Part 1 and Part 2 Objectives

1. Identify your role in the interdisciplinary team to attain and maintain clients highest level of function and reduce hospital re-admissions

2. Identify how to provide comprehensive, patient centered plans of care and functional outcome driven treatment interventions

3. Identify how occupational therapists and occupational therapy assistants can effectively communicate and collaborate to ensure clients are achieving health, well-being, and participation in life through engagement in occupation
Thank You

- For your courage
- For your compassion
- For your dedication
- For your sacrifices

You Are Essential

- OT practitioners recognized as essential by U.S. Dept. of Homeland Security on 3/19/20
  
  Caregivers (e.g., physicians, dentists, psychologists, mid-level practitioners, nurses and assistants, infection control and quality assurance personnel, pharmacists, physical and occupational therapists and assistants, social workers, speech pathologists and diagnostic and therapeutic technicians and technologists)
COVID-19 Public Health Emergency

PHE flexibilities can help providers:
- PHE started 1/27/2020
- PHE renewed 1/16/2022
- PHE effective until 4/16/2022 unless renewed again
- CMS flexibilities started in 3/2020:
  - Telehealth, window visits
  - OTs can open home health cases
  - SNF 3-day hospital stay requirement
  - IRF 60%, 3-hour therapy rules

Unwinding the PHE

- 3/3/22: HHS renews commitment to provide 60 days’ notice to states before allowing PHE to expire
  - CMS Medicaid PHE Unwinding page
- 4/7/22: CMS Returning to Certain Pre-COVID-19 Policies in Long-term Care and Other Facilities | CMS
  - CCSQ memo: Update to COVID-19 Emergency Declaration Blanket Waivers for Specific Providers (cms.gov)
- Monitor CMS announcements
  - Current emergencies | CMS

More to come... watch for updates
Occupational Therapy Skilled Intervention Re-Imagined

Past
What did skilled interventions look like pre-COVID?

Present
What does current skilled interventions look like?

Future
What can skilled occupational therapy interventions look like?

Interdisciplinary Team Collaboration - Inclusiveness

- Resident
- Resident family/caregivers
- Physician
- Pharmacist
- Case manager
- Nursing
- Occupational therapy practitioners
- Physical therapy practitioners
- Speech therapy practitioners
- Respiratory therapists
- Home health aide
- Restorative aide
- Wellness coordinator
- Athletic trainers
- Admissions
- Administrator/executive director
- Dietician
- Social services
- Psychologist
- Housekeeper
- Maintenance
Interdisciplinary Team Collaboration- COVID-19 Barriers

**Resident:**
- Change in daily schedule/routine
- Change in visitation/outings/communication
- Change in caregivers/therapists
- Change in roommates
- Change in behavior/mood
- Change in function
- Change in medical condition/new medical diagnosis

**Interdisciplinary Team:**
- Change in staffing/schedules
- Change in behavior
- Change in how activities are delivered
- Change in how IDT communicates with resident/family
- Change in how therapy is delivered
- Change in how caregiver training is completed
- Change in how discharge planning is completed

Interdisciplinary Team Collaboration- Solutions

**IDT Solutions/Best Practices:**
- Re-evaluate/re-establish meetings and meeting agendas
- Walking rounds
- Education/review of critical element pathways
- New admission review
- Change of condition/risk review and meetings
- Review of quality measures (i.e. CASPER)
- Review of resident concerns

**We learned:**
- We learned that we are all focused on our residents
- We learned that our residents need us
- We learned that we are resilient and adaptable
- What else did we learn?
- What are some best practices?
Clinical Programs

- Cardiac
- Self-Care/Mobility
- Fall Prevention
- Medication Management
- Discharge Planning
- Cognition/Mental Health
- Low Vision
- Urinary Incontinence
- Orthotic
- Neuro
- Pain Management

Comprehensive Plans of Care—Going Beyond the Reason for Referral.....

