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Use of Self-Care Standardized Assessments in Occupational Therapy Skilled Nursing Home Practice

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Requirements for the Degree of
Doctor of Occupational Therapy

Eastern Kentucky University
College of Health Sciences
Department of Occupational Science and Occupational Therapy

Courtney M. Green
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EASTERN KENTUCKY UNIVERSITY
COLLEGE OF HEALTH SCIENCES
DEPARTMENT OF OCCUPATIONAL SCIENCE AND OCCUPATIONAL THERAPY

Certification

We hereby certify that this Capstone project, submitted by Courtney M. Green conforms to acceptable standards and is fully adequate in scope and quality to fulfill the project requirement for the Doctor of Occupational Therapy degree.

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This project, written by Courtney M. Green under direction of Dr. Anne Fleischer Faculty Mentor, and approved by members of the project committee, has been presented and accepted in partial fulfillment of requirements for the degree of

DOCTOR OF OCCUPATIONAL THERAPY

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Executive Summary

Background: Understanding why occupational therapists select certain self-care standardized assessments within the skilled nursing setting is important to ensure outcomes are accurately measured. Consistent use of self-care standardized assessments can further support the utilization of occupational therapy services. Limited research is available to understand why occupational therapists use self-care standardized assessments in general as well as specifically within skilled nursing facilities (SNFs).
Purpose: The objective of this project is to discover the supports and barriers to utilizing self-care standardized assessments among occupational therapy practitioners who work within for-profit SNFs.
Theoretical Framework. Theoretical framework utilized to evaluate the intrinsic and extrinsic factors to selecting self-care standardized assessments was the Person-Environment-Occupation-Performance model.
Methods. This case series, which includes three occupational therapists with varying levels of experience, explored the phenomenon of their decision to use or not use self-care standardized assessments.
Results. Thematic analysis of each case's interview revealed intrinsic and extrinsic themes that were either supports or barriers in selecting self-care standardized assessments in skilled nursing practice. Common themes among all three cases included education and work environment. Different themes among the cases included culture, insurance and functionality.
Conclusions: Findings from the case series were consistent with previous research which included the following reasons for not routinely administering self-care standardized assessments: unfamiliarity with assessments, workload, and time to complete them.

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Section One: Nature of Project and Problem Identification

Health care is ever changing, requiring health care professionals to stay abreast of the changes so they can provide reimbursable evidence-based care. Specifically, skilled nursing is changing from a fee-for-service model to a service-based repayment model. This change directly relates to the American Occupational Therapy Association's [AOTA] Vision 2025 that aims to amplify "health, well-being and quality of life for all people, populations and communities through effective solutions that facilitate participation in everyday living (Metzler, 2019, para 6)." This new payment model, Patient Driven Payment Model (PDPM), focuses on the individualized needs, goals, and characteristics of each patient rather than volume of services provided (Centers of Medicare and Medicaid Services [CMS], n.d.). In regard to therapy, this approach allows the therapist to return the focus to occupation rather than impairment (Metzler, 2019).

Outcome measurements determine the amount of change that has occurred throughout the course of treatment for specific clients or groups of individuals. Outcome measures are taken prior to, during, and at the conclusion of treatment. In occupational therapy, outcomes focus on change within an individual's ability to complete an occupation. Therefore, it is important to utilize outcome measures to demonstrate the intervention effectiveness in meeting the individual's occupational goal. Within the PDPM, patient outcomes are measured utilizing a set of standardized elements within the Minimum Data Set (MDS) section GG (CMS, 2019b), which is required to be completed on all nursing home residents. MDS is a federally mandated standardized assessment tool that measures health status for nursing home residents in Medicare/Medicaid-certified nursing facilities. Section GG was developed to provide comprehensive standardized measures of therapy needs and functional status, which have been

found to be predictive of physical and occupational therapy costs per day (CMS, 2019b). Within occupational therapy there are three measurable self-care components included in section GG function score: eating, oral hygiene, and toileting hygiene (CMS, 2019b). Other components such as dressing and bathing are also included; but are not used to calculate the function score (CMS, 2019b). Section GG function score is the outcome measure utilized to calculate reimbursement for skilled occupational therapy services.

Outcome measures such as those found within section GG are important in occupational therapy practice because they measure the amount of functional change that occurred from admission to discharge of therapy services. This functional change is used to support therapy reimbursement (Unsworth, 2000). Outcome reporting is further supported by providing a uniform approach through use of standardized assessments (Kaplan, 1996). With the change to PDPM and focus on reporting the Section GG function score, occupational therapists need to return focus on self-care standardized assessments to aid in functional outcome reporting.

Therefore, it is important to discover the barriers that occupational therapy practitioners face when selecting self-care standardized assessments. Research since the 1990s has shown the effectiveness of using standardized assessments (Kaplan, 1996; Foto, 1996); however, there has not been complete adoption of standardized assessments among occupational therapists. In previous studies, occupational therapy practitioners reported minimal use of standardized assessments due to unfamiliarity, limited availability, lack of knowledge, time requirements, workload, and lack of interest in standardized assessments (Bland et al., 2013; Bowman, Lanin, Cook & McCluskey, 2009; Piernik-Yoder & Beck, 2012; Robertson & Blaga, 2013; Wales, Lannin, Clemson & Cameron, 2018). Occupational therapists have been found to develop their own quick informal self-care assessments instead of utilizing standardized assessments

(Robertson & Blaga, 2013). Research has shown that non-standardized assessments do not translate into outcome measures that can be used to show the effectiveness of occupational therapy interventions (Wales et al., 2018). If occupational therapists continue to use non-standardized assessments, it will be difficult to support the score reported within the section GG under the PDPM and potentially leading to reimbursable services.

To understand why occupational therapists do not routinely use standardized assessments, the principal investigator conducted a search of the literature with the following key words: *standardized assessments, self-care standardized assessments, occupational therapy, occupational therapist,* and *outcome measures.* The following databases within the Eastern Kentucky University library were searched: Gerontology, Academic Search Complete, Child Development & Adolescent Studies, CINAHL Complete, CINAHL with Full Text, Cochrane Central Register of Controlled Trials, Cochrane Database of Systematic Reviews, Consumer Health Reference eBook Collection, eBook Academic Collection, Health Source – Consumer Edition, MEDLINE, OpenDissertations, Primary Search, Primary Search Reference eBook Collection, PsycARTICLES, Psychology and Behavioral Sciences Collection, PsycINFO, Research Starters – Sociology, Social Work Abstracts, SocINDEX with Full Text, Sociological Collection, TOPICsearch and Urban Studies Abstracts. This search yielded several peer-reviewed articles on impairment-driven standardized assessments and pediatric standardized assessments, but not any articles related to standardized assessments used within skilled nursing facilities (SNFs). Bowman, et al. (2009) found that less than 30% of allied health professionals utilize standardized assessments effectively to produce outcome measures. This proportion insufficiently supports therapy outcomes and services provided. To develop an environment supportive of outcome monitoring, research is needed to understand

occupational therapy practitioners' perceived supports and barriers to using standardized assessments within skilled nursing.

Problem Statement

Wales and colleagues (2018) found that even though numerous standardized assessments exist, use of standardized assessments in occupational therapy practice has been poorly adopted. When occupational therapy practitioners use standardized assessments, they routinely use impairment-driven standardized assessments over self-care standardized assessments (Alotabi, Reed & Nader, 2009). Within the new payment model, occupational and physical therapy outcome scores in section GG will be used to calculate the function score (CMS, 2019b). Therefore, the expectation will be for occupational therapy to utilize self-care standardized assessments to justify reported outcome scores.

Purpose of the Project

The purpose of this capstone project is to describe occupational therapists' use of standardized self-care assessments within for-profit SNFs.

Project Objective

The objective of this project is to discover the supports and barriers to utilizing self-care standardized assessments among occupational therapy practitioners who work within for-profit SNFs.

Theoretical Framework

Person-Environment-Occupation-Performance Model. The Person-Environment-Occupation-Performance (PEOP) model is a transactive system model that focuses on how everyday occupations are affected by the person or people and the person's context (Baum, Bass-Haugen & Christiansen, 2005; Cole & Tufano, 2008; Wong & Fisher, 2015). *Person* is defined

by the intrinsic characteristics of the client consisting of physiological, neurobehavioral, spiritual, cognitive and psychological factors (Baum & Christiansen, 2005; Cole & Tufano, 2008; Wong & Fisher, 2015). *Environment* is defined by the extrinsic characteristics composing of social, cultural, natural, physical and societal systems (Baum & Christiansen, 2005; Cole & Tufano, 2008; Wong & Fisher, 2015). *Occupation* is defined as what the person needs or wants to do in their daily lives (Baum & Christiansen, 2005; Cole & Tufano, 2008). *Performance* is defined as the act of doing the occupation (Baum & Christiansen, 2005; Cole & Tufano, 2008). Occupational participation and performance are the constructs derived from the complex relationship among person, environment, and occupation (Baum & Christiansen, 2005).

