Underserved Population (UP)
Network Webinar
presented by
Home Health Quality Improvement (HHQI)
National Campaign

Using Occupational Therapy to Optimize Outcomes

Guest Speakers:
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Principal, The Home Remedy

Using Occupational Therapy to Optimize Outcomes
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The most important things we want you to understand today:

- Daily activities and routines are a critical aspect of self-management of chronic conditions.
- Appropriate occupational therapy plans of care contribute to improving self-management, regardless of diagnosis.

You will be able to:

- Explain the relationship between daily activities and self-management of chronic conditions.
- Identify and describe 6 strategies for using occupational therapy to improve clinical outcomes.
- Evaluate occupational therapy care plans for relevance to health management and outcomes.

Questions for You

- What types of treatments do you typically see in your OT plans of care?
- What do you expect from your OTs?
- What kinds of outcomes do you typically get from an OT plans of care?
- MORE importantly.... What kinds of outcomes do you NEED from your OTs?
**Outcome Indicators**

<table>
<thead>
<tr>
<th>Outcomes Measures</th>
<th>State</th>
<th>Nat'l</th>
</tr>
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<tbody>
<tr>
<td>How often patients got better at walking or moving around</td>
<td>59%</td>
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<td>56%</td>
<td>56%</td>
</tr>
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<td>63%</td>
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**Most common primary home health diagnosis, Medicare beneficiaries, 2010**


<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>ICD-9-CM Code</th>
<th>% total served with this HH 1st diagnosis</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diabetes</td>
<td>250</td>
<td>10.3</td>
</tr>
<tr>
<td>Essential hypertension</td>
<td>401</td>
<td>9.3</td>
</tr>
<tr>
<td>Heart failure</td>
<td>428</td>
<td>7.4</td>
</tr>
<tr>
<td>Chronic ulcer of skin</td>
<td>707</td>
<td>4.3</td>
</tr>
<tr>
<td>Osteoarthrosis related dx</td>
<td>715</td>
<td>3.7</td>
</tr>
<tr>
<td>Cardiac dysrhythmias</td>
<td>427</td>
<td>2.6</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>37.6</td>
</tr>
</tbody>
</table>

**Management of chronic conditions**

- "As much as 90% of the management of a chronic condition must be performed, not by health care providers, but by the person who has the condition."
  - California Healthcare Foundation, 2008
- "Patients with chronic conditions self-manage their illness. This fact is inescapable. Each day, patients decide what they are going to eat, whether they will exercise, and to what extent they will consume prescribed medication."
What are we really expecting?
- Every instruction...
- Every recommendation...
- Is prescribing a behavior (Prochaska, 2013)...
- That we expect a patient (or caregiver) to implement...
- Not just once—but repeatedly, routinely...
- Often for the rest of his/her life.

Don’t confuse...
- Knowledge
- Verbalizing understanding
- Behavior
- Implementation

But don’t confuse
- Return demonstration
- One time performance
- Spontaneous
- Consistent
- Routine performance
### Management of chronic conditions

- Medications (obtain, administer as directed, refill)
- Self monitoring (BP, glucose, skin, weight)
- Other treatments (oxygen, nebulizer, insulin)
- Physical activity (exercise, pacing)
- Diet (carbs/glycemic index, sodium, potassium)
- Attend and participate in healthcare encounters

### All self-management tasks involve changing lifelong ways of doing

<table>
<thead>
<tr>
<th>Self Management Tasks</th>
<th>Lifelong Ways of Doing</th>
</tr>
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<tbody>
<tr>
<td>Medications</td>
<td>Habits</td>
</tr>
<tr>
<td>Self monitoring</td>
<td>Routines</td>
</tr>
<tr>
<td>Other treatments</td>
<td>Lifelong preferences</td>
</tr>
<tr>
<td>Physical activity</td>
<td>Familiar ways of doing</td>
</tr>
<tr>
<td>Diet</td>
<td>Roles</td>
</tr>
<tr>
<td>Attend and participate in healthcare encounters</td>
<td>Role-related activities and habits</td>
</tr>
</tbody>
</table>

### Previously effective management can be disrupted by new events

- Stroke
- Fracture
- New meds (or dosing instructions)
- Move/change residence
- Change in caregiving
- Emotional stressors
- Cognitive changes
- Limit or disrupt ability to self-administer meds or other in-home treatment
- Reduce level of physical activity
- Limit ability to obtain foods consistent with diet
- Affect ability to prepare meals consistent with diet
- Affect ability to adequately self-monitor symptoms
- Limit access/participation in healthcare encounters
Self Management

- "Self-management is defined as the tasks that individuals must undertake to live well with one or more chronic conditions. These tasks include having the confidence to deal with medical management, role management, and emotional management of their conditions."
  - Institute of Medicine, 2003

- Introducing medical management of conditions into a patient’s life cannot ignore role and emotional management.