- Observe the resident
- Listen to the resident/family/caregivers
- Review medical record
- Review medication list
- Assess the resident....go beyond the reason for referral (i.e. primary medical diagnosis)
- Utilize standardize tests and measures
- Expand the tools in our tool boxes
- Demonstrate the distinct value of OT
Comprehensive Plans of Care

Figure 1. 4Ms Framework of an Age-Friendly Health System

- **What Matters**: Know and align care with each older adult’s specific health outcome goals and care preferences including, but not limited to, end-of-life care, and across settings of care.
- **Medication**: If medication is necessary, use Age-Friendly medication that does not interfere with What Matters to the older adult, Mobility, or Mentation across settings of care.
- **Mentation**: Prevent, identify, treat, and manage dementia, depression, and delirium across settings of care.
- **Mobility**: Ensure that older adults move safely every day in order to maintain function and do What Matters.


Occupational therapy evaluations include the following components:

- Occupational Profile and Client History
- Assessment of Occupational Performance
- Clinical Decision Making
- Development of Plan of Care
Cognitive skills refer to the ability to attend, perceive, think, understand, problem solve, mentally sequence, learn, and remember resulting in the ability to organize occupational performance in a timely and safe manner. These skills are observed when: (1) a person attends to and interacts with task tools and materials; (2) carries out individual actions and steps; and (3) modifies performance when problems are encountered.

Definitions

Performance deficits refer to the inability to complete activities due to the lack of skills in one or more of the categories below (ie, relating to physical, cognitive, or psychosocial skills).

Physical skills refer to impairments of body structure or body function (eg, balance, mobility, strength, endurance, fine or gross motor coordination, sensation, dexterity).

Cognitive skills refer to the ability to attend, perceive, think, understand, problem solve, mentally sequence, learn, and remember resulting in the ability to organize occupational performance in a timely and safe manner. These skills are observed when: (1) a person attends to and interacts with task tools and materials; (2) carries out individual actions and steps; and (3) modifies performance when problems are encountered.

Psychosocial skills refer to interpersonal interactions, habits, routines and behaviors, active use of coping strategies, and/or environmental adaptations to develop skills necessary to successfully and appropriately participate in everyday tasks and social situations.

Comprehensive Plan of Care

97165 Occupational therapy evaluation: high complexity, requiring these components: an occupational profile and medical therapy history, which includes review of medical and/or therapy records relating to the presenting problem; an assessment(s) that identifies 1-3 performance deficits (ie, relating to physical, cognitive, or psychosocial skills) that result in activity limitations and/or participation restrictions; and clinical decision making of low complexity, which includes an analysis of the occupational profile, analysis of data from problem-focused assessment(s), and consideration of a limited number of treatment options. Patient presents with no comorbidities that affect occupational performance. Modification of tasks or assistance (eg, physical or verbal) with assessment(s) is not necessary to enable completion of evaluation component. Typically, 30 minutes are spent face-to-face with the patient and/or family.

97166 Occupational therapy evaluation: moderate complexity, requiring these components: an occupational profile and medical therapy history, which includes an expanded review of medical and/or therapy records and additional review of physical, cognitive, or psychosocial history related to current functional performance; an assessment(s) that identifies 3-5 performance deficits (ie, relating to physical, cognitive, or psychosocial skills) that result in activity limitations and/or participation restrictions; and clinical decision making of moderate analytic complexity, which includes an analysis of the occupational profile, analysis of data from detailed assessment(s), and consideration of several treatment options. Patient may present with comorbidities that affect occupational performance. Minimal to moderate modification of tasks or assistance (eg, physical or verbal) with assessment(s) is necessary to enable patient to complete evaluation component. Typically, 45 minutes are spent face-to-face with the patient and/or family.

97167 Occupational therapy evaluation: low complexity, requiring these components: an occupational profile and medical therapy history, which includes review of medical and/or therapy records and extensive additional review of physical, cognitive, or psychosocial history related to current functional performance; an assessment(s) that identify 5 or more performance deficits (ie, relating to physical, cognitive, or psychosocial skills) that result in activity limitations and/or participation restrictions; and a clinical decision-making of high analytic complexity, which includes an analysis of the patient profile, analysis of data from comprehensive assessment(s), and consideration of multiple treatment options. Patient presents with comorbidities that affect occupational performance. Significant modification of tasks or assistance (eg, physical or verbal) with assessment(s) is necessary to enable patient to complete evaluation component. Typically, 60 minutes are spent face-to-face with the patient and/or family.