This relationship can be explored at the individual level; among a group of individuals; or at the community level (Baum & Christiansen, 2005; Wong & Fisher 2015). Using this model, the occupational therapist evaluates the relationship among the person, environment, and occupation in order to determine the supports and barriers to occupational participation and performance (Baum, Bass-Haugen & Christiansen, 2005; Cole & Tufano, 2008; Wong & Fisher, 2015). This model was used to organize the themes that emerged from the interviews to understand the intrinsic and extrinsic factors associated with utilizing self-care standardized assessments within SNFs.

Situational analysis was used to understand the occupational participation and performance requirements of selecting and administering self-care standardized assessments by occupational therapists who work with a SNF (Aldrich & Rudman, 2016). This included interviewing occupational therapists (i.e., person) about the supports and barriers to utilizing self-care standardized assessments (i.e., occupational performance) within the for-profit SNF where they work (i.e., environment). Findings were organized into intrinsic and extrinsic factors

that fell within the categories of person (i.e., intrinsic) and environment (i.e., extrinsic). After organizing the data, the investigator identified which factors were supports or barriers (Baum, Bass-Haugen & Christiansen, 2005).

Significance

Findings from this project describe why occupational therapists use or do not use self-care standardized assessments within for-profit skilled nursing settings. These findings describe what intrinsic and extrinsic factors either led to or prevented the occupational therapists from routinely administering self-care standardized assessments.

Summary

Understanding why occupational therapists select certain standardized assessments within the skilled nursing setting is important to ensure outcomes are accurately measured. Consistent use of standardized assessments will support the utilization of occupational therapy services. Limited research is available to understand why occupational therapists use standardized assessments in general as well as specifically within SNFs (Piernik-Yoder & Beck, 2012). Furthermore, previous research has shown that occupational therapists select impairment-driven standardized assessments over self-care standardized assessments (Alotaibi, Reed & Nadar, 2009). Accordingly, this capstone project aimed to understand why SNF occupational therapists do not routinely use self-care standardized assessments.

Section Two: Detailed Literature Review

Skilled Nursing Facilities

SNFs are mandated to be in compliance with all the requirements in the federally mandated regulation: 42 CFR Part 483, Subpart B to receive reimbursement from Medicare or Medicaid programs (CMS, 2019b). In addition to federally mandated regulations, SNFs and nursing homes must also pass a Life Safety Code survey along with a standard state survey to become or remain certified (CMS, 2019b). These surveys are not announced to the facility prior to their arrival; therefore, it is in the SNFs' best interest to be in compliance to receive reimbursement from the Center of Medicare and Medicaid services. Upon successful completion of the survey, the SNF or nursing home receives a certification of compliance, meaning the facility is in compliance with the federal requirements (CMS, 2019b).

To qualify for a stay within a SNF, an individual must meet the requirements mandated by their insurance. For the purpose of this capstone project, information will be given surrounding Medicare Part A because it is the main insurance provider for individuals admitted into a SNF. Medicare Part A covers up to 100 days within a SNF as long as services are deemed medically appropriate and necessary (CMS, 2019c). Medically appropriate and necessary care as defined by Medicare Part A include the following components: a) a qualifying hospital stay of three consecutive days not including day of discharge prior to SNF admission; b) a physician order for a SNF admission; and c) a documented need for daily skilled care which is reasonable and necessary for the treatment of the client's diagnosis (CMS, 2015). Prior to the implementation of PDPM, daily skilled care was defined as receiving therapy services five or six days a week (CMS, 2015); this criterion has continued with PDPM.

Improving Medicare Post-Acute Care Transformation (IMPACT) Act

The IMPACT Act was signed into law on October 6, 2014. This act requires standardized patient assessment data to be collected, reported, and shared among different acute care providers (CMS, 2018). Acute care providers include SNFs, home health agencies, long-term care hospitals, and inpatient rehabilitation facilities. These standardized assessments include the Long-Term Care Hospital CARE Data Set; the Minimum Data Set; the Outcome and Assessment Information Set; and the Inpatient Rehabilitation Facility Patient Assessment (CMS, 2018).

The IMPACT Act allows for data from the different required standardized assessments to be used to improve Medicare outcomes through care coordination, shared decision making, and enhanced discharge planning (CMS, 2018). The Minimum Data Set (MDS) is used as the primary standardized assessment tool to collect data that is then shared among all SNFs. Within the MDS, the section GG is completed by therapists to calculate the function score, which is used to determine the rate of reimbursement.

Patient Driven Payment Model

Patient Driven Payment Model (PDPM) began on October 1, 2019 as the new reimbursement model for individuals receiving Medicare Part A skilled care at SNFs. PDPM is a case-mix reimbursement model that replaces the fee-for-service model previously used by Medicare Part A. Previously, reimbursement was based on the Resource Utilization Group, Version IV (RUG-IV; CMS, 2019b), which focused on volume of services provided regardless of the patient unique needs or goals (CMS, 2019b). Under PDPM, patients are categorized within payment groups based on specific patient features (CMS, 2019b).

Payment groups under PDPM are derived from a combination of five payment components along with a variable per diem adjustment (Appendix B). The five payment components include utilization of physical therapy, occupational therapy, speech language pathology, nursing, social services, and/or non-therapy ancillary (NTA) services (Acumen, 2018; CMS, 2019b; CMS, n.d.). The sixth component, variable per diem adjustment, varies the rate of reimbursement throughout the client's SNF stay (Acumen, 2018; CMS, 2019b; CMS, n.d.; Appendix C). Each component has criteria used as the basis for classification. In regard to occupational and physical therapy, the clinical category and functional score are used to determine payment (CMS, 2019b).

Clinical categories are determined based on the client's primary diagnosis that warranted a SNF stay (CMS, 2019b). PDPM utilizes ten clinical categories: (1) major joint replacement or spinal surgery; (2) non-surgical orthopedic/musculoskeletal; (3) orthopedic—surgical extremities not major joint; (4) acute infections; (5) medical management; (6) cancer; (7) pulmonary; (8) cardiovascular and coagulations; (9) acute neurologic; and (10) non-orthopedic surgery (CMS, 2019b). These ten PDPM clinical classifications are sorted into four occupational and physical therapy clinical categories. CMS (2019b) defines the four categories for occupational and physical therapy to include major joint replacement or spinal surgery (PDPM 1); non-orthopedic surgery and acute neurologic (PDPM 9-10); other orthopedic (PDPM 2-3); and medical management (PDPM 4-8).

History of the function score. The function score is often referred to as section GG because it is within Section GG of the Minimum Data (MDS) Set 3.00—a comprehensive assessment that is federally mandated to be completed on all residents who reside or are admitted to SNFs—([MDS], CMS, 2019b; CMS n.d). Creation of Section GG evolved from the

Improving Medicare Post-Acute Care Transformation Act (IMPACT Act), which required SNFs to collect data related to self-care scores and physical and occupational therapy utilization since 2016 and report it to CMS (Acumen 2018; CMS, 2019b).

CMS (2019b) has found that some of the self-care scores are reliable and valid predictors of skilled nursing utilization; therefore, CMS has begun using these scores—found within Section GG--as the basis of payment and patient classification under PDPM. CMS (2019b) will consider adding and/or deleting items within section GG if additional self-care items demonstrate a meaningful relationship with utilization of skilled nursing services or previous items no longer demonstrate this relationship.

Due to the rising cost of skilled nursing services, Acumen, LLC (2018) was hired by CMS in 2012 to develop alternative reimbursement models for SNFs (Acumen, 2018). Within Acumen's, LLC (2018) technical report, the development of the comprehensive alternative payment model is explained, including independent variables that predicted physical and occupational therapy utilization. This comprehensive alternative payment model was created in two separate phases. The first phase consisted of identifying potential skilled nursing resident characteristics that were good predictors of physical and occupational therapy utilization. Methods included reviewing the literature and receiving input from a technical expert panel. The background of the panel included physical therapists, attorneys, Gerontology professors, registered nurses, occupational therapists, long-term care community coalition director, government accountability officer, speech therapists, administrator and statistician. Information gathered from the literature and the expert panel informed the initial statistical exploration of the CMS data (Acumen, 2015).