What can occupational therapy address?

The Domain of Occupational Therapy

<table>
<thead>
<tr>
<th>Areas of Occupation</th>
<th>Performance Skills</th>
<th>Performance Patterns</th>
<th>Content &amp; Environment</th>
<th>Activity Demands</th>
<th>Client Factors</th>
</tr>
</thead>
<tbody>
<tr>
<td>ADL, IADL, &amp; daily Education, work, Play, Leisure, Social participation</td>
<td>Motor &amp; praxis skills, sensory-perceptual skills, Emotion regulation skills, Cognitive skills</td>
<td>Habits, routines, rituals, roles, Cultural, personal, values, beliefs &amp; spirituality</td>
<td>Occupants &amp; their properties, Social demands, Required body structures, Required body functions, Values, beliefs &amp; spirituality, Demands, resources</td>
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What should an OT evaluation address?

**Evaluation**

**Occupational profile:**
- Elicit history, strength, needs from perspective of the client
- Needs related to daily performance (from perspective of patient and caregiver)
- “Before” (and how long before)
- Roles and routines
- Priorities
- Clues in the home environment indicating problems or risks associated with daily activities
Evaluation

- Occupational profile
- Analysis of selected aspects of performance
- Review findings with patient
- Collaboratively identify/agree on outcomes

Care Plan

- Care plan is the roadmap defined by the answers to these questions:
  - What will this patient look like (health/daily performance) when home health discharges?
  - What will this patient’s trajectory be at discharge? What will the patient look like 3-6 months after discharge?
  - Will the discharge trajectory be less positive without OT?
  - Will the discharge trajectory be better with OT?
  - What will occupational therapy contribute to that discharge picture and that trajectory?

Outcomes

- What will the result of OT intervention be?
- Will it be sustainable?
  - Capable of being sustained
  - Resources needed to sustain
- Will it matter?
  - A shift in metrics from possible to practical
  - Are the resources required to achieve the result worth the result achieved?
  - Are the resources required to sustain the result reasonable?
Perspectives on Outcomes

- Patient
- Caregiver
- Medicare: End Result Outcomes
- Trajectory as outcome

*Begin with the outcome in mind!*

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### Outcomes which are meaningful to patients, caregivers and payers

- Staying at home
- Reducing risk at home
- Managing at home
- Self management
Care Plan Reasoning

- Objective and measurable goals linked to outcomes
  - Meaningful measures of performance
  - Procedures and Modalities
  - Frequency and duration
  - Dosing (intensity of OT services) in response to needs and changes in patient performance or habits
- Discharge planning

Care Plan

- Plan that includes
  - Objective and measurable goals
  - Occupational therapy intervention approach based on theory and evidence, and
  - Mechanisms for service delivery including coordination with aide care plan
  - Consider discharge needs and plan
  - Select outcome measures
  - Make recommendation or referral to others as needed

- What will the patient look like? What will performance be like? Described in ways that mean you or anyone else can look at the patient and determine whether the goal has been met?
- What will this patient look like if I do nothing? Identifies areas where intervention is needed to stabilize or sustain performance/safety.
- Interventions: What will occupational therapy do to achieve these goals?
- How often and how many visits will be needed to implement these interventions and achieve these goals?
- What other actions will be required from occupational therapy to achieve these outcomes or support the patient to sustain the outcomes after discharge from home health?

“Improvement” or “Rehab Potential” NOT a Criterion for Receiving OT

- Stabilization measures (rolled out with OBQI in 2002) exist because evidence indicated that potential for improvement is not realistic for many home health patients, but stabilizing a declining trajectory is both realistic and desirable.
- 2013 Jimmo v. Sebelius confirmed that expectation of improvement or evidence of improvement cannot be requirement to receive otherwise covered services (including OT).
Implementing Intervention

- Three strategies
  - Face to face encounters
  - Monitoring
  - Homework
- Isolated vs. habitual performance
  - Skill building vs. habit building
  - Modifying strategy vs. modifying routine

Intervention-coordination with nursing intervention and aide care plan

- Instruction from other disciplines integrated into performance—and routines—by OT
- Spontaneous, consistent performance is the ultimate teach-back response
- Use aide services as an opportunity for patient to practice to refine performance (practice that does not require a skilled therapy practitioner to be present)

Six Strategies for Using OT to Improve Outcomes

- Managing medication routines
- Integrating dietary recommendations into meal preparation and daily routines
- Conserving energy as lifestyle
- Incorporating physical activity into daily routines
- Self-monitoring as lifestyle
- Problem solving (reducing hospitalization risk)
Medication management is the most important IADL!
- Focus on the task and the routine
- Within scope of occupational therapy
- Not medication teaching
- Analysis of the component skills required
- Identification and implementation of appropriate compensatory strategies
- Integration of medication management into daily habits and routines

