

To: MCC Workgroup

From: Judy Thomas, Senior Policy Manager

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Subject: MCC Strategic Framework - Comments

The American Occupational Therapy Association (AOTA), representing the interests of over 140,000 occupational therapy practitioners nationwide, appreciates the opportunity to comment on the Interagency Workgroup's Strategic Framework 2010 -2015 for Optimizing Quality of Life for individuals with Multiple Chronic Conditions (MCC). We are pleased to see this initiative, which acknowledges the relationship between chronic conditions and functional status. Indeed functional limitations for individuals with MCC can negatively influence their ability to manage their conditions and to live independently, which in turn may result in increased needs for health care and other resources.

Historically, occupational therapy has addressed the functional limitations and barriers to activity and participation as defined by the International Classification of Function (ICF) terminology. As stated in the *Occupational Therapy Practice Framework: Domain and Process (2nd Edition)*, occupational therapy supports "health and participation in life through engagement in occupation." There are multiple definitions for the term "occupation" in the context of occupational therapy, but in short, "the profession uses the term occupation to capture the breadth and meaning of 'everyday activity.'" (AOTA 2008)

We strongly believe that the existing patient classification and payment systems, which rely heavily on ICD-9-CM diagnoses, are major deterrents to improving the focus on chronic care management, which should include a functional approach to patient needs. It is difficult for providers to embrace the goals of this vision and framework, because of the competing adverse incentives to compartmentalize patient needs by medical diagnosis.

Comments on Specific Goals

As previously stated, AOTA supports the overall goals of the Framework and its desired outcomes. Following are some comments and recommendation on sections where we see gaps/barriers or would like the Workgroup to place particular emphasis.

Goal 1.

Guidance and training, such as accessible continuing education (CE) for health care personnel are critical. Specific emphasis should be placed on tools and training for physicians, nurse practitioners, and other professionals that are the patient's entry point into the health care system. It is essential that primary care practitioners not only recognize the need for coordination of services, but also the value of assuring patients have access to the full spectrum of needed

services through appropriate referrals to therapists and other non-physician practitioners (NPPs). Physicians often are focused on the disease or injury progression and not the individual's functional status.. Physician offices also should follow-up on referrals for specific services to assure effective coordination of care.

Incorporating training relevant to the complexities of individuals with MCCs into existing medical and NPP educational program curricula should be a long-term goal. Funding for additional research into best practices and assuring access to CE should be considered early in the process.

The footnote to strategy 1.A.1. identifies care areas, such as nutrition, physical activity, medication management, etc. Health or social service providers may view these care areas as discrete activities, but for individuals with MCCs, these all relate to functional performance and particularly the performance of daily activities. It is essential that all providers recognize this relationship.

Goal 2. This goal explicitly recognizes a critical factor identified in *Crossing the Quality Chasm* (Institute of Medicine, 2001): *The patient is the source of control*. Effective management of MCCs must move away from a model based on patient "compliance" to a model where patients are active partners with health and social service providers in the management of the patient's health. In the self management literature, self management is framed for the patient in terms that explicitly link traditional provider goals with the patient's experience and priorities.

"Self Management Tasks

1. To take care of your illness
2. To carry out your normal activities (such as chores, employment, social life, etc).
3. To manage your difficult emotional changes" (Lorig, Holman,et.al, 2006)

These goals capture the challenges that individuals with MCC face: managing their condition while simultaneously managing daily life and emotional changes.

Self-care management services are important, but self management must be an implicit goal of health and social service providers and of individuals with MCC. As noted previously, management of MCCs is related to functional status. But this relationship also extends to self management. The areas mentioned in goal 1: physical activity, nutrition, medication management, etc, must be integrated with the other activities and responsibilities of a patient's daily life. Occupational therapy literature contains evidence that inclusion of goals that reflect an individual's specifically stated participation "needs and wants" is related to positive outcomes in Activities of Daily Living (ADL) and Instrumental Activities of Daily Living (IADL) (Yuen, 2007). Much of occupational therapy intervention is about integrating activities which "take care of illness" into routine performance of daily life activities.

The goal of "improving access to in-home and community services" relies on a public policy shift to value the types of programs and services that support independence. Although additional training and re-training of aides is needed, more important is the recognition that professional services and oversight, as well as periodic assessment of function are needed to sustain the positive results of interventions and assure continued success. In a large scale study of community dwelling older adults with MCCs, such an approach, which combining group and individual occupational therapy interventions, health and functional status was sustained and

health costs were lessened as compared with controls receiving usual care. (Clark, Azen, et. al, 1997) More importantly, health and functional status was sustained post-intervention. (Clark, Azen, et. al, 2001) This lifestyle management approach has since been implemented with adults with chronic conditions such as diabetes and chronic pain. We believe that a functional assessment and a course of occupational therapy interventions followed by monitoring of functional status (including use of telehealth resources) would be very effective for many people with MCCs.

Goal 3.