The second phase consisted of selecting the final variables that were the most predictive of resources used during a SNF stay. Acumen, LLC found functional status, age, cognitive impairment, comorbidities recorded, prior utilization of services, and services received during skilled nursing stay were predictive of service utilization. This information was applied to create the function score under section GG.

OT and PT function score. The function score for physical and occupational therapy, known as section GG, is determined through the sum of seven physical therapy components and three occupational therapy components found to be predictive of physical and occupational therapy costs per day (CMS, 2019b; CMS, n.d.). Self-feeding, toileting hygiene, and oral hygiene are the three reported by occupational therapy within section GG. Other self-care areas such as toileting, dressing, and bathing are included in the reporting for the Section GG but are not used to calculate the function score (CMS, 2019b). No data is currently available within the resource utilization database that predicts occupational therapy costs per day using toileting, dressing, and bathing levels of independence (CMS, 2019b).

Section GG scoring. Section GG scores assigned based on the following ratings: a four indicates independence or requiring set up assistance; three denotes supervision or touching assistance; two reflects partial to moderate assistance; one means substantial to maximal assistance; and a zero means dependence, refused, not applicable, not attempted due to environmental limitations, or not attempted due to medical condition or safety concerns (CMS, 2019b). A higher function score indicates a greater level of independence.

Private Insurance Reimbursement

For skilled therapy services, Medicare Part A is one of the few reimbursors that does not require preauthorization or routine updates in order to determine a client's length of stay. For

clients who have managed Medicare insurance plans and/or private health insurance, therapy updates are required. These insurance plans use these updates to determine if therapy services are skilled and warranted, or if the client needs to be discharged from therapy services. Updates typically include the client's current status in the following areas: mobility, bed mobility, transfers, self-feeding, grooming/hygiene, toileting, bathing, and dressing. Insurance companies do not require standardized assessments to be used within updates. However, by utilizing standardized assessments the therapist can build a stronger case for continuation and justification of services, if the client's SNF's admission is medically reviewed.

Research on Standardized Assessments from the 1990s

Research into the use of standardized assessments started in the mid-1990s. A critical evaluation of standardized tests was completed by Kaplan (1996) in response to the need to illustrate the effectiveness of occupational therapy interventions through use of standardized assessments. Within this critical evaluation, Kaplan (1996) found that non-standardized assessments were the most common type of assessment used, which is consistent with the recent findings reported by Robertson and Blaga, (2013). They found that occupational therapists often develop their own non-standardized assessments, which did not adequately communicate outcome measures (Robertson & Blaga, 2013).

Foto (1996) added further to the literature with discussion on the importance of outcome studies to illustrate occupational therapy interventions are effective and efficient. Findings such as these became more important because insurance companies during the 1990s were starting to determine how skilled therapy services were being utilized and delivered (Foto, 1996), which continues to be done (Unsworth, 2000).

Standardized Assessments

Standardized assessments are tools that have been empirically developed and are scored in a consistent way (American Speech-Language-Hearing [ASHA], 2019). When using standardized assessments, the results can be compared over time for one person or among groups of individuals who received a similar treatment intervention (ASHA, 2019). This differs from non-standardized assessments where results cannot be compared; however qualitative information can be gathered within non-standardized assessments such as living environment and social situations. Both of these types of assessments are used within occupational therapy and have distinct purposes.

Serial use of standardized assessments throughout the plan of care will show if occupational therapy services are effective or ineffective, which cannot be illustrated with non-standardized assessments. This is further supported by the research that shows that use of standardized assessments can be used to facilitate continuity of care, assist in development of the plan of care, support decision making and predict a client's prognosis and function (Bland et al., 2013). Improvement in scores illustrate effective services compared to declining scores which illustrate ineffective treatment and/or change in the client's medical status. By monitoring these outcomes, therapists can tailor the plan of care to meet the client's needs and develop achievable goals.

Impairment driven standardized assessments. Standardized assessments that focus on impairments, such as range of motion, coordination, or strength, are defined as impairment driven assessments. Impairment driven standardized assessments focus on a specific impairment rather than the individual's occupational performance. The following are examples of typical impairment driven assessments.

Range of motion. Range of motion is an assessment of joint mobility that can be measured actively, passively or with assistance (Shiel, 2018). Goniometry is the standardized assessment tool used to measure the amount of movement within the joint, using degrees of movement (Flinn, Latham & Podolski, 2008).

Coordination. Coordination is defined as the ability to use different parts of the body together proficiently and effectively (Lexico, 2019). Commonly used standardized assessments that address coordination include Nine-hole Peg Test (Mathiowetz et al., 1985a), Purdue Pegboard Test (Lafayette Instrument Company, 2015) and Minnesota Rate of Manipulation Test (Lafayette Instrument Company, 1998).

Strength. Strength can be measured using a variety of different measures. Common standardized methods include manual muscle testing (National Institute of Environmental Health Service (n.d.)), grip/pinch strength through use of dynamometer (Mathiowetz et al., 1985b) or bicep arm curl test (Wood, 2008).

Impairment driven standardized assessments have been found to be used more often than self-care standardized assessments among occupational therapists (Alotabi, Reed & Nader, 2009). Use of impairment driven assessments are relevant if the impairment being measured directly relates to the dysfunction in occupational performance (Alotabi, Reed & Nader, 2009). For instance, after completing a self-care standardized assessment, it was observed that the client scored low on toileting due to inability to manage clothing from impaired coordination. Since hand coordination is directly related to the ability to perform clothing management—self-care performance--then an impairment driven standardized assessment measuring hand coordination can be used as a follow-up assessment.

Self-care driven assessments. Standardized assessments that focus on areas of occupational performance such as feeding, toileting, dressing, bathing, or grooming are considered self-care driven assessments. These standardized assessments focus on basic activities of daily living (ADLs) when the focus of occupational therapy intervention is to return to prior level of function. Commonly used self-care driven standardized assessments are the Barthel Index (Mahoney & Barthel, 1965), Modified Barthel Index (Shah, Vanclay & Cooper, 1989), Activity Measure of Post-Acute Care (Shirley Ryan Ability Lab, 2003), KATZ Index of Independence (Wallace & Shelkey, 2007) and the Functional Independence Measure (UB Foundation Activities, Inc, 2002).

Self-care standardized assessments can be used in conjunction with the section GG function score to further support and strengthen the outcome measure being reported. The function score within section GG addresses self-care performance, therefore utilizing self-care standardized assessments can provide valid and reliable support for the function score. However, use of self-care standardized assessments other than the section GG has been poorly adopted into occupational therapy practice (Wales et al., 2018).

Outcome measures. Occupational therapy's use of standardized assessments can measure the amount of change that occurred from the beginning to the end of the intervention (Unsworth, 2000), which provides support for the effectiveness of occupational therapy intervention (Foto, 1996; Unsworth, 2000). These measures are taken prior to, during, and at the conclusion of treatment. When standardized measures are used, therapists are better equipped to make therapy decisions (Colquhoun et al., 2017).

Despite the growing evidence that occupational therapy needs to provide proof that their interventions are effective, recent researchers have found many occupational therapists do not

embrace this fact. An important tool for illustrating the effectiveness of occupational therapy treatment is the use of standardized assessments. Colquhoun and colleagues (2017) conducted surveys that found low utilization of standardized assessments and/or utilized inconsistently among rehabilitation professionals. Wales and colleagues (2018) found that occupational therapists utilize non-standardized assessments; however, these do not translate into metrics for showing effectiveness of therapy services. If therapists continue to utilize non-standardized assessments or inconsistently use them, the effectiveness of occupational therapy cannot be measured. When insurance companies are uncertain if interventions are effective, reimbursement for services is frequently denied because they are not considered skilled or medically necessary (CMS, 2019a).

Routine use of standardized assessments as outcome measures assists with making clinical decisions, such as determining and/or adjusting the treatment approach (Colquhoun et al., 2017; Simning et al., 2018). Specifically, changes in outcome measures show maintenance, improvement, or decline in function. With this data, the occupational therapist can adjust the plan of care and treatment intervention to meet the needs of the client more effectively. Another advantage to the use of outcome measures is the ability to monitor the client's health and well-being through the plan of care (Colquhoun et al., 2017; Simning et al., 2018).

