You have a seat at the table. Now what?

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Good morning. Thank you for welcoming me to the Indiana Occupational Therapy Association conference and to the great state of Indiana. I am honored to present your Keynote Address this morning and I am delighted to be here with you today.

Over the thirty-plus years of my career I have become more and more invested in the promotion of our great profession, occupational therapy. Advocacy, or the public support for a cause has become more and more central to the future of our profession and to our profession's ability to achieve our Centennial Vision. That vision is to become a powerful, widely recognized, science-driven, and evidence-based profession with a globally connected and diverse workforce meeting society's occupational needs. Next year, in 2017 we will celebrate our 100th Anniversary and I am happy to say that the state of our profession has never been more optimistic.

I am particularly fond of stressing how important it is to have a “seat at the table” in order to be effective advocates. This imagery suggests that key discussions and key decisions take part within a confined space, and that presence **in that space** often occurs only at invitation.

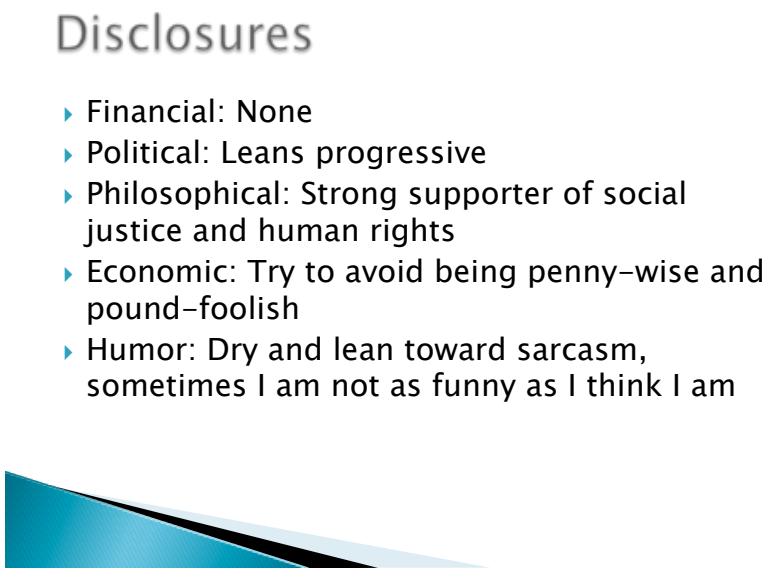
For many years I believe we have focused on what we need to do to be invited to sit at the table with policy makers, with key stakeholders and with decision makers in the organizations for which we work. More and more often we are seeing that the value of occupational therapy has been recognized and occupational therapy practitioners are being asked to sit at the table and to provide their unique perspectives on how to solve difficult problems.

Just recently for example, occupational therapists Tim Wolfe of the University of Missouri, Mary Radomski o7f the Courage Kenny Research Center and I were invited participants on a National Institutes of Health Subject Matter Expert Panel. The panel was convened to review current literature and practice patterns, identify opportunities

and gaps in cancer rehabilitation and make recommendations to NIH for funding priorities to promote quality cancer rehabilitation care. Likewise, occupational therapist Robin Newman and I recently participated in a subject matter expert roundtable at the National Cancer Institute titled, "*Evidence-Based Approaches for Optimizing Employment Outcomes among Cancer Survivors."* The objective of this expert panel was to identify future directions and priorities for research and research funding related to cancer and employment. It was exciting to have two occupational therapists invited to sit at the table.

There are countless other examples of occupational therapy practitioners sitting at the table at the National Institutes of Health, at governmental bodies such as SAMSHA, the Substance Abuse and Mental Health Administration, or at non-profit health related policy organizations such as the National Quality Forum. There is no doubt that the value of occupational therapy has been recognized and we are gaining golden opportunities to influence decisions.

Before I continue with my talk, it has become common practice at conference for speakers to disclose interests that might influence their thinking and their actions, or be potential conflicts of interest, so let me get that out of the way. Here are my disclosures:



- Financial: I have no financial disclosures related to this talk.
- Political: I have to say that more and more as I have aged, that I lean toward progressive political principles.
- Philosophical: I am strong supporter of social justice and human rights; I believe that given the riches of our country we should decide without hesitation that health care is a basic human right.
- Economic: In health care policy I believe what my grandmother taught me about life in general; try not to be penny-wise and pound-foolish
- Finally, my humor tends to be dry and I use sarcasm liberally. Unfortunately sometimes I am not as funny as I think!

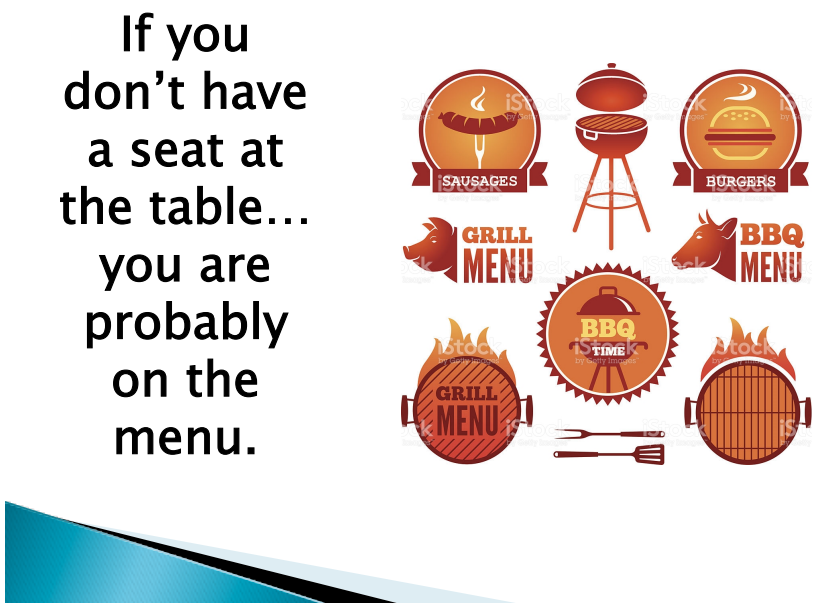
That's all I have to disclose and I'll try and reign it all in recognizing that just three days before the election that I am in Indiana and with a diverse group of colleagues. I do want to stress however, that no matter which candidate wins the election on Tuesday, no matter which political party has the majority in Congress, the business of health policy

churns on and we all should have an investment in influencing it to work in the favor of occupational therapy and the persons we serve.

As I said, I have strong views on health, healthcare, health disparities and social justice. If I say something today that you disagree with, even vehemently, and it stirs you to organize your thoughts into a clear and sound counter opinion, better yet if it results in your choosing to publicly and respectfully enter the conversation and advocate for your perspective, I'll consider that I have been successful.

To return to my theme of having a seat at the table, I would like to tell you a short story. In the summer of 2012, I had the honor to be invited to the home of the Honorable Annise Parker, the former three-term elected Mayor of Houston, for a fundraising event for Senator Tammy Baldwin of Wisconsin. As Senator Baldwin addressed the room she used the analogy of having a seat at the table, saying that if we aren't at the table speaking, we are likely be spoken about……..

A gentleman in the crowd politely interrupted the Senator to share that as with many other things we see things just a little bit differently in Texas. He said,



"Senator. Here in Texas we say, "If you don't have a have a seat at the table, you are probably on the menu!"