97168 Reevaluation: occupational therapy established plan of care, requiring these components: an assessment of changes in patient functional or medical status with revised plan of care; an update to the initial occupational profile to reflect changes in condition or environment that affect future interventions and/or goals; and a revised plan of care. A formal reevaluation is performed when there is a documented change in functional status or a significant change to the plan of care is required. Typically, 30 minutes are spent face-to-face with the patient and/or family.
Occupational Profile

Assessments

- Pain Assessments (i.e. Wong Baker Faces)
- Katz ADL Index
- Modified Barthel ADL Index
- Timed Up and Go (TUG)
- Berg Balance Scale
- The St. Louis University Mental Status Exam (SLUMS)
- The Routine Task Inventory (RTI)
- Geriatric Depression Scale
- Generalized Anxiety Disorder (GAD-7)
- Global Deterioration Scale
- Allen Cognitive Level (ACL)
- Perceived Stress Scale (PSS-10)
- The Delirium Rating Scale (DRS)
- Brief Trauma Questionnaire
- Trauma Checklist
- Trauma Screening Questionnaire (TSQ)
- Occupational Profile of Sleep
- Medi-Cog

*not an inclusive list
Brief Interview for Mental Status-BIMS

https://www.youtube.com/watch?v=qv-RhrFQoWE

Staff Assessment of Mental Status

https://www.youtube.com/watch?v=qv-RhrFQoWE
Patient Health Questionnaire-9 (PHQ-9)

### Section D: Mood

**D0.94. Resident Resistant to Interview or Communication**
- Attempt to conduct interview with all residents.
- Note if resident is uncooperative or refuses to answer questions.
- Note if resident displays signs of confusion or agitation.
- Note if resident has difficulty hearing or understanding.
- Note if resident is physically unable to respond.
- Note if resident is fluent in a language other than English.
- Note if resident has a hearing impairment.
- Note if resident has a visual impairment.
- Note if resident is too ill to answer questions.
- Note if resident is too confused to answer questions.
- Note if resident is too agitated to answer questions.
- Note if resident is too fatigued to answer questions.
- Note if resident is too disoriented to answer questions.
- Note if resident is too emotionally distressed to answer questions.
- Note if resident is too cognitively impaired to answer questions.
- Note if resident is too physically impaired to answer questions.
- Note if resident is too mentally impaired to answer questions.
- Note if resident is too socially impaired to answer questions.
- Note if resident is too technologically impaired to answer questions.
- Note if resident is too physically active to answer questions.
- Note if resident is too physically inactive to answer questions.
- Note if resident is too physically strong to answer questions.
- Note if resident is too physically weak to answer questions.
- Note if resident is too physically fit to answer questions.
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- Note if resident is too physically energized to answer questions.
- Note if resident is too physically lethargic to answer questions.
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MDS Section GG: Self-Care & Mobility

06. Independent
Resident completes the activity by him/herself with no assistance from a helper.

05. Setup or clean-up assistance
Helper SETS UP or CLEANS UP; resident completes activity. Helper assists only prior to or following the activity.

04. Supervision or Touching Assistance
Helper provides VERBAL CUES or TOUCHING/STEADYING/CGA assistance as resident completes activity. Assistance may be provided throughout the activity or intermittently.

MDS Section GG: Self-Care & Mobility

03. Partial/moderate assistance
Helper does LESS THAN HALF the effort. Helper lifts, holds, or supports trunk or limbs, but provides less than half the effort.