Justification of Services

Even though the section GG is a standardized assessment, it does not adequately measure an individual's occupations. Section GG only focuses on the occupations of self-feeding, oral hygiene and toileting hygiene which does not show an individual's full capability. Therefore, utilizing other self-care standardized assessments, a clearer picture of an individual's capability can be developed. If this is done routinely, occupational therapy interventions will support the

improvement of other self-care skills; such as dressing and bathing. This evidence may lead to adding these self-care areas to the calculation of the function score within the GG section. Not only will this support occupational therapy utilization; but the residents of SNFs will receive the services needed to regain self-care independence or require less assistance.

Section Three: Methods

Project Design

Case series allows the investigator to focus on a specific group of people or phenomenon (Portney & Watkins, 2009). Specifically, it allows the principal investigator to analyze individuals' experiences and thoughts rather than abstract notions and expand the knowledge of individuals' occupational experience (Jones & Hocking, 2015). This case series, which included three occupational therapists with varying levels of SNF experience, explored the phenomenon of their decision to use or not use self-care standardized assessments when assessing and reassessing their clients self-care skills

Setting

Semi-structured interviews were conducted within a predetermined quiet and private location agreed upon by the principal investigator and the participant.

Inclusion Criteria

Occupational therapists were chosen to be interviewed based on the following criteria: a) between six months to 10 years of experience, b) 10-20 years of experience and c) greater than 20 years of experience. Each therapist was required to work within a for-profit SNF, and complete evaluations, recertifications, and discharge summaries.

Exclusion Criteria

Occupational therapists, who worked less than 6 months within SNF, were excluded.

Project Methods

This study was approved by the Eastern Kentucky University's Institutional Review Board on September 11, 2019.

Recruitment. A convenience sample of participants--known by the principal investigator--were invited to participate in this study via a text message. If they responded favorably to the text, a time was scheduled to review and sign the informed consent prior to conducting the interview (Appendix A).

Data Collection. Twenty to forty-five-minute semi-structured interview, using questions informed by the literature and the PEOP model was conducted (Appendix D). Interviews were recorded and transcribed via the Otter Voice Meeting Notes app on a password protected iPhone. All recordings were assigned a unique code. Immediately after the interviews were completed, the recordings and transcriptions were edited by the principal investigator to ensure accuracy. All transcriptions were uploaded to a password protected laptop, where they were reviewed a second time for accuracy. All recordings and transcriptions were deleted from the iPhone after being uploaded to the password protected laptop.

Data Analysis. Six-step process of thematic analysis by Braun & Clarke (2006), was used to analyze the transcripts deductively to understand the supports and barriers to utilizing self-care standardized assessments through the lens of the Person Environment Occupation Performance model.

Thematic analysis procedure. Otter Voice Meeting Notes App transcribed the interview. The principal investigator reviewed and edited the transcription for accuracy; and re-read the transcriptions several times to become familiar with the data. Next, the principal investigator studied the transcriptions several times to develop a list of initial codes. After producing a list of codes, the principal investigator completed a Mind Map for each case to provide a visual representation of the initial codes that emerged from each case's interviews. By coding and creating the Mind Map, themes emerged. Each case's themes were compared and contrasted

among the three cases. This process allowed the principal investigator to make some initial assumptions regarding potential barriers and supports to administering self-care standardized assessments within SNF among occupational therapists, with varying levels of experience.

Ethical Considerations

When conducting semi-structured interviews, there were several ethical considerations. These included privacy and confidentiality, informed consent and harm (Allmark et al., 2009).

Privacy and confidentiality. The principal investigator ensured the participants' privacy and confidentiality by assigning each participant a unique code and removing any identifying information from the transcripts and analyses.

Informed consent. The principal investigator reviewed the informed consent and answered all the participant's questions prior to the participant signing the informed consent.

Harm. Risk for harm was minimal within this study. Potential harm included suffering mild stress when discussing barriers to completing job duties. No participants indicated any signs or symptoms associated with mild stress during the interviews.

Section Four: Results and Discussion

Case One: Sally

Occupational therapist who has a master's degree and six years' experience working in SNFs was case one.

Intrinsic factors.

Theme: Functionality. Sally prefers functional based standardized assessments because, "…I'm trying to make my goals more function based. So, then they'll correlate more." Sally selected the self-care standardized assessment, the Barthel Index, because it measures areas of function which are part of her evaluation. Additionally, Sally indicated that she uses her knowledge as an occupational therapist to select the standardized assessment which measures areas relevant to her client.

> I feel like the only time I would ever choose impairment driven is if I picked up a long-term patient. And I am literally picking up for a specific goal of self-feeding because they lost the fine motor control strength. And maybe then I will use more like the nine-hole peg test or a standardized test like that for their self-feeding, because I'm only addressing that one task that they've always been dependent in their dressing and their toileting. And I'm not going to change that and I'm only going to focus on that one area, then yes, I will use the impairment driven but when I'm working with a patient that is short term, who was independent before or fairly independent before and that's what my goals are addressing.

Theme: Education and training. Sally felt that she had a good educational background regarding different types of standardized assessments and their use.

> We had to do a lot of research. So, then we became familiar with standardized tests and the goals, the purpose, the effects, and why we want them. I like to use it for that same reason of you know, it's not it's not biased eval as much you have that proof to kind of categorize or group your patients and follow them under standardized tests.

Extrinsic factors.

Theme: Work environment. Sally was driven by her work environment to complete standardized testing with evaluations, progress reports, recertifications, and discharge

summaries. Sally was required to complete at least one standardized test, which was monitored through weekly audits. Therefore, completing standardized assessments was a formed habit for Sally based on the work environment.

> Every week, our director, program director will pull out three patients. Typically, we try to get three patients that have been on caseload for a while, or if it's a part B patient, somebody that has exceeded their cap for the year or is close to exceeding their cap. A different discipline will audit that patient's chart, so they're looking at their evaluation, their daily notes, their progress notes, their recerts, and then discharge if it's been completed or when it will be completed. And one of the very specific questions on the audit is, what standardized test was used? What were the outcomes? Is there progress in the standardized tests between the evaluation, the progress note and the recert. So the purpose of the audit is for us to, you know, to show us, you know, like, the like, we have to be able to show that progress, we want to incorporate that, that justifies our needs, and allows us to continue and improves our documentation.

Theme: Culture. Culture did not affect Sally's selection of standardized assessments, rather it changed the way Sally conducted her assessment of the client. Regardless of age, gender or diagnosis, the Barthel Index would be the standardized assessment of choice. Only difference would be the number of steps needed to complete certain self-care tasks.

> know that a big question that I'll asked in my evaluation is about bathing and I'll assess bathing, and then I'll ask about their bathing at home. And the number of women that say I don't bathe at home, I just sponge bathe. I don't get as many men that tell me that. So, when scoring that [bathing], you kind of have to play that [bathing] into effect, because it is it is different. The amount of help that you would need with a sponge bath, could be different than the amount of help that you would need. In the regular shower, women spend more time with the grooming and bathing, they may need more help with the grooming or bathing, they might need more help with hair versus a man who doesn't. So yeah, they do score differently over with a man you may have more grooming, with difficulties with shaving that you wouldn't have with the woman. So yeah, I do believe there are differences between male and female.

Theme: Insurance. Being a newer occupational therapist, the change to Medicare reimbursement from the RUGS-IV to PDPM is the first major change Sally has experienced. However, Sally does not feel that the change to PDPM will affect how she selected standardized assessments or what standardized assessments to use.

> I think it's going to be a huge adjustment for all of us. And this is the first big change that I'll experience as a therapist… It's going to cut back on the need of the actual therapists being assistants and therapists. I think it's going to be a huge adjustment. I do think that people are going to overreact and in about nine months to a year, it's going to kind of come back to how it is right now.
>
> The administration of it? I don't think so. I hope not. I think that I will still just include it. with my evaluations. That's not going to go away, I'm still gonna have to evaluate everybody.

Supports and barriers. In the case of Sally, she did not describe any barriers to completing self-care standardized assessments in skilled nursing practice. Sally felt that she had a good background of different standardized assessments and their uses because of what she learned during her master's level of occupational therapy education. Sally found a way to incorporate standardized assessments as part of the evaluation process; so, productivity expectation pressure did not influence her decisions to either use or not use standardized self-care assessments (See Figure 1).