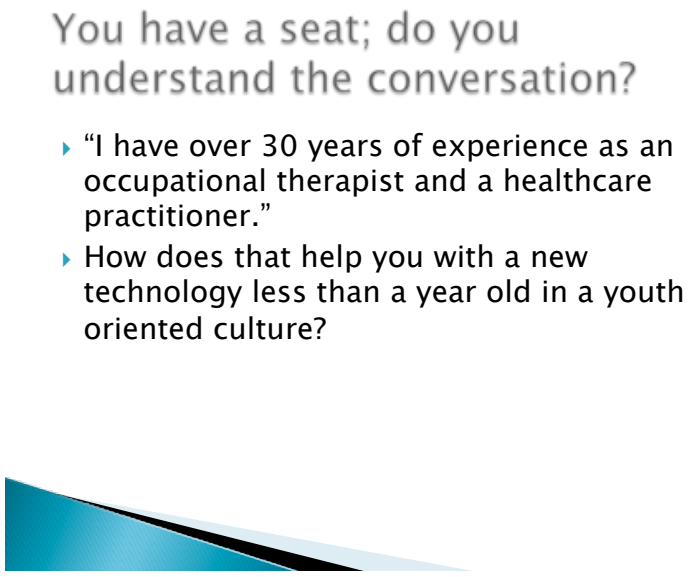
This is as true today as it has ever been. Regardless of our political affiliations, I think we can all agree that there are limited resources and growing needs. According to the Centers for Medicare and Medicaid U.S. health care spending grew 5.3% in 2014, reaching $3.0 trillion or $9,523 per person. As a share of the nation's Gross Domestic Product, health spending accounted for 17.5% in 2014 and is projected to grow at an average rate of 5.8% through 2022. This is one percentage point faster than the expected average annual growth in the GDP (https://www.cms.gov/research-statistics-data-and-systems/statistics-trends-and-reports/nationalhealthexpenddata/nhe-fact-sheet.html).

Limited resources translate to limited opportunities to address society's occupational needs. Despite the fact that we have fewer Americans without health

insurance that at anytime in recent history, estimates are around 9 percent, we know that many Americans go without needed care including occupational therapy.

My focus today is to share what I believe are a few key principles and concepts that all occupational therapy practitioners should feel comfortable discussing anytime they are invited to take part in an important conversation.

I believe that often, this is much less complicated than we might expect. As occupational therapy practitioners we can look to the past successes of our profession and our collective experiences, point to the contributions we are making in classrooms, hospital rooms and board rooms, and focus on one central fact. We help to solve problems caused by the presence of occupational needs.



First of all we must be sure that we understand and are prepared to have a conversation. No matter how much experience we have we have to be careful and not assume that we can rely on our existing knowledge because the world is changing so

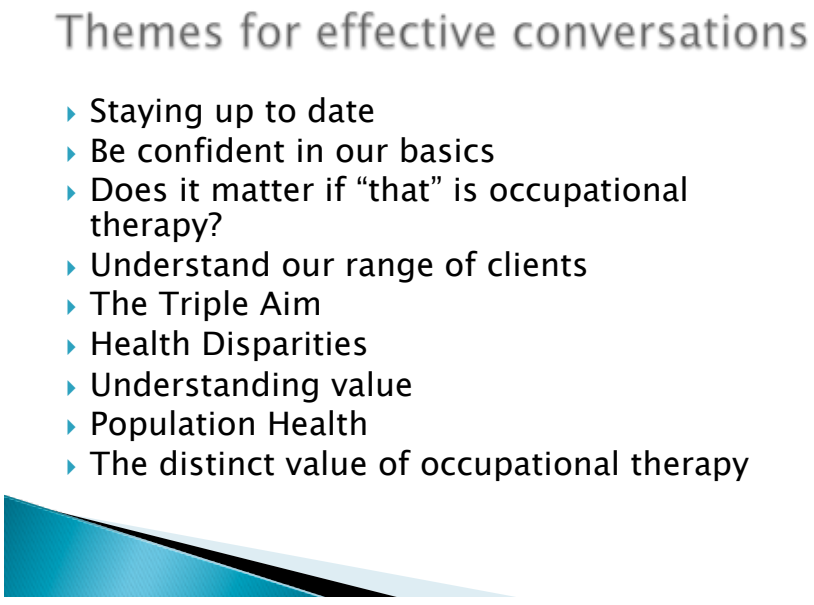
fast! It took 38 years for radio to reach a market audience of 50 million people. It took just 2 years for Facebook to reach a market audience of 50 million people.

The initial release date of “Face-time” was just a little over 6 years ago. It is currently being widely used in translation services in hospitals and the use of Face-time and other tele-health delivery is exploding.

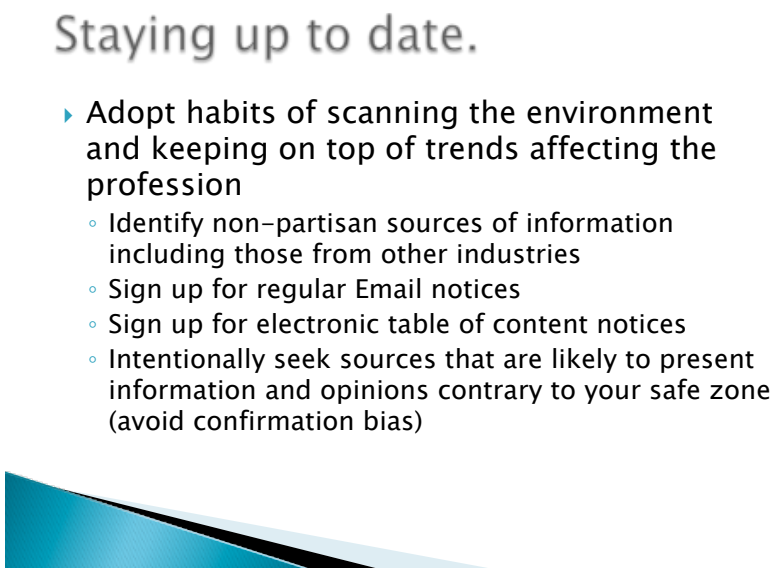
Ask yourself, what will be the next technological change that will impact your occupational therapy practice and will you be ready to discuss it?

And it is not just technological change but changes in payment, policy, and organizational relationships; let alone the constantly evolving evidence not only in paradigmatic occupational therapy knowledge but in all of the areas of related knowledge that affect our clients’ occupational performance such as neuroscience and pharmacology.

Here are the themes I am going touch on today.



When I look at the list is seems to be quite ambitious. However, I hope that I can convince you that there are basic connections between what we value and understand as occupational therapy practitioners and each of these topics.



So how do we stay up to date? First of all we need need to adopt habits and patterns that help us stay up to date. We need to stay up to date not only in the science of occupational therapy and related knowledge but also in the areas of policy and social trends affecting our clients and the organizations in which we work. There are constant changes that influence our service delivery and it is our duty to keep abreast of these changes and take proactive responses. Attending conferences such as this is one strategy and I congratulate you for that.

There are other strategies and some take relatively little time or effort. Here are a few:

- Identify non-partisan sources of information that you trust such as health related foundations like the Kaiser Family Foundation or the Commonwealth Foundation.

- Sign up for daily or weekly Email notices from foundations or health related associations. These “push” notices show up in your Email box to be reviewed at your convenience. I get several each day and while I admit that some days I get behind and mostly hit delete, I will say that almost everyday I find one link to one article that is of interest and it usually takes relatively little time to scan and at least read general themes. Are payers adopting new behaviors? What are issues that consumers care about? Is there new evidence to support or refute a practice?
- Sign up for electronic table of content notices so that you regularly receive the entire table of contents of new issues of journals or you can be sent a notice anytime an article is published on topics of importance to you.
- Perhaps most importantly, intentionally seek out sources that are likely to present information and opinions contrary to what you already believe. We have to work hard to prevent confirmation bias by only reading information that confirms what we already think we know; we have to put ourselves in the uncomfortable position of considering the possibility that we are wrong!

These are some of the sites and sources that I visit often or that send me regular updates and alerts. I visit others but have tried to list a variety of sources including conservative, progressive and Libertarian slanted organizations.

Some suggestions.

