

Via electronic submission to: info@qualityforum.org

November 17, 2009

National Quality Forum
601 Thirteenth Street, NW
Suite 500 North
Washington, D.C. 20005

Re: **AOTA Comments on NQF Report Regarding Care Coordination**

Dear Sir or Madam:

The American Occupational Therapy Association (AOTA) represents the interests of over 140,000 occupational therapists, occupational therapy assistants, and therapy students, many of whom are covered and reimbursed as practitioners under a variety of payment sources. We appreciate the opportunity to provide comments on the *NQF Consensus Report: Endorsing Preferred Practices and Performance Measures for Measuring and Reporting Care Coordination* (hereinafter “NQF Report”) on behalf of the professional we represent for the purpose of providing enhanced quality of care to patients.

AOTA has worked closely with the Centers for Medicare & Medicaid Services (CMS) and the American Medical Association’s Physician Consortium for Performance Improvement (AMA PCPI) to assign appropriate measures for reporting by occupational therapists since the introduction of the PQRI Program in 2007. Furthermore, AOTA continues to support the development of measures in an open process emphasizing participation by all appropriate professional associations.

We offer the following comments on the NQF Report:

I. Occupational Therapy

Occupational therapy is a health, wellness, and rehabilitation profession working with people of all ages experiencing stroke, spinal cord injuries, cancers, brain injury, congenital conditions, developmental delay, joint replacements and surgeries, mental illness, and other conditions. Occupational therapists also work to prevent the occurrence of conditions and promote wellness among all client groups. Occupational therapists help people regain, develop, and build skills that are essential for independent functioning, health, and well-being in the home and community. Occupational therapy professionals have unique expertise in evaluating participation and enabling engagement in meaningful occupations (e.g., activities of daily living (ADLs)) while addressing the context (e.g., the individual’s limitations), environment and other factors. Occupational therapy evaluation and treatment is used for individuals with acute and chronic conditions. It includes a

multifaceted evaluation of a patient’s functional abilities, capacities, limitations (sensory, cognitive, motor function, judgment, etc.), home and community needs and roles, social and psychosocial contexts, and other elements.

II. Add Role of Occupational Therapy to Preferred Practices 6, 9 and 10

Occupational therapy practitioners bring a unique skill set and expertise that can and should be a vital component of any new or existing care coordination models to achieve optimal client outcomes and deliver more targeted, effective care. Occupational therapy addresses issues of daily living that are often ignored but are critical to care coordination and maintaining healthy habits, particularly for individuals with chronic conditions. Occupational therapy is particularly effective in addressing children with disabilities like autism in school or in other settings (*American Journal of Occupational Therapy*, 2008) or families addressing Alzheimer’s disease (*The Gerontologist*, 2000).

AOTA respectfully requests that the role of occupational therapy be recognized in Preferred Practices 6, 9 and 10 with regard to lifestyle therapy, education and counseling activities and participation in life and community activities:

Preferred Practice 6: The healthcare home should have structured and effective systems, policies, procedures, and practices to create, document, execute, and update a plan of care with every patient.

AOTA requests that NQF add the following bullet (additions in *italics*) under the section “Elements of the plan of care should include, but are not limited to”:

- *evaluating participation and enabling engagement in meaningful occupations (e.g., activities of daily living (ADLs))*

Preferred Practice 9: The plan of care should include community and nonclinical services as well as healthcare services that respond to a patient’s needs and preferences and contributes to achieving the patient’s goals.

Specifically, Preferred Practice 9 goes on to state “a needs assessment for the patient should be employed to assess social and environmental factors that may influence care, such as housing and transportation” and “the healthcare home should be aware of environmental/home, lifestyle, and other community issues and incorporate those factors into the plan of care”.

AOTA requests additional language regarding a patient’s participation in ADLs be added to the statement about needs assessment such as:

- a needs assessment for the patient should be employed to assess social, environmental, *and participation* factors that may influence care, such as housing and transportation *or enabling engagement in meaningful occupations”*

In the same vein, AOTA requests the following additional language to the statement about health care home be added:

- The healthcare home should be aware of environmental/home, lifestyle, *participation*, and other community issues and incorporate those factors into the plan of care.

Preferred Practice 10: Healthcare organizations should use cardiac rehabilitation services to coordinate care for patients with a recent cardiovascular event, where available, appropriate, and accessible.

Under Preferred Practice 10, the recommendation is that “An individualized treatment plan is then designed and implemented that includes a comprehensive program of lifestyle therapy, education, counseling, and medical treatments, all of which are done in coordination with the patient’s primary medical care provider.”

AOTA requests that additional language be added to the “Additional Specifications” (such as the language recommended in italics here) to recognize the cardiac rehabilitation patient’s “*participation needs/daily activities while addressing the context (e.g., the individual’s limitations), environment and other factors*” in a similar manner as noted for Preferred Practices 6 and 9.

According to CMS in the Proposed Rule, a cardiac rehabilitation program is physician-supervised and would include the following: physician-prescribed exercise; cardiac risk factor modification, including education, counseling, and behavioral intervention; psychosocial assessment; and outcomes assessment. Occupational therapy practitioners are educated to provide many of these skilled interventions and do provide them currently, billing the services as therapy.