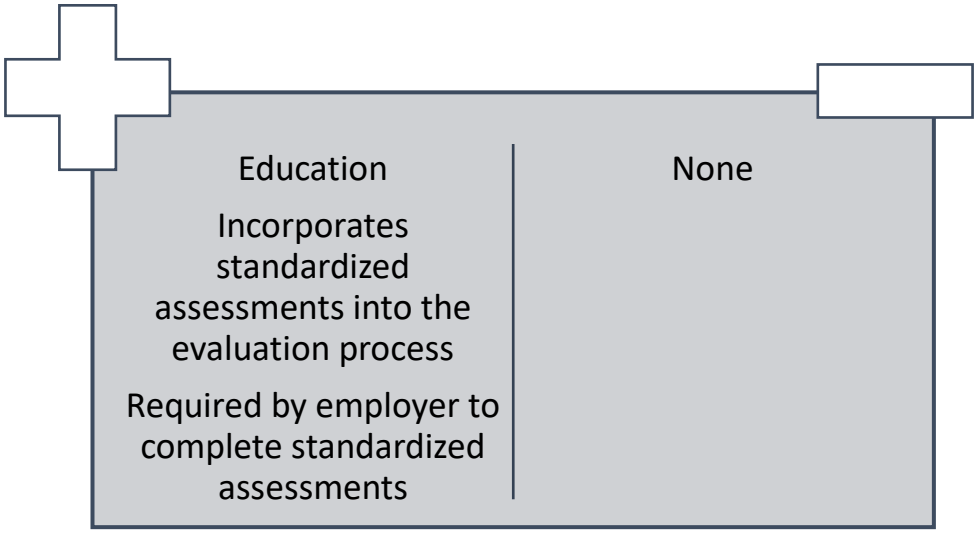

Figure 1: Case One: Sally supports (+) and barriers (-) to administering self-care standardized assessments

Case Two: Jacob

Occupational therapist who has a bachelor's degree and 16 years' experience in SNF was case two. Also, he has worked in other settings such as outpatient, acute care, and home health.

Intrinsic factors.

Theme: Patient driven. Jacob felt that he chose impairment-driven and self-care standardized assessments based on the needs of the patient, and his belief that they are important.

> I think both are relevant. I like functional performance… But I do believe there's a place for both… I think the needs of the patient helps me if I, if I have to get something that's like a nine hole peg test, or if they have, you know, if they have weakness out there, their biceps, the curl test, and there are things in there. It's kind of easy, because you do that assessment. Anyway. So, I think the patient is what drives me to do it. I think it's silly to ask somebody to do something that's not relevant to the patient. It's a waste of time.

When selecting a functional performance-driven assessment, Jacob preferred the Barthel Index because it was functional. Jacob also emphasized the importance of knowing the validity and reliability of the standardized assessment when making selections.

> I love the Barthel**.** I just do. Like I said, it's all about function. There's a short form to it. So, it makes it a little bit easier. I think that it's a standard, you know, a standard assessment that most OTs will use.

> And that's one thing I would say with all standardized tests, because there's a ton of them out there. And when you look at them, you know, whether you look at the KELS or you look at the Barthel or even if you look at the Allen, you have to look at the test and look how valid is it for what you're doing. And look at the reliability of that test for each patient, because if you want to make, you know, one standardized assessment for everybody, I don't know that that will work. Because people's experiences are different people's skills are different, how they interact with you, uh, you know, me being a male occupational therapist may be different with how they act with it react with a female occupational therapist. So, the validity of the validity of the tests really do matter when you're looking at that. And that's it's hard to judge at, always from patient to patient, because you're never going to find a universal test that you want to use.

Theme: Education. Jacob felt that because his occupational therapy (OT) program was transitioning from bachelor to master's degree, he was exposed to a wide range of standardized assessments. However, Jacob reported that as a student, he primarily learned how to administer

pediatric developmental standardized assessments. As a result of this experience, he did not receive much student training on standardized assessments used within a geriatric setting.

> Our program was really good about a lot of the standardized tests, we had a lot of exposure to it. They were transitioning to the masters … But we got a lot of exposure, we got a lot of exposure in the pediatric setting, we got a lot of exposure in the geriatric setting, a lot of the standardized assessments. I don't know that they really told us the whys as much I think, you know, your other classes as you incorporate that in, I think help, but when you're going through them, you know, they showed us a ton of them. I mean, I had a whole folder full of them. I mean, I must have had 20 or 25 different tests at some point, maybe even more than that…But I mean, I remember getting so much exposure to standardized tests, especially because again, you know, we had peds rotations and everything. And there's a lot of developmental tests there that are standardized, and a lot of a lot of the motor visual tests and things like that. I mean, they're standardized tests, and they're good tests. They're just not always appropriate for somebody who's 78.

A lack of training provided by the facility also played a role in the selection of standardized assessments. Jacob reported that his workplace had a folder full of assessments at their disposal, but they did not provide any extra training.

> You know, one of the things that I've seen is the last company I worked for, they had a whole folder full of standardized tests that never got picked up. And the reason it never got picked up is because they never did any training on it, they really only wanted a standardized test to put it in there, it was just okay, we got a standardized test done good, it didn't matter what it was or function, even though they would tell you that there was no follow through.

Extrinsic factors.

Theme: Lack of time. Jacob was not required by any employer to complete standardized assessments as part of the evaluation, recertification on discharge process. When Jacob was asked to describe how his work environment supports the use of standardized assessments, he stated, “I think that skilled nursing does support it, I think that outpatient supports that a lot, … So, you're really needing to justify what you're doing.” Jacob felt that the biggest barrier to selecting and completing standardized assessments in SNFs was time. If more time was available to complete standardized assessments, Jacob felt that they would use them more.

> It's difficult to be efficient. You know, we count every minute, we have, you know, you start your stopwatch when you start with a patient, stop when you stop working with them. But at the end of the day, it's really difficult to meet the expectations. I think they've gone up a lot since I have practice. And I would say to the point that sometimes it's unfair, it's unfair for therapists to be pushed so hard. You know, if you go to if you go to a car mechanic, you know, do they expect, you know, 85% of their day to be you know, tearing apart engines? … But when you're working with people, it's difficult, you know, they don't always follow the same timeline. So, I think that pro- productivity expectation sometimes adds a lot of stress to a job.

Throughout the interview, Jacob reiterated several times that time was a factor in completing standardized assessments. Jacob stated, "I like the idea of standardized testing. You know, like I said, in summary, I just wish I had more time to do that." This is due in part to productivity and efficiency standards set by the workplace and finding a balance to include standardized testing.

> I think what you have to be aware of, though, and I think that's more of a management issue, as far as culture is understanding that everything you do takes time. And there's a big emphasis on getting things done efficiently. And they want more and more things done... Everything takes a lot of time... The problem is, is there needs to be a separate category that allows us the time to do it and allows us the time to interpret it to be effective. Because what happens now is, we throw them all out there, and we want them done. But they're done generically. They're done quickly. You know, the things that are being done, are just to try to appease people on the other end of it for payment. It's not for the best interest of the resident for function. And that's, that's my number one reason for not doing it is time.

Theme: Culture. When questioned about culture, Jacob felt that there was a difference in administering standardized assessments between different ages. Jacob thought that young-old adults—40-60 years--get more frustrated when asked to complete standardized testing after the evaluation has already been completed. Although old adults—70-90 years--may get frustrated with taking extra time to complete testing, they were typically more accommodating to standardized assessments being administered than young-old adults. Other than different perceptions among young-old adults and old adults, Jacob believed that culture did not play a role in selection of standardized assessments.

> I really try to look at the patient. I don't believe that that's been a relevant thing that I've had to think about. That's a difficult question to answer. Because, you know, as an occupational therapist, you look holistically at them. I don't believe that, you know, the culture of the patient, or the culture of the department has affected the way that I that I look at the patient.

Theme: Insurance. Jacob reported that the change to PDPM will result in a change in the mode of thinking. Therapists will no longer be "driven by minutes, you're going to be driven by diagnosis which has its positives and negatives." Jacob reported that with the change to PDPM, he feels there will be a rise in the use of standardized assessments to show that treatment is effective.

> I think it's going to put more emphasis on having standardized tests to say that they came in at this score, and then they progress to this score… I think using a standardized test, a standardized assessment is a good idea. Because they're going to want to know what you're doing as an effective ...they want to see what you're doing is effective, which is the whole point of putting in the GG model. You know, they want to see what they're paying for is effective for people… I do believe that if you utilize standardized tests, it helps your case to argue that, you know, hey, they moved from this to this. I guess the biggest thing that we need to figure out is, does insurance companies care about that? Does Medicare care about that? Because if you're utilizing those, and they see that, you know, what's the point that you get them home at what's the safe discharge home, because the standardized test isn't going to tell you that for everybody.