- America's Health Insurance Plans (Professional)
- American Enterprise Institute (Conservative)
- Brookings Institute (Progressive)
- Cato Institute (Libertarian)
- Commonwealth Fund (Liberal)
- Heritage Foundation (Conservative)
- Kaiser Family Foundation (Independent)
- Rand Corporation (Independent)
- Urban Institute (Liberal)

http://www.thebestschools.org/features/most-influential-think-tanks

And here are more suggestions that are accessible to each of us who are members of AOTA.

Some more suggestions.

- OT Practice
- AJOT (at least scan abstracts!)
- AOTA SIS Quarterly Connections
  - Now a compendium of all 11 SIS groups
  - Scan the SIS content in areas not related to your daily practice

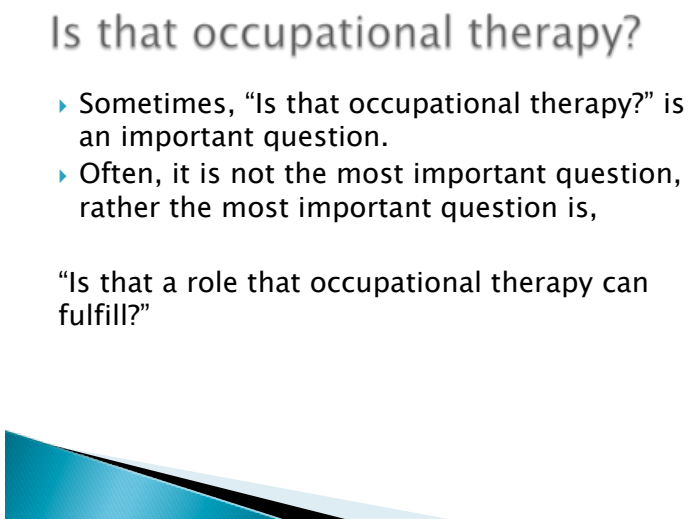
Now I get it, you may already be thinking. "Who has time to read all of this stuff and keep up with so many sources?"

But the point is that we don't have to read everything; we need to develop the habit and skill of scanning sources and focusing on the material important to us or scanning to become familiar with an evolution in an area of practice.

When I speak about advocating for our profession I am careful to make this point. It is true that occupational therapy continues to expand and explore new roles and emerging areas of practice. That only makes sense; as the occupations that humans perform and the environments and contexts in which we perform them continue to change and expand. However, we should acknowledge that as a profession we continue to practice in, and be key players in traditional areas of practice including mental health, school systems, skilled nursing facilities and others. AOTA remains invested in advocating for our clients served by these systems and the practitioners who work there. Each of us should feel confident in describing the breadth of roles and settings in which occupational therapy practitioners work and the focus of their interventions, another reason to scan OT Practice, the AOTA Website or AJOT on a regular basis.

Part of being effective when you are engaging in important conversations is maintaining an awareness of where the profession is growing and by this I don't only mean areas of "emerging practice." I don't necessarily have a problem with the term "emerging practice" but I am not sure it is always the best descriptor and sometimes I think it undervalues our history. For example, as a profession we have trying to make inroads in the areas of prevention and wellness for decades. Maggie Reitz (1992) documented elements of wellness found in our earliest practitioners in her historical review of occupational therapy's roles in preventive health and wellness published in AJOT in 1990. It has been near 20 years since the first publications on UIC's Well Elderly study and the introduction of the concept of Lifestyle redesign by Florence Clark and colleagues (Jackson et al, 1998). I was providing rehabilitation services to patients with cancer in 1989 in an acute care hospital center of excellence, and yet 27 years later I am the Director of the largest cancer rehabilitation department in the country and much

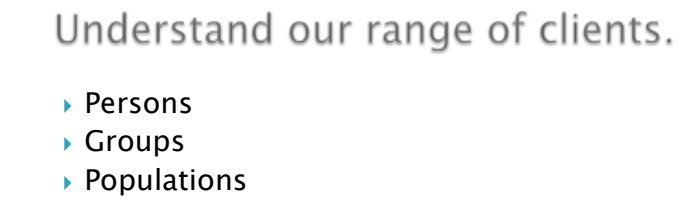
of my time is spent consulting with others about the cancer rehabilitation boom with new cancer hospitals opening in places like the University of Nebraska and Ohio State.



Sometimes the most important question to answer is, “Is that occupational therapy?” Luckily we have numerous brilliant scholars focused on refining occupational therapy conceptual practice models such as the Model of Human Occupation or the Canadian Model of Occupation. Of course we need to be familiar with our scope of practice and be ready to address questions about what is within the scope of practice as defined within our state licensure acts.

But you know, sometimes, I don’t really care whether something is, or is not occupational therapy. Sometimes the more important question is whether or not occupational therapy practitioners have the knowledge to develop the skills and competencies to assume a role or function. For example, I think this is the case to me for the role of case manager. Entry-level practitioners do not necessarily have the skills to become effective case managers and may need to pursue additional specialty

education depending upon the setting and expectations, but occupational therapy practitioners certainly have the knowledge and the skills to become well positioned for such roles.

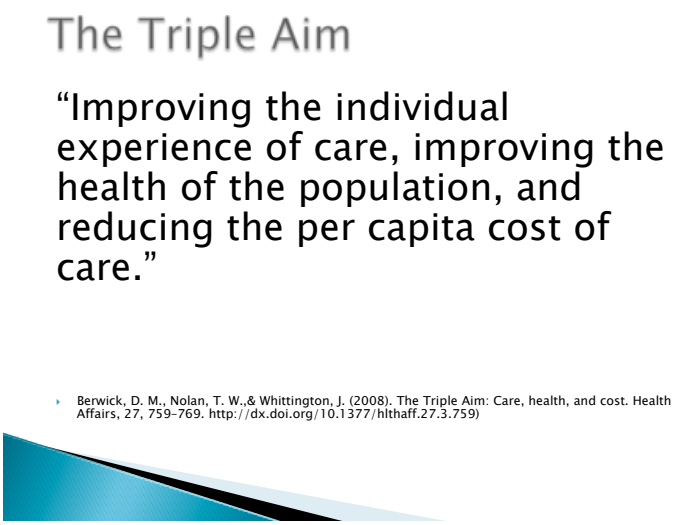


It is also important that we each feel confident explaining how the occupational therapy process can be applied to a variety of clients. According to the 3rd edition of the occupational therapy practice framework, the term client is defined as persons, groups and populations (AOTA, 2014). This means that we appropriately include both organizations and communities as client groups and as the appropriate focus of occupational therapy intervention.

I understand that many practitioners may not feel comfortable personally consulting to organizations, communities and other populations. But, we must be careful how we speak about the work of our colleagues who pursue these efforts.

Too often I hear concerns over whether this type of work diffuses our professional focus, if it detracts from promoting our message or confuses the public about the definition of occupational therapy.

The simple truth is that whether we provide individual therapy to a patient, provide consultation to an organization or system, or work with community leaders our role is the same; to promote the occupational performance of all persons involved and to help meet society's occupational needs.



The Triple Aim is a concept that is often cited as a guiding principle of health care and health insurance reform and underlies many of the efforts and strategies of the Affordable Care Act. Bodies such as the Centers for Medicare and Medicaid and the Department of Health and Human Services have used the Triple Aim to develop both regulatory and payment policy. Berwick, Nolan and Whittington (2008) defined the Triple Aim as "improving the individual experience of care, improving the health of populations, and reducing the per capita cost of care" (p. 760).

The Triple Aim provides a common core for advocacy by occupational therapy practitioners in many areas of practice. It ties our skills and competencies to bettering the health of individuals, society and the organizations in which we work.

Earlier, I disclosed that my political leanings tend toward the progressive. For example, I am one of those who are extremely dissatisfied with the Affordable Care Act; but only because it did not go far enough in my opinion. I favor full expansion of Medicaid in all 50 states and the District of Columbia and I fully support a public option for Medicare. But I argue that even the most conservative of you in the audience and I can find common ground. Improving the individual experience of care is certainly not a partisan ideal. Neither is improving the health of the population nor reducing the per capita cost of health care.

