Occupational Therapy in Primary Care: Self Management & Performance Patterns

Carol Siebert MS, OTR/L, FAOTA
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Learning Objectives

- After attending and participating in this workshop, the learner will be able to:
  - Translate occupational therapy terms and constructs to the language and constructs of chronic condition management.
  - Articulate the unique role and contribution of OT services in improving self-management and quality of life for patients at risk of or living with chronic conditions.
  - Describe intervention approaches and outcomes relevant to primary care.

Chronic conditions by the numbers . . .

- 7 out of 10 deaths among Americans each year are from chronic diseases. Heart disease, cancer and stroke account for more than 50% of all deaths each year.
- In 2005, 133 million Americans – almost 1 out of every 2 adults – had at least one chronic illness.
- Obesity has become a major health concern. 1 in every 3 adults is obese and almost 1 in 5 youth between the ages of 6 and 19 is obese (BMI ≥ 95th percentile of the CDC growth chart).
- About one-fourth of people with chronic conditions have one or more daily activity limitations.
- Arthritis is the most common cause of disability, with nearly 19 million Americans reporting activity limitations.
- Diabetes continues to be the leading cause of kidney failure, nontraumatic lower-extremity amputations, and blindness among adults, aged 20-74.

CDC: http://www.cdc.gov/chronicdisease/overview/index.htm

More numbers . . .

- Average healthcare costs for someone who has one or more chronic conditions is 4-5x average cost for someone without any chronic conditions.
- Chronic diseases account for approximately 75% of healthcare costs in the United States. That’s $3 of every $4 spent on healthcare.
Cost in dollars

- Heart Disease and Stroke: $432 billion/year
- Diabetes: $174 billion/year.
- Lung Disease: $154 billion/year.
- Alzheimer’s Disease: $148 billion/year

Stroke

- Cost of care in the first 30 days following stroke is $13,019 in mild cases, $20,346 in severe cases.
- Lifetime cost of a stroke is approximately $140,048, mainly chronic care and rehabilitation.
- Incidence of strokes decreased 12.8% between 1995-2006 but trend likely to reverse as population ages.
- Projected increase in spending from $65.6 billion in 2008 to $2.2 trillion by the year 2050 if there are no changes in treatment, preventive care, or trends of risk factors (i.e. incidence of obesity).

Diabetes

- Mortality of diabetes increasing by 1.2% annually.
- Predicted 52.9% increase in incidence rate between 2003 and 2023.
- 10% of current healthcare dollars spent on overall direct costs related to diabetes. $92 billion a year (1.5 times the amount spent on stroke or heart disease).
- CDC predicts spending on diabetes care will reach $192 billion in 2020.
Managing chronic conditions has two aspects:
- Care provided by health care professionals
  - Ongoing monitoring/reassessment
  - Prescribing medications/biologicals
  - Laboratory and other tests to monitor the status of the condition
  - Interventions to restore or compensate for impaired body structures and body functions
  - Interventions to restore or compensate for limitations in activities
  - Interventions to address difficult emotions associated with living with a chronic condition

90% of the management of a chronic disease must come from the person who has the disease. California Healthcare Foundation, 2008

(Self) care of one’s chronic condition involves daily living activities.

Managing chronic conditions has two aspects
- (Self) care provided by the person who has the condition
  - Administer/manage medication
  - Administer/manage other treatments
  - Self monitoring activities
  - Activity adjustments
  - Dietary adjustments
  - Role adjustments
  - Coping with difficult emotions
  - Making/attending/participating in encounters with health care professionals

Self management tasks
- Administer/manage medication
- Administer/manage other treatments
- Self monitoring activities
- Activity adjustments
- Dietary adjustments
- Adjusting habits and routines
- Making/attending/participating in encounters with health care professionals
Self management involves:
- Learning and mastering new skills
- Learning new activities
- Altering existing ways of doing
- Incorporating new skills and new activities into existing ways of doing
- Balancing managing the condition(s) with the managing daily life

Self management is

An Approach
- A more patient-centered partnering in problem-solving than the traditional use of knowledge-based patient education on a specific condition.

