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Submitted via electronic and regular mail

Agency for Healthcare Research and Quality
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Dr. Wilson:

On behalf of the American Occupational Therapy Association (AOTA), we would like to thank you for your work on the Health Care Quality Initiative and for this opportunity to provide feedback on the Initiative's Strategy and Plan (Strategy). The AOTA serves as the professional association for the more than 140,000 registered occupational therapy practitioners in America.

The work of occupational therapy practitioners in the health care field is very diverse and encompasses treatment across the lifespan, from early intervention to geriatrics. Our focus is achieving and/or maintaining maximal independence and occupational performance, that is, the ability to perform one's daily activities, which may include self-care, driving, work/school tasks, play, recreation/leisure, or fulfillment of roles such as caregiver or parent. Therefore, our view on a person's health is not focused solely on health condition or seeking a cure for disease. Rather, occupational therapy practitioners focus more on a person's quality of life and ability to "live life to its fullest". From this perspective, we submit the following comments in response to AHRQ's feedback questions.

Question #1: Are the proposed Principles for the National Strategy appropriate? What is missing or how could the principles be better guides for the Framework, Priorities and Goals?

The principles as outlined are appropriate for setting a framework and goals for improving health care quality. However, we would advocate the inclusion of a principle regarding the *measurement* of this health care quality initiative, specifically for the inclusion of *quality of life* as a measurement, rather than status of disease. As occupational therapy practitioners, we work with clients to improve their ability to perform functional tasks regardless of level of physical or cognitive impairment, thereby increasing their satisfaction and quality of life. Measuring health care outcomes utilizing quality of life as a measure removes the focus from the quantity of medical procedures or the status of disease and places the emphasis on the person's *wellbeing* and perception of health.

Furthermore, we believe an addition should be made to the existing principles regarding a new focus on preventive care, rather than reactive. Studies show that health care with a prevention focus can reduce occurrence of disease as well as health care costs, especially when administered at a community level (e.g., Lloyd-Jones, et al., 2010; Smith, et al., 2010). While reducing cost is important, the issue of quality health care should reflect the level of care that a patient is receiving. When a person can receive individualized preventive care and avoid disease or complications of disease, the person, as well as the health care system, benefits.

Question #2: Is the proposed Framework for the National Strategy sound and easily understood? Does the Framework set the right initial direction for the National Health Care Quality Strategy and Plan? How can it be improved?

While we do find that the Framework is easily understood by the public, we would like to see slight amendments made to further increase clarity, as well as better encompass what we believe would contribute to increased health care quality. First of all, we would like to see further clarity in the first section under “Better Care”. It reads, “Person-centered care that works for patients and providers.” We would like to see further definition of the word “works” in this sentence. How will works be defined and applied? We would rather see something more specific and more individualized, such as “Person-centered care that is meaningful and appropriate for each individual patient/client, while also considering the needs and expertise of the provider as well as the capacity of the health care system.”

Additionally, we would like to see Affordable Care include wording about measuring costs of care provided. While we recognize that the Affordable Care Act (ACA) does not allow for measures of quality adjusted life years (QALYs) or other similar measures, the ACA is explicit about increasing comparative effectiveness research (CER) and is also permissive to allow for determining quality of care while tracking cost savings. By implementing prevention-focused care, we can avoid acute admissions, expensive surgeries, procedures, and chronic prescriptions, and health care costs are projected to decrease. However, if costs are not measured as a part of determining Affordable Care, making this claim and truly assessing quality of care is difficult.

Furthermore, one of the principles is to eliminate health care disparities, yet this is not outwardly carried through to the Framework. We believe that as part of the Framework, eliminating disparities should be included with Healthy People/Healthy Communities. (“Improving health and wellness at all levels *and eliminating health disparities* through strong partnerships between health care providers, individuals, and community resources.”) Intervention and collaboration at the community level is one of the strongest ways to make an impact on health disparities. Health disparities affect people of lower socioeconomic status, minority race groups, and those living in either densely populated areas of cities (where poverty rates are high) or rural areas. Providing intervention and community-based programs run by members of the community who understand the culture, needs, and desires of the neighborhoods will be more successful in implementing effective, culturally relevant, preventive care to eliminate disparities.