We may disagree over implementation strategies but we can certainly agree on the core principles of the Triple Aim. More importantly, when we speak with each other and when we sit at a table and speak with stakeholders, we need to keep clear the difference between our personal political and policy beliefs that we support and promote as individuals, and the policy aims that will help move our profession forward no matter what we may believe.

Health Disparities

"Population-specific differences in disease rates, health outcomes, and access to health care services" (p. S48).

American Occupational Therapy Association.(2014).Occupational therapy practice framework: Domain and process (3rd ed.).*American Journal of Occupational Therapy, 68*(Suppl.1), S1-S48.http://dx.doi.org/10.5014/ajot.2014.682006

Another topic that I think we each need to be able to discuss with some level of understanding is health disparities. Health disparities are specific differences in disease rates, health outcomes and access to health care services. More specifically, health and health care disparities often refer to differences that cannot be explained by variations in health care needs, patient preferences, or treatment recommendations. Disparities in health and health care are caused by a complex and interrelated set of individual, provider, health system, societal, and environmental factors. Health disparities can affect the occupational performance of students, workers and family members.

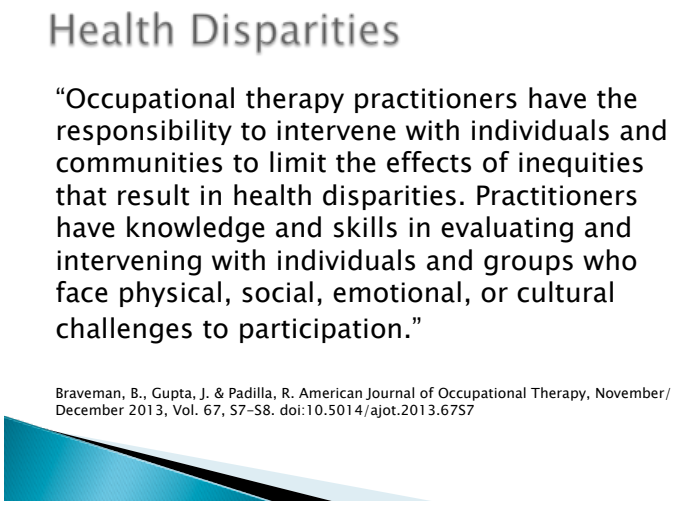
According to the Kaiser Family Foundation (2016 http://kff.org/disparities-policy/issue-brief/disparities-in-health-and-health-care-five-key-questions-and-answers/) Among nonelderly adults, Hispanics, Blacks, American Indians and Alaskan Natives are more likely than Whites to delay or go without needed care. Moreover, nonelderly Black and Hispanic adults are less likely than their White counterparts to have a usual source of care or to have had a health or dental visit in the previous year.

Low-income individuals also experience more barriers to care and receive poorer quality care than high-income individuals.

Lesbian, gay, bisexual, and transgender (LGBT) individuals are more likely to experience challenges obtaining care than heterosexuals.

In addition, individuals with limited English proficiency are less likely than those who are English proficient to seek care even when insured.

Patient experiences and satisfaction levels also differ by race, gender, education levels, and language.



The American Occupational Therapy Association states that as occupational therapy practitioners we have a responsibility to intervene where we can to limit the impact of inequities that result in health disparities. Surprisingly this is sometimes a controversial idea (Braveman, Gupta, Padilla, 2013).

Some may ask "Is it really our role, our responsibility as a profession and as individual practitioners to address patterns that may have developed over decades?"

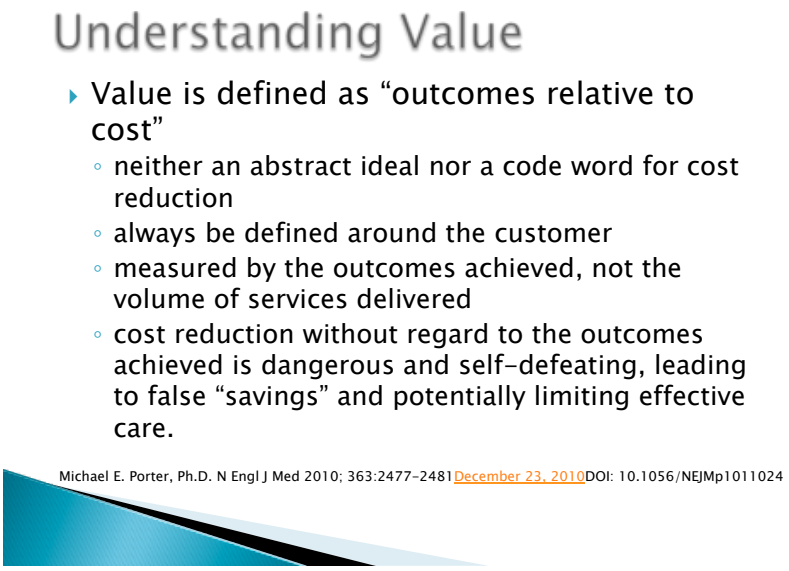
I say definitively yes, **because it is what we do**. We help to meet occupational needs and in this case we can help to meet occupational needs due to health disparities caused by systematic discrimination and other factors. We may not be responsible for eliminating underlying systematic discrimination in education, early screening and detection, wellness and preventative services, or in disadvantages that arise due to poverty or poor environmental conditions. However are responsible to intervene to promote more positive occupational participation by identifying strategies that limit the physical, social, emotional or cultural challenges to occupational participation.

Moreover, we need to understand that as occupational therapy practitioners we have the skills to address the implications of health disparities and be ready to speak about these skills when we sit at the table with system leaders and policy makers.

For example, we can speak about our involvement in helping the homeless, the educationally disadvantaged, or persons struggling with addiction to learn the habits and skills that support employment and community living.

We can speak about our involvement in classrooms in the most impoverished of school systems to promote the healthy development of social relationships and limit the negative impact that poverty can have on classroom learning.

We can speak about our awareness of the need to screen for the early onset of diabetes or other conditions caused or exacerbated by poverty as part of home health or primary care teams.



Understanding value. Value is a basic but critical concept for each of us to understand any time we take a seat at the table in the coming decade. We must

understand the concept of value in our health system, so that in turn we can frame the distinct value of occupational therapy services for others.

Michael Porter (2010) defined value in the New England Journal of Medicine simply as outcomes relative to cost. Porter made the important point that value is not an abstract ideal. Value, even in health care can be quantified and measured because we can measure both the numerator (Quality) and the denominator (Cost).

Discussing cost is something that we need to become 100 percent comfortable with! After all, how many of us have the option of often saying, “Cost is no object!” And yet I sometimes read the proposition that seeking to contain or reduce costs is automatically at odds with quality evidence-based and occupation-based intervention…. or that we need to focus on evidence-based and occupation-based practice and let others worry about cost.

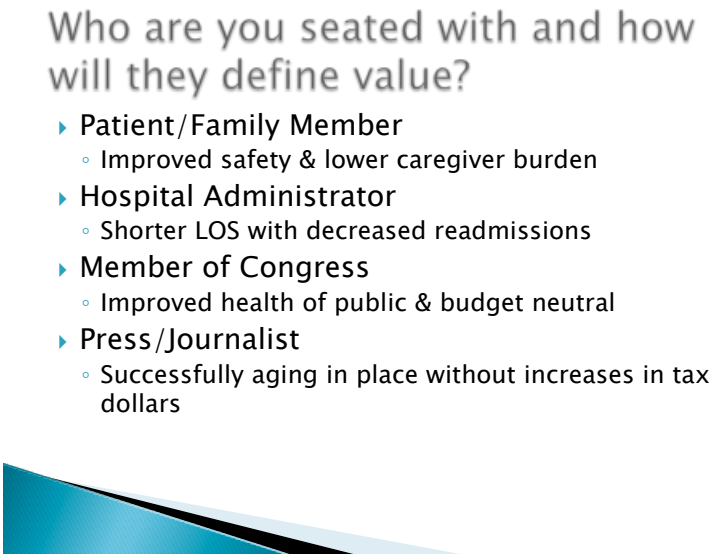
As the director of a large rehabilitation department leading over 120 occupational therapy and physical therapy practitioners I think about quality and cost every day. I can report that at least in my world, strategies such as the early mobilization of patients in the Intensive Care Unit or interprofessional enhanced recovery strategies for surgical cancer patients are leading to improved outcomes AND lower costs, improved value, for patients and my institution.