Supports and barriers. Jacob believed in demonstrating functional outcomes for his interventions and knew that this can be achieved by using standardized assessments. He had a strong knowledge base of different standardized assessments and chose these assessments based on the clients' needs. Jacob also thought that the changes occurring as a result of PDPM, such as group or concurrently therapy, will support his ability to routinely administer standardized assessments.

The biggest barrier Jacob faced, when utilizing standardized assessments, was time. This was due to employer productivity and efficiency standards imposed by the RUGS payment model. Prior to PDPM, admission evaluations included a variety of components (i.e. physician

order, write ups), which led to insufficient time to administer standardized assessments. Large caseloads were also a barrier to administering standardized assessments. Additionally, Jacob also alluded that clients did not want to wait for the therapist to complete standardized assessments after completing the admission evaluation. Lastly, employers provided different standardized assessments, however, they did not provide education or training on how to administer the assessments (See Figure 2).

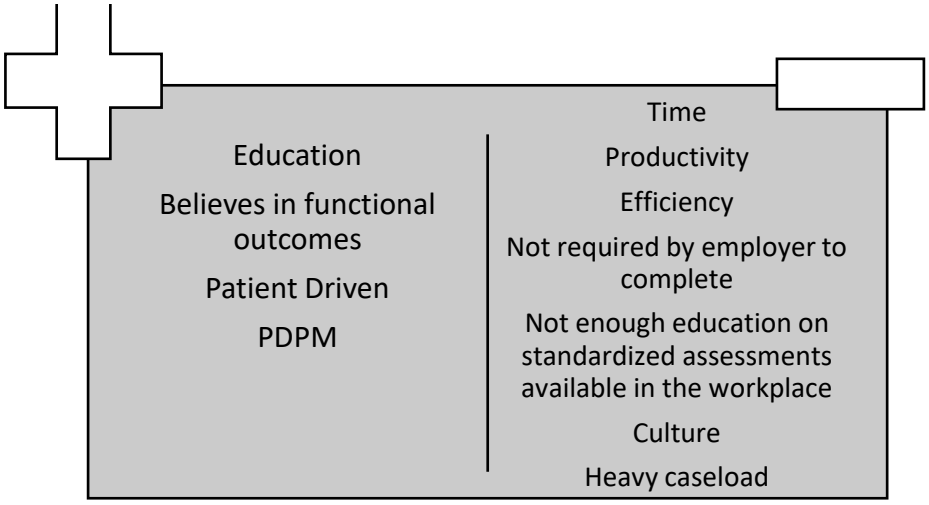

Figure 2: Case Two: Jacob's supports (+) and barriers (-) to administering self-care standardized assessments

Case Three: Carol

Occupational therapist who has a bachelor's degree and 44 years of experience in SNFs. Also, she has also worked in other settings such as Bureau of Worker's Comp, home health, school systems, outpatient and sheltered workshops.

Intrinsic factors.

Theme: Education. Carol alluded that the majority of her knowledge regarding standardized assessments occurred through self-learning. Occupational therapy programs in the 1970s did not focus on standardized assessments but rather on activity knowledge.

> As an OT way back when. If they did, I mean, it was, I mean, truthfully, I mean, I went to school in the late 60s, early 70s. So, we were really based on activity. And as payor sources changed and became more demanding to justify our services that's done less and less and less. So, it's a little bit different. So, I think now we have to kind of justify it and I think a lot of this I've learned through my CEU (continuing education units) education and You know, I, you know, try to keep up…

Theme: Knowledge of standardized assessments. Carol alluded to the fact that the majority of her knowledge regarding standardized assessments was self-taught. Carol kept a notebook of standardized assessments to reference. When asked about use of standardized assessments in skilled nursing practice, Carol typically responded with non-self-care standardized assessments. Carol focused on the impairments that were impeding the client's performance with their self-care tasks. Carol stated several times that she wished she knew of a good self-care standardized assessment.

> I mean, I use a dynamometer. Yeah, manual muscle test. Those basic ones. Pain levels. I mean, that's another assessment … But yeah, as far as a true ADL, there's really not. I haven't really found a really good one.

> I was more encouraged not so much in the, in the SNF here, because I think they have, basing a lot of it on their ability to do their ADLs. And I don't know I really don't have a really good ADL assessment that I use.

> So, I don't know maybe the impairment is a little bit more based in this area. Because basically, I based my, I'm gonna say my long-term goal and to get them back to prior level function so they can discharge out that's kind of where I work at it that way.

Theme: Psychological factors. Carol stated she does not let stress of the job—productivity--influence her decision when selecting and administering standardized assessments.

> I just figured I get my work done and I try my best to be as productive as I can. But if it takes me a little bit longer to do something, we'll do it. So, I mean, I do, it's in the back of my mind, but it's no pressure with me.

Extrinsic factors.

Theme: Work environment. Carol is encouraged, but not required, to complete standardized assessments by her current employer. If she feels that standardized testing is

indicated, Carol will complete testing regardless of the time that it requires to complete the assessment. Carol also lets the other therapy departments guide what assessments are administered. According to Carol, at her current employer, physical therapy tends to complete balance assessments, while speech therapy completes cognitive assessments.

> I kind of, since I've been in multiple, multiple facilities, I kind of let the facility guide me what the PT department does, and the speech department does. Cognitive assessments, I the only one I really do is the KELS mostly…

Theme: Culture. Carol stated that most of the clients are from a rural background/setting and did not feel that this influenced her selection of standardized assessments. Carol reported that gender played a role in how she formally assessed a client. Different questions or clarification questions were asked regarding instrumental activities of daily living based on gender. However, Carol stated that with standardized assessments, gender does not play a role.

> No, I think with the ones I use are basically pretty, either way either sides going to do. I can't think of anything that really you know that's female base or male base. I do a lot of times when I just verbally assess them and talk to them and not just a formal assessment. I say what do you get for men especially so what do you do in house unless they live alone? But if they have a spouse, a lot of times, they don't cook. They don't do the laundry. So, I said, Well, what about your yard work? Do you go out and you know, do you know so you take the trash out? I mean, that's something, do get the mail. So that's kind of way I look at it a little bit different. I mean, that's different, how I assess it just informally.

Theme: Insurance. Carol felt more standardized assessments will be administered since the reimbursement model has changed to PDPM--to justify occupational therapy services. Additionally, Carol indicated that she does not feel stressed with the recent change to PDPM because she had previously experienced the change from prospective payment systems to RUGS.

> Since I've been in the field a long time, I went to prospective payment systems. Now at that point in time, it really changed. And I mean, to the point where really a lot of OTs, a lot of PTs were not in the building every day. It was all run by assistants pretty much when we came in and did evals and recerts and sign notes. And you know, did it, really, and that, but I don't find that right now with this. I think it's pretty even keeled.

> I think I may, want to start using them more I think it'll justify our services. Since we're kind of basing it. It won't change our funding but at least it will support more, why we're important in the whole mix of things.

Supports and barriers. Carol did not let the stress of productivity or efficiency be a limitation to administering standardized assessments. If a standardized assessment was indicated for a client, Carol would complete the assessment regardless of the time that it took, or if it was detrimental to her productivity. Carol felt that PDPM will support routine administration of standardized assessments within her evaluations. Her knowledge of administering standardized assessments has been through self-learning and continuing education courses.

Carol went to school in the late 1970s and early 1980s when the focus for occupational therapy education was on activity and activity analysis. Carol's formal education did not provide a good background on the use of standardized assessments. Carol's employer has a number of standardized assessments; however, her employer has not provided any education or training on the administration of standardized assessments. During the interview, Carol asked the principal investigator's advice on what is considered a good ADL assessment, since she primarily used impairment driven standardized assessments (See Figure 3).