Question #3: Using the legislative criteria for establishing national priorities, what national priorities do you think should be addressed in the initial National Health Care Quality Strategy and Plan in each of the following areas:

a. Better Care: Person-centered care that works for patients and providers. Better care should expressly address the quality, safety, access, and reliability of how care is delivered and how patients rate their experience in receiving such care;

From the viewpoint of occupational therapy, as well as studies that have been published in recent years, the manner to achieve better care is to focus on *self-management* as a means of healthy lifestyle redesign, prevention, disease management and elimination of chronic disease. Self-management programs are inexpensive, client-centered, and when guided by occupational therapy practitioners, are implemented at the level of an individual’s habits and routines. By providing self-management training and education for individuals with chronic conditions, they become empowered to take on and maintain an active role in their own health and wellbeing. According to research from the California Health Care Foundation, 90% of the “care” for a chronic condition needs to be provided by the person who has the condition (2008).

Individuals need to be in control of their care and have a high level of self-efficacy, or belief and self-confidence in their abilities, to be able to implement habit changes and impact their health in a positive way with permanent changes. In a study by Hay and colleagues (2002), self-management programs resulted in significant carryover of skills and positive health outcomes at follow up. In addition to education and training in healthy habits, we also need to ensure that our health care system monitors patient/client progress in *regular follow up* appointments. Follow up appointments are important to patients as they maintain healthy choices

and medication management, but these follow ups are also important to determine the efficacy and sustainability of self-management education programs to ensure best practices are recognized and utilized.

Related to self-management and healthy habits, the AOTA advocates that as a part of better care we improve services to *families*, and especially *children*. Intervention provided in adulthood aimed at changing life habits is often very challenging. Rather, interventions should be designed and implemented with children in order to teach them lifelong healthy habits at a young age when life habits and roles are still forming. This increases the implementation of prevention both in the short term as well as into the future as children grow into adulthood.

Furthermore, to increase quality of care, we need to increase our focus on *children and healthy development*. Many occupational therapy practitioners work with children to promote achievement of developmental milestones, learning through play, and improvement of school performance. In the practice area of early intervention (birth-age 3), however, occupational therapy practitioners and the health care system are limited by only providing care to those children who receive a diagnosis of a developmental condition. We advocate that in order to provide better care, children should receive medical attention and skilled therapies as appropriate as soon as developmental milestones are not being achieved. Requiring a diagnosis prior to treatment interventions limits the child's ability to develop at a normal rate and can continue to affect him/her throughout childhood, adolescence, and even into adulthood. If we are truly trying to create better care in our health care system, we must be prepared to reach out to children, both to teach healthy, lifelong habits and to intervene in developmental delays.

In order to achieve better care and increased quality, we must also ensure better care coordination. As part of this, the AOTA encourages the prioritization of the use of *coordinated care teams* that include occupational therapy to improve 'quality and efficiency' of care. We advocate a coordinated health care system with a collaborative focus that addresses health from a holistic perspective and recognizes the unique roles and competencies of all health professionals, and does not rely as much on initial physician referral or prescription medications. A health care system must provide open access to receiving the full range of health care services available with increased ease of navigation to meet the needs of all individuals. A truly collaborative and open approach to patient care, with an increased focus on health and wellness, will lead to improved health outcomes, reduced medical errors, decreased redundancy in care, and decreased costs.

However, in order to establish and maintain such a coordinated system, attention must be paid to *workforce trends* and intervention provided as appropriate. There are many medical professions that are short of practitioners, occupational therapy included. As a part of a health care system that provides better care, we must monitor the number of health care practitioners, especially in rural areas as we work to eliminate health care disparities. Incentives or other programs must be explored to increase the number of health care professionals as well as increases the availability of professionals all across the nation.

b. Affordable Care: Care that reins in unsustainable costs for families, government and the private sector to make it more affordable;

In achieving a quality health care system that provides affordable care, we would like to reiterate our points from above paragraphs regarding improving the health care system's focus on prevention and implementation of Lifestyle Redesign® as a means of reducing acute admissions, surgeries, and health care over-utilization. We must also implement a system of increased follow up appointments to reduce costly readmissions or relapses.