This leads to two other important points made by Porter. First that value must always be defined around the customer and second that value is measured by the outcomes achieved and not the volume of services delivered. We must understand what quality means to our patients including the specific performance characteristics that

apply to each element of our intervention so that we can measure and grade the quality of the occupational therapy services we provide.

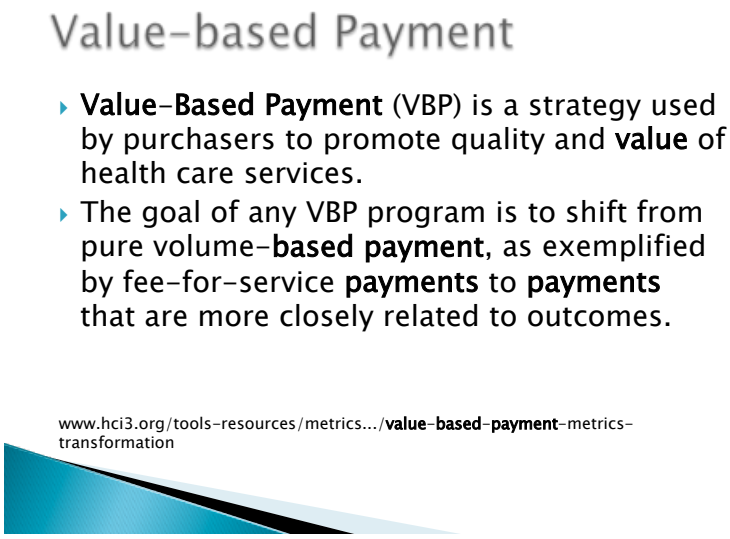
When we accept responsibility for doing the hard work it takes to remain current and to be evidence-based, and the effort it takes to be client focused we can increase value to the client …..and can lower cost and deliver the just right level of service.

Going further, Porter reminds us that seeking to reduce costs without regards to the outcomes achieved is dangerous, and self-defeating. Short-term false savings limit the effectiveness of care, and we end up shooting ourselves in the foot in the long run with complications of care and readmissions.



One key to taking the most advantage of invitations to sit at the table is to understand whom we are seated with and what they are specifically concerned about as stakeholders. We all need to have our 30 second elevator conversation ready to answer the question, “What is occupational therapy?” and I’ll talk more about that later in this address; we need to be prepared far beyond that when meeting with key stakeholders such as hospital or school administrators, patients and families, members of Congress,

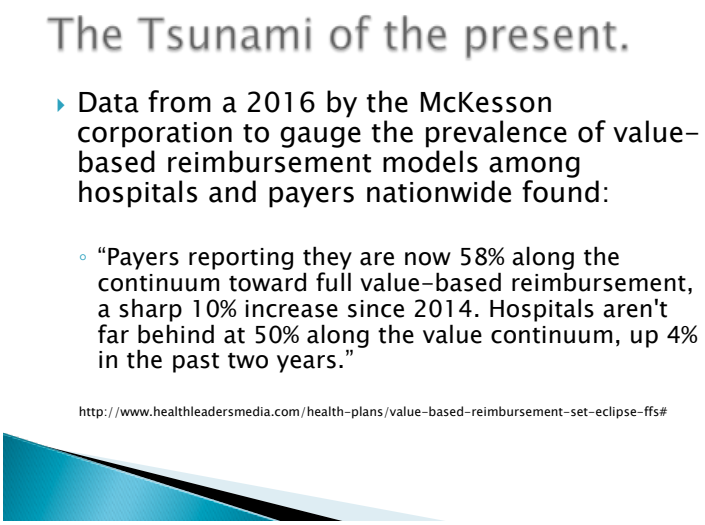
or members of the press or journalists. We need to be able to anticipate how each stakeholder understands the value proposition in terms of outcomes relative to costs and we need to be able to speak in a language that each specific stakeholder understands.



Value-Based Payment (VBP) is a strategy or group of strategies used by health care purchasers including Medicare, Medicaid and private insurers to promote the quality and value of health care services. The goal of any VBP program is to shift from pure volume-based payment, as exemplified by fee-for-service payments to payments that are more closely related to outcomes.

The underlying principles of value-based payment are not completely new. To a certain degree they were the basis of prior cost containment and value strategies including diagnostic related groups or DRG's in acute care hospitals and health maintenance organizations or HMO's.

In today's environment, with the implementation of strategies such as bundled-payments and accountable care organizations, we see increased emphasis on shifting risk from the payer to the provider and on holding providers accountable for both quality and for the prevention of costly complications.



Value-based payment strategies are likely here to stay. These strategies have been supported to some extent by both democrats and republicans and it is unlikely that we will see them abandoned. The McKesson Corporation found in 2016 that payers reported an increase in valued-based payment with 58% of their payments falling into some value-based strategy and hospitals cited almost a 50% increase. Health Leaders Media described value-based reimbursement models in healthcare as *having graduated from the wave of the future to the tsunami of the present* http://www.healthleadersmedia.com/health-plans/value-based-reimbursement-set-eclipse-ffs#

Value-based Payment

- The department of Health and Human Services announced that, “it would seek to make 30% of Medicare payments for hospitals and physicians through alternative payment models such as ACOs and bundled payments by the end of 2016, and to make 50% of Medicare payments through APMs by the end of 2018”

(Advisory.com, 2016).

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6 most common forms of VBP

- Medicare Quality Incentive Programs
- Pay for Performance
- Accountable Care Organizations
- Bundled Payments
- Patient Centered Medical Homes
- Payment for Coordination

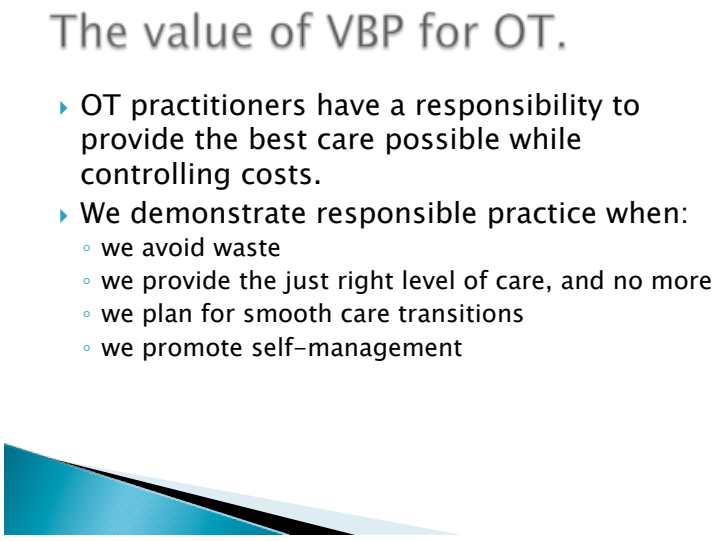
http://hitconsultant.net/2014/05/29/6-most-common-value-based-payment-models/

Here are six of the most common forms of value-based payment. Each of should have at least the ability to recognize each form of payment and what it means for us as consumers of health care and as providers if we work in a system implementing one or more of these strategies (http://hitconsultant.net/2014/05/29/6-most-common-value-based-payment-models/.