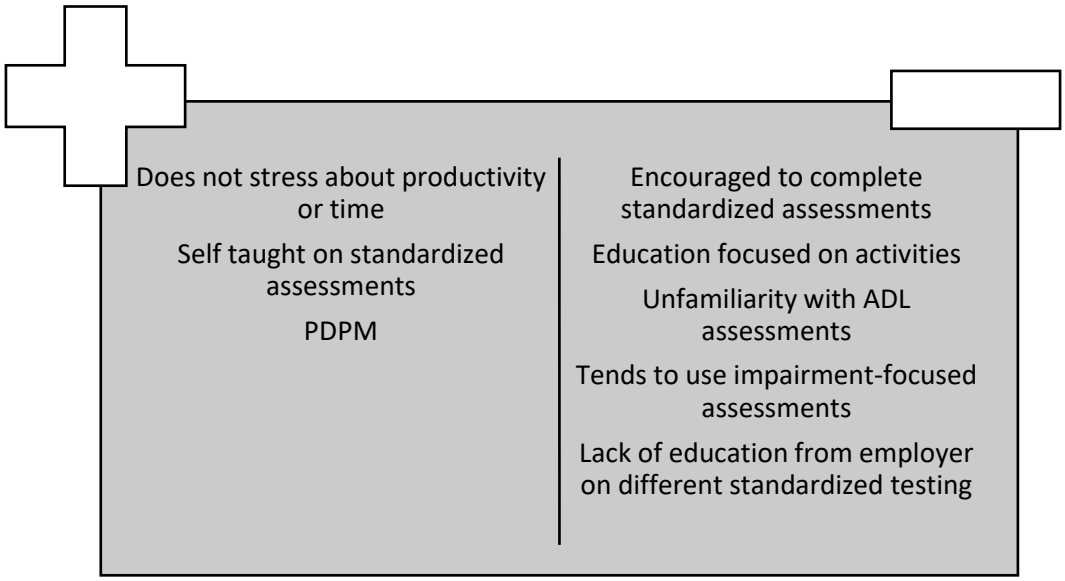

Figure 3: Case Three: Carol's supports (+) and barriers (-) to administering self-care standardized assessments

Discussion

Analysis of barriers to administering self-care standardized assessments among occupational therapists who work in skilled nursing practice was consistent with previous research. Similar barriers found were a) minimal use of standardized assessments due to unfamiliarity, b) limited availability, c) lack of knowledge, d) time requirements, e) workload, and f) lack of interest in standardized assessments (Bland et al., 2013; Bowman, et. al, 2009; Piernik-Yoder & Beck, 2012; Robertson & Blaga 2013, & Wales et al., 2018). Another finding consistent with the research is the frequent use of impairment driven standardized assessments compared to self-care standardized assessments (Bland et al., 2013; Bowman, et. al, 2009; Piernik-Yoder & Beck, 2012; Robertson & Blaga 2013, & Wales et al., 2018).

Within this case series, it appeared that the occupational therapists who had a graduate level of education were more likely to use standardized assessments within their evaluations, recertifications, and discharge assessments compared to occupational therapists with a bachelor's degree. Within this study, the occupational therapist with a master's degree described having more knowledge and awareness of why functional standardized assessments are important. On the other hand, the occupational therapist with a bachelor's degree described focusing on activity/ activity analysis and administering impairment-driven standardized assessments rather than self-care standardized assessments.

Unique to this study was the belief that more occupational therapists will utilize self-care standardized assessments within their evaluations, recertifications and discharge summaries to support the effectiveness of their interventions. Two of the three occupational therapists specifically indicated that the change in Medicare reimbursement to PDPM was the main reason

for why they felt more occupational therapists will administer more self-care standardized assessments.

Strengths of the Study and Implications for Practice

Strengths of a case series design include the ability to analyze the a) social context of SNFs and b) complex processes occupational therapists face when selecting and administering self-care standardized assessments.

Findings from this capstone project can be used to remove barriers and provide supports to occupational therapists when selecting and administering self-care standardized assessments. For instance, providing training to occupational therapists on how and when to administer self-care standardized assessments efficiently would remove the barrier—limited knowledge of self-care standardized assessments. Additionally, the support of providing strategies to therapy companies to incorporate self-care standardized assessments into the electronic documentation software would create a routine of including self-care standardized assessments within initial evaluations, recertifications and discharge summaries.

Limitations of the Study and Considerations for Future Research

The primary limitation to this case study design is the small convenience sample. As a result, the findings cannot be generalized to all occupational therapists who complete self-care standardized assessments in skilled nursing setting.

Future research is needed to understand the supports and barriers to administering self-care standardized assessments by occupational therapists within SNFs. Research should include: a) larger sample sizes, b) exploring the impact of different educational degrees, and c) investigating the effect of embedding the self-care standardized assessment within the electronic medical record initial evaluation, recertification and discharge summary templates.

Conclusion

Unfamiliarity with self-care standardized assessments, workload, and time to complete standardized assessments were reasons occupational therapists did not routinely complete self-care standardized assessments. Additionally, the occupational therapists featured within this case series indicated that the PDPM may encourage more occupational therapists to utilize self-care standardized assessments routinely. Lastly, it appeared that the level of occupational therapy education may be a predictor to the therapists' usage of self-care standardized assessments. As the entry level of occupational therapy advances more consistent use of self-care standardized assessments may be used.

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Appendix A: Informed Consent

Consent to Participate in a Research Study

Use of Self-Care Standardized Assessments in Skilled Nursing Home Occupational Therapy Practice

EKU
Institutional Review Board
Protocol Number
2765
Approval Valid
9/11/19-12/31/19

Key Information

You are being invited to participate in a research study. This document includes important information you should know about the study. Before providing your consent to participate, please read this entire document and ask any questions you have.

Do I have to participate?
If you decide to take part in the study, it should be because you really want to volunteer. You will not lose any benefits or rights you would normally have if you choose not to volunteer. You can stop at any time during the study and still keep the benefits and rights you had before volunteering. If you decide to participate, you will be one of about three people in the study.

What is the purpose of the study?
The purpose of this Capstone Project is to understand the supports and barriers Occupational Therapy practitioners experience when selecting and using standardized assessments within skilled nursing facility. Inclusion criteria includes occupational therapists who complete evaluations, recertifications or discharge summaries with clients referred for occupational therapy within skilled nursing facilities in Ohio.

Where is the study going to take place and how long will it last?
The research procedures will be conducted at predetermined private location agreed upon the participant and principal investigator. The interviews will last no more than 45-60 minutes.

What will I be asked to do?
You will participate in an interview lasting no longer than 45-60 minutes. The interview will take place in a private predetermined location. The principal investigator will record the entirety of the interview through the Otter Voice Meeting Notes app. The recording will be saved on a password protected laptop and given a unique code to ensure confidentiality.

Are there reasons why I should not take part in this study?
You should not participate in this study if you do not want to share your experience administering evaluations, recertifications and/or discharge summaries within skilled nursing facilities

What are the possible risks and discomforts?
There are minimal risks within this study. Participants may suffer mild stress when discussing barriers to complete their job duties

What are the benefits of taking part in this study?
You are not likely to get any personal benefit from taking part in this study. Your participation is expected to provide benefits to others by adding to the occupational therapy literature regarding use of standardized assessments in skilled nursing facilities.

If I don't take part in this study, are there other choices?
If you do not want to be in the study, there are no other choices except to not take part in the study.

Now that you have some key information about the study, please continue reading if you are interested in participating. Other important details about the study are provided below.

Other Important Details

Who is doing the study?
The person in charge of this study is Courtney Green, MOT, OTR/L at Eastern Kentucky University who is being mentored by Anne Fleischer, PhD, MPH, OT/L, CLT-LANA.

What will it cost me to participate?
There are no costs associated with taking part in this study.

Will I receive any payment or rewards for taking part in the study?
You will not receive any payment or reward for taking part in this study.

Who will see the information I give?
Your information will be combined with information from other people taking part in the study. When we write up the study to share it with other researchers, we will write about this combined information. You will not be identified in these written materials.

We will make every effort to prevent anyone who is not on the research team from knowing that you gave us information, or what that information is. You will be assigned a unique code. All transcriptions and records will be labeled with this unique code. Any identifying information mentioned in the interview will be removed. All if any identifiable information will be kept in a locked file cabinet in the Principal Investigator's personal office.

However, there are some circumstances in which we may have to show your information to other people. For example, the law may require us to show your information to a court. Also, we may be required to show information that identifies you for audit purposes.

Can my taking part in the study end early?
If you decide to take part in the study, you still have the right to decide at any time that you no longer want to participate. You will not be treated differently if you decide to stop taking part in the study.

What happens if I get hurt or sick during the study?
If you believe you are hurt or get sick because of something that is done during the study, you should call Courtney Green, MOT, OTR/L at 740-497-7794 immediately. It is important for you to understand that Eastern Kentucky University will not pay for the cost of any care or treatment that might be necessary because you get hurt or sick while taking part in this study. Also, Eastern Kentucky University will not pay for any wages you may lose if you are harmed by this study. These costs will be your responsibility.

Usually, medical costs that result from research-related harm cannot be included as regular medical costs. Therefore, the costs related to your care and treatment because of something that is done during the study will be your responsibility. You should ask your insurer if you have any questions about your insurer's willingness to pay under these circumstances.