02. Substantial/maximal assistance
Helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the effort.

01. Dependent OR Helper does ALL of the effort
Resident does none of the effort to complete the activity, OR the assistance of 2 or more helpers is required for the resident to complete the activity.
Activity Not Attempted

- **07**: Refused
- **09**: Not Applicable - The resident did not perform this activity prior to current illness, exacerbation, or injury
- **10**: Not attempted due to environmental limitations - e.g. lack of equipment, weather constraints
- **88**: Not attempted due to Medical or Safety Concern

GG0130: Self Care Items

- **Eating**
  - The ability to use suitable utensils to bring food and/or liquid to the mouth and swallow food and/or liquid once the meal is presented on a table/tray. Includes modified food consistency.
  - Eating involves bringing food and liquids to the mouth and swallowing food. The administration of tube feedings and parenteral nutrition is not considered when coding this activity.
  - If the resident does not eat or drink by mouth and relies solely on nutrition and liquids through tube feedings or total parenteral nutrition (TPN) because of a new (recent-onset) medical condition, code GG0130A as 88, Not attempted due to medical condition or safety concerns.
  - Assistance with tube feedings or TPN is not considered when coding Eating.

- **Oral Hygiene**
  - The ability to use suitable items to clean teeth.

- **Toileting Hygiene**
  - The ability to maintain perineal hygiene, adjust clothes before and after voiding or having a bowel movement. If managing an ostomy, include wiping the opening but not managing equipment.
GG0130: Self Care Items

- **Shower/bathe self**: The ability to bathe self, including washing, rinsing, and drying self (excludes washing of back and hair). Does not include transferring in/out of tub/shower.

- **Upper Body Dressing**: The ability to dress and undress above the waist; including fasteners, if applicable.

- **Lower Body Dressing**: The ability to dress and undress below the waist, including fasteners; does not include footwear.

- **Putting On/Taking off Footwear**: The ability to put on and take off socks and shoes or other footwear that is appropriate for safe mobility, including fasteners, if applicable.

GG0170: Mobility Items

- **Roll Left and Right**: The ability to roll from lying on back to left and right side, and return to lying on back on the bed.

- **Sit to Lying**: The ability to move from sitting on side of bed to lying flat on the bed.

- **Lying to Sitting on Side of Bed**: The ability to safely move from lying on the back to sitting on the side of the bed with feet flat on the floor, and with no back support.
**GG0170: Mobility Items**

**Sit to Stand**

The ability to come to a standing position from sitting in a chair, wheelchair, or on the side of the bed.

**Chair/Bed to Chair Transfer**

The ability to safely transfer to and from a bed to a chair (or wheelchair).

**Toilet Transfer**

The ability to safely get on and off a toilet or commode.

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**GG0170: Mobility Items**

**Car Transfer**

The ability to transfer in and out of a car or van on the passenger side. Does not include the ability to open/close door or fasten seat belt.

**Walk 10 Feet**

Once standing, the ability to walk at least 10 feet in a room, corridor, or similar space. If admission performance is coded 07, 09, 10, or 88 Skip to GG0170M, 1 step (curb).

**Walk 50 feet with two turns**

Once standing, the ability to walk at least 50 feet and make two turns.
GG0170: Mobility Items

**Walk 150 Feet**
Once standing, the ability to walk at least 150 feet in a corridor or similar space.

**Walking 10 feet on uneven surface**
The ability to walk 10 feet on uneven or sloping surfaces (indoor or outdoor), such as turf or gravel.

**1 Step (Curb)**
The ability to go up and down a curb and/or up and down one step. (skip pattern per CMS)

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**GG0170: Mobility Items**

**4 Steps**
The ability to go up and down four steps with or without a rail.

**12 Steps**
The ability to go up and down 12 steps with or without a rail.

**Picking up object**
The ability to bend/stoop from a standing position to pick up a small object, such as a spoon, from the floor.
MDS Section GG: Self-Care & Mobility

Does the resident use a wheelchair/scooter?

- 0. No - Skip to H0100, Appliances
- 1. Yes - Continue to GG0170R, Wheel 50 feet with two turns

Once seated in wheelchair/scooter, the ability to wheel at least 50 feet and make two turns.

Indicate the type of wheelchair or scooter used:
- 1. Manual
- 2. Motorized

Wheel 150 feet

Once seated in wheelchair/scooter, the ability to wheel at least 150 feet in a corridor or similar space.