Integrating dietary adherence into meal preparation and daily routines
- Analysis of how food is obtained, who and how it is prepared and compatibility with daily routines
- Analysis of skills (cognitive and sensorimotor) to obtain food and prepare meals consistent with dietary recommendations
- Identification of appropriate compensatory or alternative strategies to obtain food and prepare meals
- Integration of strategies into routines

Conserving energy as lifestyle
- Analysis of existing routines and habits in relation to energy demands and capacities
- Pacing and planning to balance demands to capacities
- Self-monitoring energy and energy expenditure
- Adapting routines
- Specific techniques (controlled breathing, relaxation, etc.)
- Use of pulse oximetry as a measure of effectiveness of interventions
Incorporating physical activity into daily routines
- Analysis of overall daily physical activity
- Incorporate physical activity into daily activity
- Analysis of avocational or leisure preferences
- Identification of long term options to sustain physical activity and physical activity capacities

Self-monitoring as lifestyle
- Analyze skills and capacities relative to demands of the task the patient is expected to perform
  - Blood pressure
  - Blood glucose
  - Skin integrity
  - Daily weights
- Integration of condition-specific self-monitoring tasks into daily routines
- Identification of compensatory strategies or needs for caregiving/supervision to support self-monitoring

Problem solving
- Actual performance in context (location/time of day) shifts teach-back from words to actions
- Analysis of performance in context to identify and problem solve to reduce risk and promote consistent performance
- Promote patient and caregiver problem recognition and problem solving
- Focus on “what to do” to identify an emerging need, problem, risk at earliest possible stage
Now…

- What **WILL** you expect from your OTs?
- Name one thing you will look for in an OT plan of care for a patient with a chronic condition
- How will you measure the effectiveness of an OT plan of care?
- How will you help your OT be the team member described today?

Resources

- American Occupational Therapy Association
  - www.aota.org
  - AOTA OT in Home Health Fact Sheet
  - AOTA Role of OT in Diabetes Management Fact Sheet
  - Other AOTA resources
  - Role of OT in Medication Routines

Outcomes in Context of Home Health

- Staying at home
- Reducing risk at home
- Managing at home
- Self management of condition

Occupational Therapy is **OuTcomes!**
Thank you!

- Karen Vance: kvance@bkd.com
- Carol Siebert: carol@the-home-remedy.com

HHQI Resources

- **Focused BPIP: Patient Self-Management**
  - Four concepts:
    - Patient Self-Management
    - Individual Motivation
    - Patient Activation
    - Action Planning
- Most BPIPs include self-management principles

Posted Resources from UP Call

- **HHQI – UP Tab**
- PowerPoint Handouts
- Occupational Therapy’s Role in Home Health
- Occupational Therapy’s Role in Diabetes Self-Management
HHQI Resources

- **Evidence-Based Health Coaching:**
  The Newest Trend in Patient Engagement
  - 1-hr webinar
  - **Melinda Huffman**, BSN, MSN, CCNS, CHC,
    - Author, writer and nationally known speaker
    - Co-founder of the National Society of Health Coaches

Next UP Network Event

- Wednesday, May 14, 2014: 3-4PM (ET)
  Best Practices for Care Transitions: Engaging Emergency Departments and Urgent Care Centers
- Guest Speaker: **Rebekah Gardner**, MD
  Senior Medical Scientist, Healthcentric Advisors
  Assistant Professor of Medicine
  Alpert School of Medicine, Brown University
- Register now at: [www.HomeHealthQuality.org/UP](http://www.HomeHealthQuality.org/UP)

The Gravity of Falls:
Evidence-Based Preventative Strategies

- Tuesday, April 29, 2014 at 2-3 pm (ET)
- **Topics**
  - Discuss validated multifactorial fall risk assessments
  - Examine your data findings and adjust your internal thresholds to identify high risk patients in need of interventions
  - Identify fall prevention interventions for implementation by clinicians in the home
  - Discuss major classes of medications that either increase risk for falls or increase risk of injury from a fall
  - Review changes in metabolism of medications commensurate with aging
- **Guest Speakers**
  - **Nancy Kimmons**, BS, PT, Home Care Therapy Operations Manager, Rehab Affiliates,
    Division of Main Line Health, Philadelphia, PA
  - **Michele James**, BSN, MS, RN-BC, Home Care Case Manager, The Home Care Network, Jefferson University Hospitals, Philadelphia, PA
  - **Chuck Lally**, RPh, Pharmacist, University Hospitals Home Care Services, Cleveland, OH
  - **Joanne M. Wile Avenmarg**, OTR/L, M.S., Director of Clinical Operations, University Hospitals Home Care Services, Cleveland OH
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THANK YOU!

This material was prepared by the West Virginia Medical Institute, the Quality Improvement Organization supporting the Home Health Quality Improvement National Campaign, under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services. The views presented do not necessarily reflect CMS policy. Publication Number: 105269-WV-100486-04-04. Approved 4/2014.