Of particular note, Section 144(a) of the 2008 Medicare Improvements for Patients and Providers Act (MIPPA) requires Cardiac Rehabilitation programs to furnish items and services including “cardiac risk factor modification.” This includes education, counseling, and behavioral intervention to the extent these services are closely related to the individual’s care and treatment and tailored to patients’ individual needs. CMS describes risk factor modification as involving the following:

We are proposing that patients must be provided with the information and tools to improve their overall cardiovascular health. Items and services furnished as part of the risk factor modification component should be highly individualized as multiple risk factors contribute to poor cardiovascular health. For example, these items and services may include smoking cessation counseling or referral, nutritional education and meal planning, stress management, prescription drug education and management information, disease history education in order to foster a better understanding of disease origins and disease symptomatology, and any other education, counseling and behavioral intervention deemed appropriate in each patient’s individualized treatment plan.

AOTA asserts that occupational therapy practitioners are appropriate personnel to provide cardiac risk factor modification interventions, as well as functional interventions and therapeutic exercise activities to increase functional status and promote energy conservation. In fact, therapists are specifically trained to teach patients to adopt different daily routines and alter lifestyle choices based upon their conditions

III. Add Role of Occupational Therapists to Communication Domain

AOTA agrees with all these Preferred Practice descriptions and further asserts that occupational therapists plays an important role and fills a void in the daily care and training of both patient and caregivers to assist the patient in achieving their everyday activities and to participate in life in a meaningful manner. For this reason, AOTA requests an expansion of the concept of communication and care coordination to the unique role of occupational therapy practitioners, as follows:

Communication among primary care providers, hospital providers, specialists and community resources is key for optimal care of patients. Currently, communication has become the forefront of many hospital programs as a vehicle to improve transitions and reduce medical errors and rehospitalizations. Several hospitals have successfully implemented patient-centered strategies that address gaps in communications by including a family member, caregiver, *therapist [occupational therapist]*, or a nurse care coordinator in the care of a patient in the hospital.

In fact, an article by Gitlin (add reference) about Project ACT (Advancing Caregiver Training) highlights the role of occupational therapy and how the therapy is coordinated well with the care of an advance practice nurse. AOTA has pasted relevant sections below:

The occupational therapist (OT) initiates the intervention by introducing the goals of the intervention and conducting an assessment of the home environment for safety, support of daily function and ease of navigation, caregiver concerns and management style, and caregiver-patient interactions. Following this initial visit, an advanced practice nurse (NU) meets with the family caregiver and provides and reviews educational materials on dementia, the importance of taking care of oneself as a caregiver (eg, NIA 2002 booklet, Caregiver Guide: Tips for Caregivers of People with Alzheimer's Disease), and medical conditions that may contribute to or exacerbate behaviors.

Following the initial OT and NU assessments, the OT continues working with the family caregiver at home. Over a series of visits and for each caregiver-identified problematic behavior, the OT provides: (1) education about the role of the environment, (2) skill-building in identifying antecedents to or triggers for the target behavior using a structured problem-solving approach, (3) specific strategies reflecting modifications to the physical and social environment to manage the behavior, and (4) stress reduction techniques. The OT provides a typed tailored action plan (one to three pages) which states the target behavior (eg, repetitive questioning), the target agreed upon treatment goals (eg, reduce frequency of occurrence of repetitive questioning in the morning and caregiver anger when behavior occurs), potential triggers that may contribute to the behavior (eg, feelings of despair and loss of control in person with dementia; unclear caregiver communication, difficulty way-finding in a cluttered environment; highly stressed caregiver), and directions for implementing customized strategies (eg, specific communication approaches, statements to

avoid, use of tone and touch to provide reassurance, use of activities to engage person).¹

We request an expansion of the concept of communication and care coordination to the role of occupational therapy practitioners and for NQF to recognize the unique contributions made by occupational therapy in the NQF Report.

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AOTA requests that due consideration be given to this comment letter. Thank you, again, for the opportunity to comment on the NFQ Report on issues that relate to occupational therapy. We look forward to a continuing dialogue with NQF on these issues. Should you have any questions, feel free to contact me at 301.652.6611 ext. 2019 or via email at cwillmarth@aota.org.

Sincerely,



Charles Willmarth
Director, State Affairs and Reimbursement & Regulatory Affairs

References/Attachments

Gitlin, L., Winter, L., Dennis, M. P., Hauck, W. (2007) A non-pharmacological intervention to manage behavioral and psychological symptoms of dementia and reduce caregiver distress: Design and methods of project ACT 3. *Clinical Interventions in Aging*, Vol. 2(4).

Occupational Therapy Practice Framework: Domain & Process (2nd Ed.), *American Journal of Occupational Therapy* (2008).

¹ Gitlin, L., Winter, L., Dennis, M. P., Hauck, W. (2007) A non-pharmacological intervention to manage behavioral and psychological symptoms of dementia and reduce caregiver distress: Design and methods of project ACT 3. *Clinical Interventions in Aging*, Vol. 2(4).