Increasing the focus of our health care system on *prevention* as well as implementation of *Lifestyle Redesign®* will address many health conditions before serious health care utilization occurs. Health care delivery that maintains a preventive focus naturally reduces long-term health care expenditures. Comparative effectiveness

trials (e.g., Clark, et al., 1997; Hay, et al., 2002) have shown a decrease in utilization of health care following preventive occupational therapy intervention, equating to decreased health care costs as compared to control groups. Increasing preventive care and screenings, as well as providing education on healthy habits and self-management, will not only reduce health care utilization, but it will reduce the amount of emergency services and expensive procedures, such as unnecessary procedures or emergency surgeries. As the Affordable Care Act continues to provide funding for comparative effectiveness research, health care services can be further improved to establish best practices and continue to reduce health care costs. However, funding must be provided to support these studies, and prevention must become a larger goal of our health care system.

In line with creating a more affordable health care system, we also need to review our procedures and practices regarding *follow up* of patients/clients. By targeting better and more focused follow up appointments with patients, we can ensure the sustainability of healthy habits and routines as part of a daily lifestyle, recovery from exacerbations or other acute care needs is appropriate, and we can continue to maintain lower levels of health care utilization. By continuing follow up care we can also *improve discharge services* and reduce the number of readmissions due to poor continuity of care, lack of follow up and decreased adherence to therapeutic recommendations. By focusing on prevention, healthy lifestyle intervention, and improved follow up and discharge planning, health care costs will be reduced, which will translate to lowered costs to the individual patients and their families, as well as the public and private sectors.

c. Healthy People / Healthy Communities: The promotion of health and wellness at all levels

One of the first components of promoting healthy people and communities is to evaluate the actual environment itself. Occupational therapy practitioners are trained to assess an environment for barriers and facilitators to participation and provide modifications to reduce or eliminate barriers and enhance facilitators. The built environment is important to participation, occupational choice/community engagement, and increased quality of life. In a study completed in Sommerville, Massachusetts, the construction of accessible bike and walking paths was designed to improve safety for bicyclists to avoid dangerous highways. However, the construction of these paths led to improved physical activity of community members because the paths were accessible, located in the community, and safe for exercise (Burke, et al., 2009). The built environment in communities is important for creating permanent healthy lifestyles.

Similarly, to improve safety and healthy habits, the current housing standards should be reevaluated, especially in areas of poverty and with consideration of people with disabilities and the elderly. Living in poor conditions while still trying to maintain a healthy lifestyle or avoid infection or disease is difficult, especially for families with young children. Census bureau statistics tell us that children of minority background living in poorer conditions are already at increased risk for poorer health and development compared with Caucasian peers who live in better areas or are of different races. We must also increase incentives to provide housing that is universally designed to allow for accessibility for people with disabilities and to allow for aging in place as the elderly population continues to increase. Accessible built environments allow people with disabilities and the elderly to remain independent as long as possible and maintain a healthy lifestyle, which reduces the cost of care typically covered by Medicare/Medicaid in these populations. Even if we can't improve the housing standards under this initiative, to improve the overall quality of health care, we must find a way to reach people living in these conditions and educate them about safe, healthy, and accessible home environments as well as healthy lifestyle habits that can be implemented in a way that is applicable, appropriate, and culturally meaningful and relevant to them.

In order to remove health disparities and improve the health of people and communities, we believe cultural competency must become an integral component of improved health care delivery. Occupational therapy intervention has a foundation of maintaining a comprehensive perspective on an individual's health across population groups, socioeconomic status, or geographic areas. Occupational therapy practitioners deliver treatment in the cultural context that is realistic and applicable to the individual and his/her family while

determining achievable goals for the individual. Cultural choice and personal preference is important to quality health care, as well as adherence to medical and therapeutic recommendations and improved health for each individual across the lifespan.

Question #4: What aspirational goals should be set for the next 5 years, and to what extent should achievable goals be identified for a shorter timeframe?

As a part of determining goals for this Strategy, a goal that we mention above and believe should be key is working toward more preventive care and a goal of prevention and wellness. Occupational therapy practitioners are concerned with a few major areas we would like to see addressed for preventive care: fall prevention, driving rehabilitation for older drivers, increasing focus on caregiver health and quality of life, mental health care for children, and increasing independence at home (or aging in place) for seniors.

As a part of this goal, we feel that an appropriate and necessary short term goal, in order to achieve effective preventive care, is to create a system to allow for billing for these interventions, including driver's screenings, fall prevention programs, caregiver health status and training, and home environment assessments and modifications. While we feel that creating a system to bill for these services would be the most efficient means to providing these services to more patients in more areas, we recognize the complexity in creating new billing language and finding funds to support these activities, but, as stated above, we believe that these preventive interventions will produce long-term savings. Therefore, we would also support funding grants for research in these areas of prevention to continue to improve upon best practices until a more permanent billing solution can be reached.

