according to Stevens and Lee (2018)?**
 - A. Kitchen safety instructions
 - B. Strengthening programs
 - C. Home modifications
 - D. Upper body strengthening exercises
4. **Why should OT practitioners not be concerned that a sub-acute care focus on falls prevention and medication management for clients to reduce health care costs could limit OT interventions to those dealing with self-care ADLs, fall risk, and medication management?**
 - A. Because OT practitioners understand the relationship of all factors and occupations by their use of common skills; addressing a fall risk skill, for example, will also address a skill for leisure activity engagement, and vice versa.
 - B. In many cases, outcomes that are important to our clients and the outcomes that are important to the health care system do not overlap, so practitioners will need to seek managerial permission to work on specific occupations important to the client.
 - C. Because of the current state of health care, including reimbursement for therapy, practitioners should focus on areas of function that are valued most by the payers and not be concerned with client interests.
 - D. Practitioners are automatically providing client-centered care in sub-acute settings because those clients are only interested in balance, medication compliance, and self-care ADLs.

5. **In October 2019, the Patient Driven Payment Model (PDPM) will be replacing the Resource Utilization Group (RUG) system. What does this mean for OT practitioners?**
- A. No changes to OT are expected under the new system.
 - B. PDPM will require OT practitioners to clearly articulate the value of their services.
 - C. Under PDPM, OT services will receive higher levels of payment than under RUGS.
 - D. OT practitioners should focus on using preparatory methods that are more easily understood by non-practitioners.
6. **Which set of five areas below represents the domain of OT, according to the Framework?**
- A. Occupations, activities, preparatory methods, preparatory tasks, and education
 - B. Occupations, client factors, performance patterns, performance skills, context and environment
 - C. ADLS, IADLs, contexts and environments, participation, engagement
 - D. Occupational profile, analysis of occupation, intervention plan, intervention review, targeting of outcomes
7. **What is PERFORM?**
- A. A detailed deconstruction of the three-part evaluation section of the OT process as described in this article
 - B. An electronic documentation system designed for OT practitioners
 - C. A new section of the fourth edition of the *Occupational Therapy Practice Framework: Domain and Process*
 - D. A detailed deconstruction of the three-part intervention section of the OT process as described in this article
8. **Which type of intervention is most distinct to OT and encompasses all factors, skill, patterns, and context/ environments?**
- A. Preparatory methods
 - B. Education and training
 - C. Occupations and activities
 - D. Advocacy
9. **Both long- and short-term goals should be written according to a goal writing system that includes:**
- A. A focus on the client, safe participation in occupation as the outcome, conditions of the outcome, criteria for success, and a timeline.
 - B. Conditions of the outcome, criteria for success, a timeline, list of deficits in occupational performance, and the expected outcome
 - C. Deficient occupation and the skills identified by the client that are creating the limit, and a timeline
 - D. Subject, task of the therapist, amount of assistance, and deadline for completion
10. **Which of the following is a well-written, long-term goal based on the identified problem?**
- A. Problem: Unable to dress self. Goal: Client will demonstrate the ability to cook dinner independently while safely using stovetop 100% of the time within 2 weeks.
 - B. Problem: Hand weakness. Goal: Client will squeeze a medium tension exercise ball 10 times without fatigue within 2 days.
 - C. Problem: Unable to brush teeth. Goal: Client will raise arm overhead 10 times to gain motion needed to bring toothbrush to mouth 70% of the time.
 - D. Problem: Unable to complete desired yard activities. Goal: Client will safely and successfully mow front yard with riding mower using one-hand technique to turn ignition, engage blade, place in gear, and steer during all attempts within 2 months.
11. **What is the name of the initiative from the ABIM Foundation that AOTA joined to advance a national dialogue on avoiding unnecessary medical tests, treatments, and procedures?**
- A. Selecting Well
 - B. Selecting Successfully
 - C. Choosing Securely
 - D. Choosing Wisely
12. **Which of the following statements best describes the distinct contribution made by OT in a home setting?**
- A. OT practitioners work to assist clients in gaining motor skills that can support medication compliance.
 - B. OT practitioners assist clients with developing useful habits and routines that can support medication compliance.
 - C. OT practitioners can provide a plastic segmented medication container to support medication compliance.
 - D. OT practitioners can teach clients about the importance of medication compliance.

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