- **The Medicare Quality Incentive Program** is a pay-for-reporting program that gives eligible professionals incentives and payment adjustments if they report quality measures satisfactorily.
- In a **pay-for-performance system**, providers are compensated by payers for meeting certain pre-established measures for quality and efficiency. Pay-for performance-programs have been implemented by both Medicare and private insurers.
- **Accountable Care Organizations (ACOs)** are groups of doctors, hospitals, and other health care providers, who come together voluntarily to give coordinated high quality care to their Medicare patients.
- The goal of **coordinated care** as a form of value-based payment is to ensure that patients, especially the chronically ill, get the right care at the right time, while avoiding unnecessary duplication of services and preventing medical errors.
- **Episode or bundled payments** are single payments for a group of services related to a treatment or condition that may involve multiple providers in multiple settings.
- The **Patient Centered Medical Home** is a team-based model based on the premise that the best healthcare begins with a strong primary care foundation, accompanied by quality and resource efficiency incentives. The patient centered medical home is

a model of healthcare based on an ongoing, personal relationship between a patient, doctor and the patient's care team. Whatever the medical needs – primary or secondary, preventive care, acute care, chronic care, or end-of-life care – the patient has a medical "home"; a single, trusted doctor and care team, through which continuous, comprehensive and integrated care is provided.

- The **Payment for Coordination model** involves payment for specified care coordination services, usually to certain types of providers. The most typical example of this is the medical or health care home model whereby the medical home receives a monthly payment in exchange for the delivery of care coordination services that are not otherwise provided and reimbursed.



So what does this have to do with occupational therapy? Is there value for occupational therapy in the value-based payment system? I think the answer is yes.

First and most importantly we can have a direct role in helping organizations to successfully implement value-based payments strategies such as caring for patients

across multiple settings in accountable care organizations by promoting our role in care coordination, family education and environmental modification.

Secondly, as occupational therapy practitioners we have a responsibility to provide the best care possible while controlling costs. By embracing this responsibility we transfer that value to our clients and secure the future of our profession.

We demonstrate responsible cost-effective practice when:

- We avoid waste in our everyday practice.
- We provide the just right level of care and we bill ethically
- We promote self-management and safety to prevent falls and to promote earlier discharges
- We plan for smooth care transitions and prevent costly readmissions

More that any other strategy we can address value-based payment by being able to clearly articulate the distinct value of occupational therapy.

Population Health

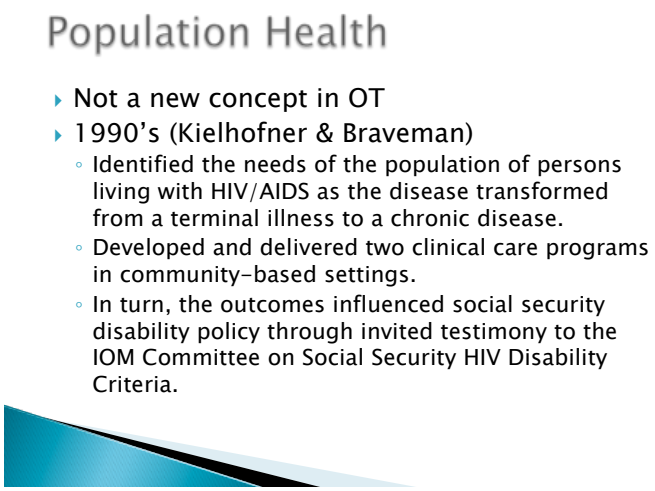
"The health outcomes of a group of individuals including the distribution of such outcomes within the group."

Kindig & Stodart (2003, pg. 381)

The next concept that all occupational therapy practitioners should consider in being ready to take a seat at the table is that of population health. A commonly recognized definition of population health is that provided by Kindig & Stodart in 2003 which is:

"The health outcomes of a group of individuals including the distribution of such outcomes within the group."

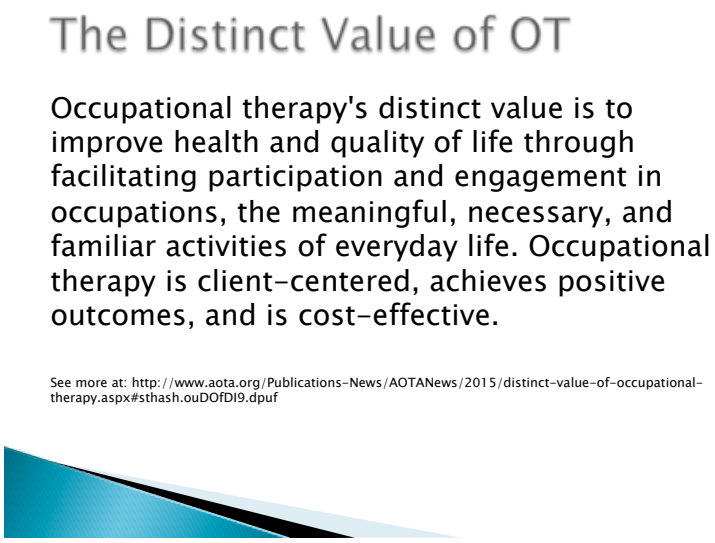
Population health as a concept ties closely to those of the Triple Aim and of health disparities.



Like the Triple Aim and health disparities, it is a mystery to me why some occupational therapy practitioners react as if population health is a new concept, or one that should be foreign to occupational therapy practitioners. In fact, population health is not a new concept and there are examples going back decades where occupational therapy scholars and practitioners have sought to improve the health outcomes of groups including communities such as those who have a disease process or disability status in common. I'll share a personal example from the 1990's.

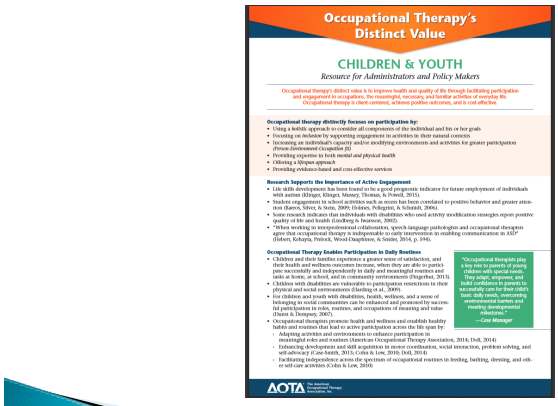
In 1992 Gary Kielhofner recruited me to join the faculty of the University of Illinois at Chicago as the Director of Clinical Practice in the UIC Medical Center. I soon became involved in doctoral studies and community-based research.

- Together Dr. Kielhofner and I identified the needs of the population of persons living with HIV/AIDS as the disease transformed from a terminal illness to a chronic disease as a result of new pharmacological treatments that became available.
- In response, we developed and delivered two clinical care programs in community-based settings designed to improve return-to–work and return-to-independent living outcomes.
- In turn, the outcomes of these programs influenced social security disability policy when I was invited to give testimony to the Institute of Medicine Committee on Social Security HIV Disability Criteria**.**
- The outcome of this testimony was that the disability criteria was revised to include more psychosocial assessment of disability and to look beyond the documentation of physicians to find evidence of disability.