We will give you a copy of this consent form to take with you.

Consent

Before you decide whether to accept this invitation to take part in the study, please ask any questions that come to mind now. Later, if you have questions about the study, you can contact the investigator, Courtney Green, MOT, OTR/L at 740-497-7794. If you have any questions about your rights as a research volunteer, you can contact the staff in the Division of Sponsored Programs at Eastern Kentucky University at 859-622-3636.

If you would like to participate, please read the statement below, sign, and print your name.

I am at least 18 years of age, have thoroughly read this document, understand its contents, have been given an opportunity to have my questions answered, and voluntarily agree to participate in this research study.

_____

Signature of person agreeing to take part in the study Date

_____

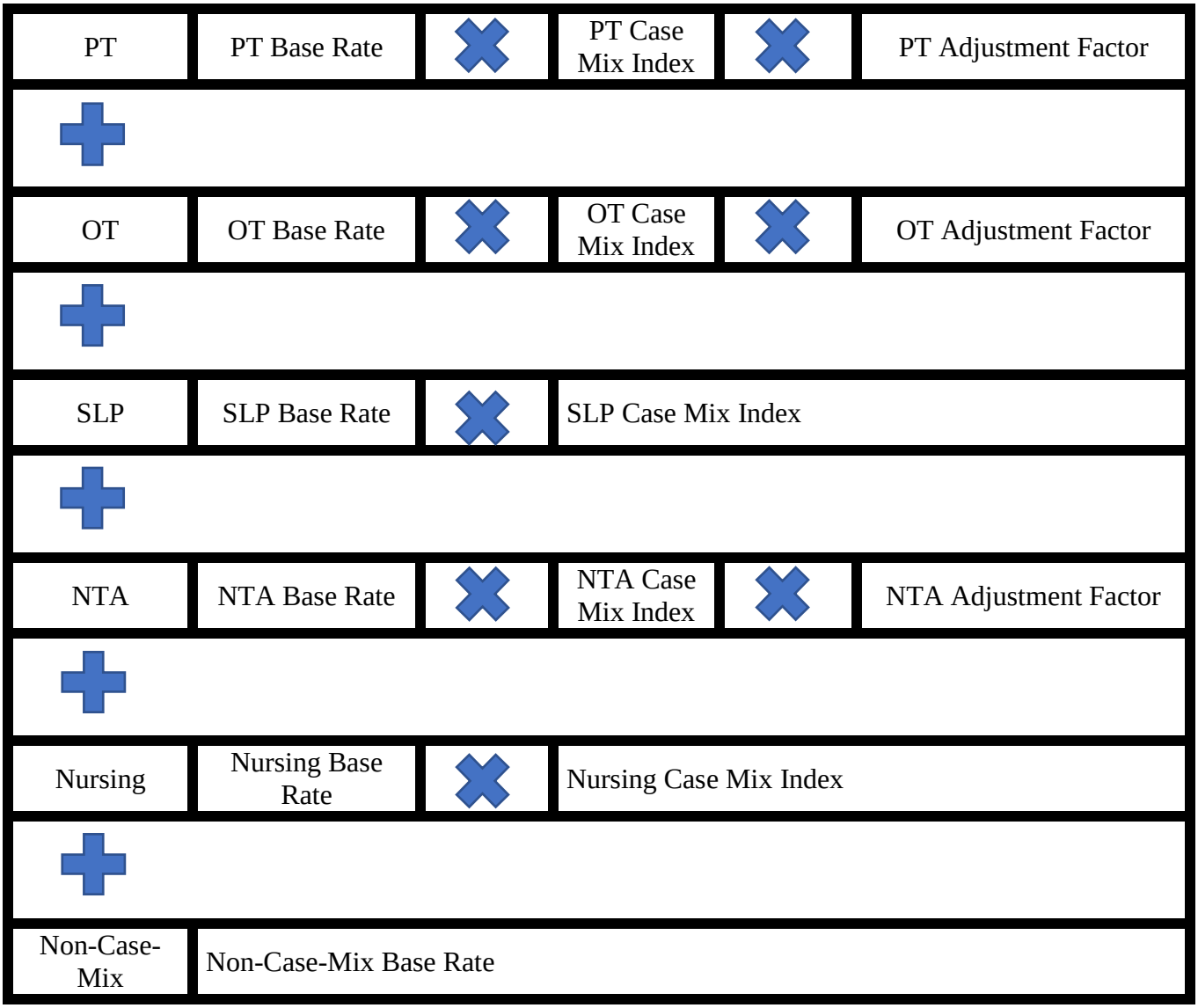
Printed name of person taking part in the study

_____

Name of person providing information to subject

Appendix B: PDPM Payment Categories

Breakdown of the reimbursement process through the Patient Driven Payment Model.



Appendix C: Variable Payment Factor

Medicare Payment Days	Adjustment Factor
1-20	1.00
21-27	0.98
28-34	0.96
35-41	0.94
42-48	0.92
49-55	0.90
56-62	0.88
63-69	0.86
70-76	0.84
77-83	0.82
84-90	0.80
91-97	0.78
98-100	0.76

Appendix D: Interview Questions

Each participant will be asked the following questions. Follow up questions will be asked to provide greater detail and understanding.

I. How long have you practicing as an Occupational Therapist?

II. What practice settings have you worked in as an Occupational Therapist?

    A. How many years have you worked in skilled nursing?

III. Do you have a bachelor's and Master's, or a Clinical Doctorate in Occupational Therapy?

IV. Tell me about the Patient Driven Payment Model coming to skilled nursing.

V. Are you required by your employer to complete standardized assessments within your evaluation?

    A. If yes, what assessments are required?

        1.Why do you use [state the name of the assessment]?

        2.Repeat V.A.1. for each assessment listed.

        3.Do you complete any assessments beyond the ones that are required?

            a. If yes, what assessments do you administer?

            b. Why do you use [state the name of the assessment]?

            c. Repeat V.A.3.b. for each assessment listed

    B. If no, do you complete standardized assessment within your initial evaluation, even though it is not required?

        1.If yes, what assessments do you use

            a. Why do you use [state the name of the assessment]?

            b. Repeat V.B.1.a. for each assessment listed.

2.If no, why do you not use standardized assessments within your initial evaluations?

VI. Are you required by your employer to complete standardized assessments within your recertifications?

A. If yes, what assessments are required?

1.Why do you use [state the name of the assessment]?

2.Repeat VI.A.1. for each assessment listed

3.Do you complete any assessments beyond the ones that are required?

a. If yes, what assessments do you administer?

b. Why do you use [state the name of the assessment]?

c. Repeat VI.A.3.b. for each assessment listed

B. If no, do you complete standardized assessment within your initial evaluation, even though it is not required?

1.If yes, what assessments do you use

a. Why do you use [state the name of the assessment]?

b. Repeat VI.B.1.a. for each assessment listed.

2.If no, why do you not use standardized assessments within your initial evaluations?

VII. Are you required by your employer to complete standardized assessments within your discharge summaries?

A. If yes, what assessments are required?

1.Why do you use [state the name of the assessment]?

2.Repeat VII.A.1. for each assessment listed

3. Do you complete any assessments beyond the ones that are required?

a. If yes, what assessments do you administer?

b. Why do you use [state the name of the assessment]?

c. Repeat VII.A.3.b. for each assessment listed

B. If no, do you complete standardized assessment within your initial evaluation, even though it is not required?

1. If yes, what assessments do you use

a. Why do you use [state the name of the assessment]?

b. Repeat VII.B.1.a. for each assessment listed.

2. If no, why do you not use standardized assessments within your initial evaluations?

VIII. Do you prefer impairment driven assessments or functional performance assessments?

A. Why do you prefer [list their preference]?

B. Why do you not prefer [list the nor preferred assessment]?

IX. Within your work environment, what "structurally" helps you complete standardized assessments?

A. How does [list the "structure"] help you complete standardized assessments?

B. Repeat IX. A.

X. Within your work environment, what "culturally" helps you complete standardized assessments?

A. How does [list the "cultural attribute] help you complete standardized assessments?

B. Repeat IX. A.

XI. Tell me how the Patient Driven Payment Model (PDPM) coming to SNF in October 2019 will affect administering standardized assessments.

XII. Describe a work environment, which would support your use of standardized assessments.

XIII. Describe what type of information that you would like or need so you could integrate standardized assessments within your care plan.

XIV. What else would you like to share with me that I have not asked regarding standardized assessments within skilled nursing facilities?