An outcome
- “Self-management refers to the individual’s ability to manage the symptoms, treatment, physical and psychosocial consequences and lifestyle changes inherent in living with a chronic condition.” (Barlow, Wright, Sheasby, Turner, & Hainsworth, 2002)

Managing Chronic Conditions

What the person with the condition does:
- Self-management
- Everyone self-manages
- Goal is effective self-management: Fewer complications or sequelae, slowed progression, lessened impact on roles and function, lower costs

What the healthcare professional does:
- Self-management support
- Recognition that patient is the manager
- Goal is effective support for self-management: Instruction titrated to patient understanding and needs, collaborative interactions, supportive approaches

Not...

Compliance

Anence
Concordance (UK)

- “Having a consultation that allows mutual respect for the patient’s and professional's beliefs, and allows negotiation to take place about the best course of action for the patient” (Hobden, 2006)
- Emphasizes the nature of the practitioner-client relationship


Administer/manage medication

- Medication routines are a *Self Care Activity* focusing on looking after and maintaining one’s own health (World Health Organization, 2001).

Administer/manage other treatments

- *Health management and maintenance*, an IADL which includes developing, managing, and maintaining routines for health and wellness promotion.
- *Personal device care*, an IADL which includes using, cleaning, and maintaining personal care items, such as hearing aids, contact lenses, glasses, orthotics, prosthetics, adaptive equipment, and contraceptive and sexual devices.
  
  OT Practice Framework, 2nd ed., AOTA, 2008
Self monitoring activities

- Health management and maintenance, an IADL which includes developing, managing, and maintaining routines for health and wellness promotion (Practice Framework, 2nd ed., AOTA, 2008).

Activity adjustments

- Aspects of activity demands:
  - Space demands-physical environmental requirements of the activity
  - Sequence and timing-process used to carry out the activity
  - Required actions and performance skills-usual skills that would be required by any performer to carry out the activity
  - Required body functions
  - Required body structures


Dietary adjustments

- Meal preparation and cleanup: An IADL involving planning, preparing, and serving well-balanced, nutritional meals and cleaning up food and utensils after meals.
- Shopping: An IADL involving preparing shopping lists, selecting, purchasing and transporting items, selecting methods of payment, and completing money transactions.


Adjusting existing habits and routines

- Habits-automatic behavior that is integrated into more complex patterns that enable people to function on a day-to-day basis
- Routines-Patterns of behavior that are observable, regular, repetitive, and that provide structure for daily life.

Making/attending/participating in encounters with health professionals

- IADL
  - Communications management
  - Community mobility
- Performance skills
  - Cognitive skills
  - Communication and social skills
  - Emotional regulation skills

*Practice Framework, 2nd ed., AOTA, 2008*

Compare . . . .

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A role for OT in self management support seems obvious!

**There are opportunities . . . .**
- Other disciplines may address aspects of ADL or IADL, OT addresses daily living activities more comprehensively
- No other discipline claims habits and routines in its domain—yet habitual, routine performance is a key aspect of self management
- Self management is about empowerment

**But there are also challenges**
- Other professions are strongly associated with self management support. OT is not.
- Activities addressed not the “usual ADLs.”
- In most settings, OT is time-limited and typically focused on skills. Difficult to address habits and routines in this context.
- Patient adherence is an important issue in many OT practice venues.

A recommendation to challenge us

"Moving adherence from good intentions to planned and deliberate actions will advance occupational therapy outcomes of care and position occupational therapy philosophy and science at the vanguard of addressing the even larger societal challenges associated with people’s inability to stick with health-promoting lifestyle changes even when they know better." (Radomski, 2011)

Motivational Interviewing

Principles
- Express empathy
- Develop discrepancy
- Roll with resistance
- Support self efficacy

Spirit
- Collaboration
- Acceptance
- Evocation
- Compassion

Motivational Interviewing

Skills
- Open ended questions
- Affirmations
- Reflections
- Summaries
- Eliciting self-motivational statements

Techniques
- Agenda setting
- Asking for permission
- Elicit-provide-elicit
- FRAMES
- Scaling (readiness, importance, confidence, commitment)
- Clarifying choices
- Decisional balance
- Change planning
- Hypotheticals