A seventh theme for holding effective conversations is the Distinct Value of Occupational Therapy. The American Occupational Therapy Association developed the distinct value statement to specifically articulate the contribution of occupational therapy as a distinct profession. It reads, “Occupational therapy's distinct value is to improve health and quality of life through facilitating participation and engagement in occupations, the meaningful, necessary, and familiar activities of everyday life. Occupational therapy is client-centered, achieves positive outcomes, and is cost-effective” (http://www.aota.org/Publications-News/AOTANews/2015/distinct-value-of-occupational-therapy.aspx#sthash.ouDOfDI9.dpuf)/

AOTA Distinct Value Resources

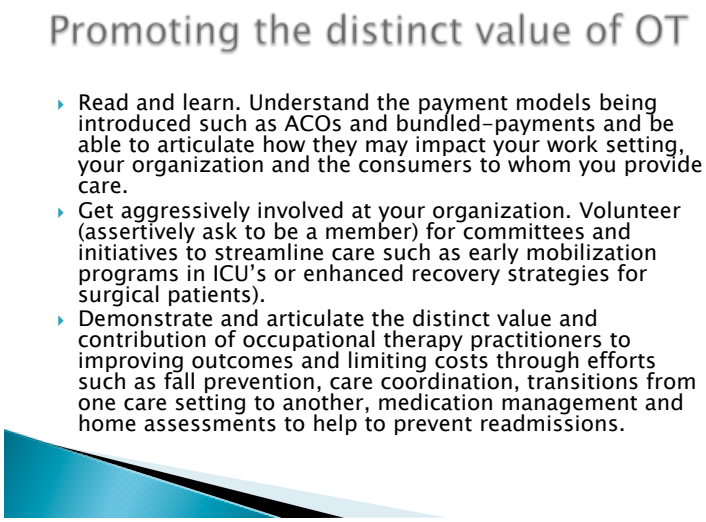


Resourceshttp://www.aota.org/~/media/Corporate/Files/Secure/Practice/Children/distinct-value-policy-makers-children-youth.PDF

You'll find valuable resources at the AOTA website to help you articulate the distinct value of occupational therapy in six areas of practice that are 1) rehabilitation practice, 2) productive aging, 3) mental health, 4) children and youth, 5) health and wellness, and 6) work and industry.

These materials are customized to each area but make some clear points:

- Occupational therapy practitioners work to improve health and quality of life.
- Occupational therapy practitioners facilitate participation in meaningful activities.
- Occupational therapy practitioners collaborate with parents, teachers, and family members.
- Occupational therapy practitioners utilize client-centered meaningful activities to achieve positive outcomes
- Occupational therapy services are cost effective.



You may be picking up on the fact that I am a fan of suggesting action. I like common sense, real life steps that each of us can take. So what can we do to make the bridge between the themes we are discussing today to our distinct value?

- Well we can read and learn. We can seek to understand the payment models being introduced such as ACOs and bundled-payments and be able to articulate how they may impact our own health care, our work settings, our organizations and the consumers to whom we provide care.
- We can get aggressively involved at your organization. Volunteer, or assertively ask to be a member for committees and initiatives to streamline care, broaden your intervention, raise awareness with parents, teachers, community organizations. We can become the “go to” person on the team.
- We can demonstrate and articulate the distinct value and contribution of occupational therapy practitioners to improving outcomes and limiting costs through efforts such as fall prevention, care coordination, transitions from one

care setting to another, medication management and home assessments to help to prevent readmissions.

- We can advocate. If you believe as I do that that achieving the Triple Aim of improving the health of the public, improving health care and providing quality care at a lower cost is critical to our future, then advocate for OTs involvement.
- We can attend AOTA's Capital Hill Day (in person or virtually) and use your voice to speak at the table with your elected representatives. I attended this year with over 600 other occupational therapy practitioners and students and advocated for final repeal of the Medicare therapy cap, for our role as qualified mental health providers and for our ability to open home health cases.

There may be some of you still questioning how you can actually get your foot in the door if you are a practitioner who provides direct treatment all day, or a front line manager who is not routinely invited to sit at the table with the folk who make day-to-day decisions about resources. What are strategies you can use to become more of an influencer?

Here are some strategies that I have used that have been successful. Share information and demonstrate a broader concern for the organization. Volunteer for Ad Hoc or permanent committees outside of your department. You don't have to wait to be invited, put your name forward and volunteer. Ask to be included and create opportunities to work on projects. Attend town hall meetings and forums every chance you get, be sure and ask a question, and mention occupational therapy!

Forward an article or news stories about a trend impacting your setting. Of course I use common sense of course about who I send these items to and when, but doing this can send a strong message about who you are as a professional and team member. It helps to create an identity as someone who is paying attention.

Socialize with coworkers outside of your department to create a network of peers. When you attend a training session or meeting, don't sit with people from your own department but seek out others you would like to have a relationship with and say hello, find something to talk about, ask them questions. Seek out training sessions and forums where you know colleagues from other departments will be present.

Say thank you to others when you seeing them doing a great job and give credit publicly for the contributions of others and be sure and copy their boss!

Here are some more ideas and some success stories from MD Anderson where I work. We have staff actively involved in an interprofessional team promoting early mobilization in our ICU. The occupational therapists and physical therapists involved have worked themselves into positions of being highly respected team members who have published and presented widely. This wasn't my effort. The staff stepped forward, volunteered and put themselves on the line. The efforts have led to improved outcomes, shortened lengths of stay and lowered costs. OT and PT are always mentioned when the physicians and nurse members describe their successes.

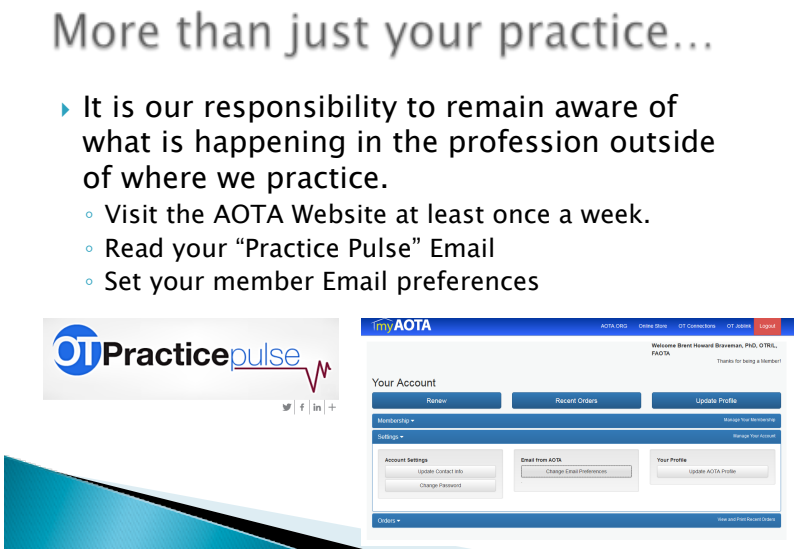
In similar efforts we have become key players in multiple efforts and teams to generalize enhanced recovery strategies throughout or 800-bed hospital.

You never know when an opportunity is going to come along. Recently my department was visited for quality rounds as part of preparation for our joint commission survey. The Chairperson of our hospital safety committee spent about 20 minutes touring the department and asking questions. When he asked if there was anything else we would like to discuss, I took advantage of the opportunity to share that I had been collaborating with several nursing directors and we had some concerns about safe patient handling. As a result he invited us to present our problem statement to the hospital safety committee for consideration and two of my nursing colleagues and I were asked chair an Ad Hoc committee to review the process for purchase, maintenance and training for all lift equipment. This is a big deal that gives us access to key organizational players not only in direct care but in sourcing and contracting and facilities management.

We also initiated a project with nursing on our hematology floors focused on increasing mobilization of our sickest patients. These efforts have become high profile and are already resulting in improved health outcomes, reducing length of stay and lowering costs. And here are two more examples.

As we started to experience problems in planning patient discharges after changes in vendor behavior due to the CMS competitive bidding process for durable medical equipment, we developed a problem statement. I presented this statement to my boss, and was asked to lead an interprofessional performance improvement team along with case management. In November we will begin a pilot of a revised process that may save the work of as many as 3 full time employees.