We also advocate for goals to address the need for person-centered care focused on chronic disease *self-management* for maximal wellbeing of each patient/client. Self-management focuses on patients/clients taking a leading role in the direction and implementation of their care, with health professionals providing expertise and advice on implementation, rather than a health plan *prescribed* by a health professional. This is another reason increasing individuals' open access to the full health care system is critical. As a part of self-management, consumers need access to all areas of health care to promote effective choices and increased quality of care. Occupational therapy practitioners are trained in developing person-centered, evidence-based treatment interventions for clients at the level of their daily habits and routines, which promote maximal adherence and integration into daily life (ACOTE, 2006). Self-management has been shown in studies to have significant impact on participants' health, disease/symptom progression and management, and quality of life, while at the same time decreasing costs in the health care system (e.g., Lorig, et al., 1999; 2001). For these reasons we feel that a focus on prevention and self-management should occupy a large role in any goals that are written as a part of the Strategy.

Question #5: Are there existing, well-established, and widely used measures that can be used or adapted to assess progress towards these goals? What measures would best guide public and private sector action, as well as support assessing the nation's progress to meeting the goals in the National Quality Strategy?

In line with our previous statements, we recommend thorough, reliable and valid measures of functional capacity and quality of life. Accurate measure of health status must include measures that are functional and person-centered, in addition to measures of medical care and utilization. Specifically, we recommend utilization of the Activity Measure for Post-Acute Care (AM-PAC) developed at Boston University and endorsed by the AOTA. The AM-PAC was developed utilizing the framework of the International Classification of Functioning, Disability and Health (ICF) by two physical therapists, one occupational therapist, and one physician and is designed as an activity limitations assessment. The AM-PAC is designed to be used across diagnoses, post-acute care health care settings, and is structured to accurately and thoroughly measure a person's functional capacity and activity engagement across 240 functional activities. The AM-PAC is widely

recognized and even included as one of four recommended assessments in Chapter 15 of the Medicare Benefit Policy Manual (Covered Medical and Other Health Services).

However, while the AM-PAC does accurately measure functional capacity at the post-acute level, for this Health Care Quality Initiative to be successful in the long term, we need assessments that will measure functional gains, health status, and quality of life across all health care settings. More comprehensive assessments must be developed, and funding must be provided to do so. A recently developed assessment currently being validated and utilized in research studies is the Continuity and Record Evaluation (CARE) Tool. The CARE Tool was developed to document and assess the medical, cognitive, functional, and discharge status of persons receiving services in both acute and post acute care. Development and utilization of the CARE Tool and others like it will provide improved communication between health care professionals (increased efficiency) and improved uniformity and ability to monitor health trends in communities and across States as well. Improved measures and data will shape best practices and improve the quality of health care, but only if funding is made available for this research and development.

Question #6: The success of the National Health Care Quality Strategy and Plan is, in large part, dependent on the ability of diverse stakeholders across both the public and private sectors to work together. Do you have recommendations on how key entities, sectors, or stakeholders can best be engaged to drive progress based on the National Health Care Quality Strategy and Plan?

The AOTA appreciates the opportunity to provide feedback on the proposed Strategy. Staff members have also attended briefings through the AMA regarding the Strategy's development and intent. Opening the Strategy to public comment is an important part of ensuring that health care professionals as well as patient/client stakeholders have a voice in policy development or grant funding prospects. We feel that continuing to offer public forums and occasions for public feedback is vital and should be continued.

Specific to occupational therapy, the AOTA would welcome the opportunity to provide further feedback, continued support and assistance, and the ability to act as liaison between occupational therapy practitioners and the AHRQ as continued efforts are made to create a Strategy that will benefit health care practitioners and patients/clients alike.

Occupational therapy is a profession that operates in the medical field from a biomedical frame of reference as well as on a person-centered level that is focused on function, participation, and community engagement. Occupational therapy is also a very broad workforce, working in many health care settings with patients throughout the lifespan, addressing diverse needs. These factors provide occupational therapy practitioners a unique, holistic view of health care and one that we believe is very valuable to increase health care's focus on person-centered care, prevention, decreasing health care disparities, increasing efficiency, and improving quality of care. We look forward to the opportunity to share this holistic view and collaborate with AHRQ and other agencies in improving the health care system for all involved.

Sincerely,



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