AOTA supports public policy changes, which would improve coordination of care for patients with MCCs. The present Medicare coverage and payment policies, as well as those of most insurance companies, do not provide payment for preventative care; nor do they promote a collaborative environment for multiple providers, as there are limits on payment for consultation time and services. Another barrier, as previously mentioned, are payment systems that categorize individuals by ICD-9-CM codes, focusing solely on medical diagnosis or specific condition. The paucity of functionally related diagnosis codes and language that will support medical necessity and payment as well as the lack of value placed on ADLs and IADLs in payer billing practices often result in claims denials. Professionals should not be adversely affected when trying to treat the “whole” patient and quality of life issues, not just the disease or injury.

Medicare Local Coverage Determinations (LCDs) are inflexible, often requiring specific ICD-9-CM codes which may or may not reflect the multiple problems of the patients. Restrictions on reporting multiple problems also inhibit the ability of occupational therapists to report and treat the array of functional deficits resulting from MCCs.

Re-hospitalizations often occur because no one is aware of changes in a person’s status until a crisis (e.g. falls, infections) arises. This is why professional monitoring with occasional intervention for follow-up to encourage the integration of risk reducing habits into a person’s daily life is essential. When patients are discharged without suitable support systems in place, their risks for re-hospitalization increase.

Electronic health records (EHRs) and other forms of electronic communication such as telemedicine can be extremely effective in treating patients with MCCs. Presently, Medicare does not cover telehealth services by therapists. In order for there to be effective electronic communication, all providers and payers should be required to consistently use an agreed upon listing of terminology and definitions. AOTA supports the use of the ICF terminology in describing barriers to independence and quality of life, and the coding system for tracking progress or regression in specific areas of participation and function.

Goal 4

AOTA supports initiatives to increase the inclusion of individuals with MCC in clinical trials. We also would welcome funding support for observational studies and other research designs that may contribute to our understanding of the effects of combined interventions in different settings. Such studies also could help inform policy by including cost-effectiveness or economic data. Measurements of health care utilization would be extremely useful, as this information is rare in existing studies.

AOTA strongly supports Objective C's intent to increase clinical and patient-centered health research. Of particular importance is the need to know how MCCs affect individuals' abilities to access care, manage their health and daily activities, and participate in their communities. Occupational therapists are ideally suited to identify and understand the complex interactions between chronic conditions, multiple environments, and performance of ADLs and IADLs.

Given the fact that functional limitations play an important role in accessing healthcare, in successfully conducting self-management, and in determining discharge setting (i.e., placement), research is needed to determine which interventions improve functional performance of individuals with a specific subset of individuals with MCCs. For example, certain interventions (e.g., rehabilitation therapies, medication management, and nutritional support) may yield functional improvements for individuals with a specific group of MCCs, such as those with intact cognition and adequate support systems, but not with others.

In summary, we recommend that as part of its tasks, the Workgroup look at existing policies that create disincentives for providers to adequately address the functional needs of people with MCCs. Many Medicare therapy rules (e.g., CCI and MUE edits, local coverage determinations (LCDs) requiring pairing of ICD-9-CM and CPT codes, annual therapy limitation), which are often adopted in part by Medicaid and private plans, reward fragmentation and limitation of coverage and interventions. Claims forms do not clearly reflect MCCs and do not in any way address functional deficits, so reviewers have no way of understanding comprehensive problems that establish the basis for many of the therapeutic services billed.

AOTA would like to see many of the goals to improve ADL and IADL levels in persons with MCCs come to fruition. To that end we would be happy to provide occupational therapy expertise as the Interagency Workgroup explores specific strategies.

Resources

American Occupational Therapy Association. (2008). *Occupational Therapy Practice Framework: Domain and Process (2nd Edition)*. American Journal of Occupational Therapy, 62, 625-683.

Clark F, Azen SP, Zemke R, et al. Occupational therapy for independent-living older adults. *JAMA* 1997;278(16):1321-6.

Clark F, Azen SP, Carlson M, et al. Embedding health-promoting changes into the daily lives of independent-living older adults: long term follow-up of occupational therapy intervention. *J Gerontol* 2001;56B(1):P60-3.

Lorig, K., Sobel, D., Gonzalez, V., Laurent, D. & Minor, M. (2006). *Living a healthy life with chronic conditions: Self management of heart disease, arthritis, diabetes, asthma, bronchitis, emphysema and others*. Boulder, CO: Bull.

Institute of Medicine. (2001). *Crossing the quality chasm: A new health system for the 21st century*. Washington, DC: National Academies Press

Stultjens EEMJ, Dekker JJ, Bouter LM, Schaardenburg DD, Kuyk M-AMAH, Van den Ende ECHM. Occupational therapy for rheumatoid arthritis. *Cochrane Database of Systematic Reviews* 2004, Issue 1. Art. No.: CD003114. DOI: 10.1002/14651858.CD003114.pub2

Triad Healthcare, Inc. TMMP 118 - ACTIVITIES OF DAILY LIVING TRAINING / SELF-CARE MANAGEMENT TRAINING (97535).

www.com.com/providers/policies/pdfs/TMMP_118.pdf

[Included as a resource for relevant articles related to ADL management]

World Health Organization. (2001). *International Classification of functioning, disability, and health*. Geneva, Switzerland: Author

Yuen, HK; Gibson, RW; Yau, MK; Mitcham, MD. *Actions and Personal Attributes of Community-Dwelling Older Adults to Maintain Independence. Physical & Occupational Therapy in Geriatrics*, Jan 2007, Vol. 25, No. 3, Pages 35-53