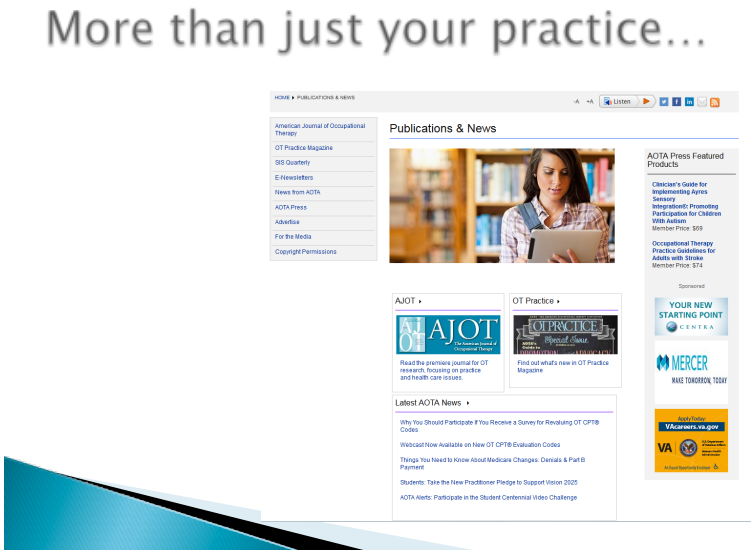
Because of our involvement in several of theses efforts we are routinely invited to participate in new initiatives by medical staff, nursing and others. We recently began participation in an interprofessional performance improvement team to apply what we have learned from other enhanced recovery programs to adults over the age of 55 who have undergone stem cell transplant.



Okay, hang on. I am getting toward the end and only have a couple of more challenges for each of you to consider.

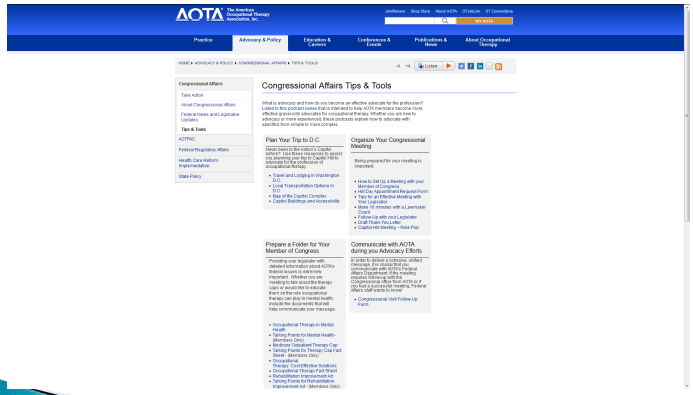
Do your best to stay abreast of issues in occupational therapy but outside of your area of practice. You never know when you will be seated not at a table, but on a plane and a critical opportunity will show itself. Visit the AOTA Website once a week. Just put it in your favorites and click on it while your having your coffee or tea. It really can take just a few moments! Scan the announcements and latest AOTA news right on the home page. Read the "Practice Pulse" email that will come to you once a week if you set your member Email preferences to receive it.

Take advantage of all of the AOTA publications including the American Journal of Occupational Therapy, OT Practice, and the Special Interest Sections compendium of newsletters. You now get all 11 in one publication.



Of course, while you are on the Website be sure and click on the Advocacy and Policy tab and check out the Congressional Affairs webpage. There in one stop you can get the latest news on legislation, changes in policy, and reimbursement at both the federal and the state levels. Be sure and sign up to for the Action Network E-list to get Email notifications of important legislative issues and when you are ready to contact your congressional representative or Senator you can find all the contact information simply by search by zip code.

Congressional Affairs Page



Most importantly, when we are sitting at any table speaking about occupational therapy, we need to speak with confidence. We need to convey utter enthusiasm for what we do everyday. The rewards we receive for the privilege of entering the lives of our clients and their families need to show clearly on our face.

If you don't speak about occupational therapy as rewarding, powerful and effective, who will?

Speaking with confidence.

- If YOU don't speak about occupational therapy as a rewarding, powerful, effective profession who will?

I am sure all of you have heard the idea of having a 30 second elevator speech practiced and ready for when someone asks you the question, “What’s occupational therapy?”

And it’s true. I find that I use mine all of the time! What are the simple keys to being effective?

Never sigh…….

Don’t act shy, apologetic or waiver, say “I love it when people ask me that!

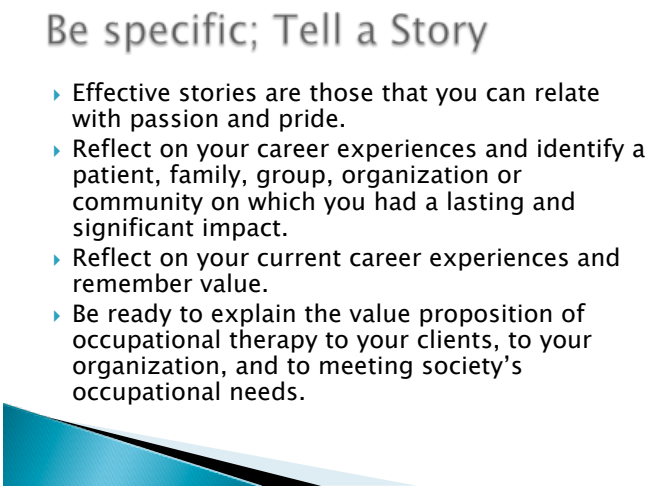
Don’t say its complicated or confusing and NEVER mention another discipline. We are not “like physical therapy…..but”

React with enthusiasm and excitement and go for the follow-up, engage your listener and get the chance to tell a story.

Effective stories are those told with passion and pride. Use your experience and tell your listener about a time when your changed someone’s life because you are an

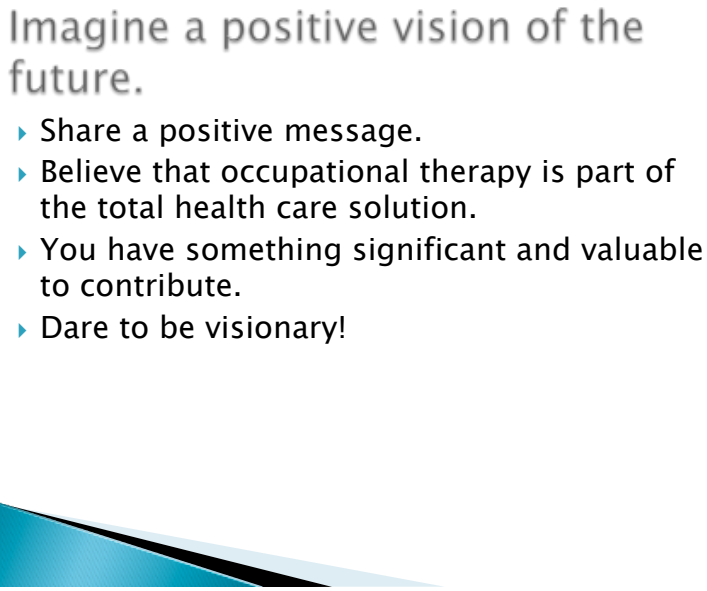
occupational therapy practitioner! Think about that. Because we are occupational therapy practitioners, we all have a story about how we changed someone's life for the better. What could be more powerful than that?!

When you have the chance to sit at table with a key stakeholder be ready to explain occupational therapy's value proposition, be ready to tell your listener a story that highlights how occupational therapy helps to meet an occupational need that they care about.



Help your listener to imagine a positive vision of the future by oozing optimism! You have to first believe that occupational therapy really is part of the total health care solution. We help people to live life to their fullest.

We really can dare to be visionary!



There is the English saying, or perhaps curse that I am sure you all may have heard which goes, “May you live in interesting times.”

Well, I have a feeling that the next few years are going to be a very interesting time to work in any health related profession, and yet, ***I am annoyingly optimistic.***

I am positive, that if we stay informed, demonstrate our understanding of the broader system in which we work, if we seek opportunities to influence our workplaces and believe that we are a powerful enough profession to warrant sitting at ANY table that our future is very bright.

Never doubt that a small group of thoughtful, committed citizens can change the world. Indeed, it is the only thing that ever has.

Margaret Mead

Thank you for inviting me to spend time with you today, and let me leave with you this thought and wish.

May you all sit at many interesting tables.

Thank you.

Contact Information

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