Motivational interviewing resources

- http://www.motivationalinterview.org

Chronic Disease Self Management Program

- Evidence based program
- Developed at Stanford University
- Manualized program, licensed by Stanford
- Two trained facilitators, one of whom must have a chronic condition
- Group program, delivered in the community
- Currently has significant support from federal DHHS to disseminate

Thanks to Paul Nagy, MS, LPC, LCAS, CCS, for this concise summary of MI basics.
Chronic Disease Self Management Program

- “Toolbox” of strategies to manage a chronic condition
- Recognition that self management involves 3 aspects
  - Managing one’s condition
  - Managing daily life
  - Managing difficult emotions associated with having a chronic condition

Chronic Disease Self Management Program

- Note: The program is designed to be facilitated by laypersons. Healthcare professionals may be certified as facilitators, but by design and by definition, the CDSMP is not skilled intervention, regardless of the credentials of the facilitator.

Lifestyle Redesign ®

Chronic condition management prompts us to revise our understanding of . . .

- Those who receive occupational therapy services.
- Their experience of living with a chronic condition.
- The conditions themselves.
Chronic conditions are associated with or the cause of many of the conditions which trigger referrals to occupational therapy.

But, many of the chronic conditions associated with high human, social and economic cost are typically not the focus of rehabilitative services.

The physicians and other practitioners who do address these conditions are not the practitioners OT typically interacts with.

OT is virtually unknown to primary care providers and also to many of the specialists who deal with conditions such as heart failure, diabetes, COPD and asthma.

Another new perspective . . .

Chronic conditions commonly addressed by occupational therapy:
- Rheumatoid arthritis and other rheumatic conditions
- Multiple sclerosis
- Other auto-immune conditions

OT typically involved at diagnosis and/or during a flare.

Importance of managing the condition to minimize or avert flares.

Management involves more than addressing the performance problems associated with the flare.

Some examples of OT interventions to support management of high priority conditions

- Hypertension
- Diabetes
- Heart failure
- Asthma and COPD

Hypertension

- Contributes to
  - Stroke
  - Heart attack
  - Kidney failure
  - Glaucoma
### Hypertension
- Skills/routines to manage medication
- Skills/routines to prepare low sodium diet
- Skills/routines to obtain low sodium foodstuffs
- Skills/routines to monitor blood pressure
- Skills/routines to implement physical activity recommendations

### Problem solving and task analysis
- What’s the most common “adherence” problem associated with management of hypertension?
- Importance of asking “why?”
- Individualized, contextually-based analysis and problem solving to address the issues and concerns associated with medication.
  - Incontinence
  - Sexual performance

### Diabetes
- An endocrine disorder which can ultimately impair almost every other body system
- Multiple sequelae
  - Vision loss
  - Kidney failure
  - Paresthesias and loss of sensation
  - Infections
  - Amputations
  - Stroke
  - Heart attack

### Diabetes
- Skills/routines to manage medication
- Skills/routines to monitor blood glucose and to respond appropriately to results
- Skills/routines to administer insulin based on prescription and self monitoring
- Skills/routines to manage skincare and skin monitoring
- Lifetime routine encounters with multiple specialists (eyes, feet, etc.)
Diabetes
- Skills/routines to implement dietary recommendations including preparing or ordering meals and obtaining foodstuffs
- Skills/routines to implement physical activity recommendations
- Strategies to routinely compensate for sensory or visual changes
- Skills/routines to recognize and respond to symptoms indicating need for urgent or emergent care

Heart failure
- Major impact on quality of life
- Strong association with emergent hospitalization and rehospitalization

Heart failure
- Skills/routines to manage medication
- Skills/routines to prepare low sodium diet
- Skills/routines to obtain low sodium foodstuffs
- Skills/routines to monitor weight
- Skills/routines to implement physical activity recommendations
- Skills to appraise effort, to pace and plan activity and to routinize energy conservation as lifestyle
- Skills/routines to recognize and respond to symptoms indicating need for urgent or emergent care

Asthma & COPD
- Asthma—more common in children, young adults
- COPD—more common in adults and older adults
### Asthma/COPD
- Skills/routines to manage medication
- Skills/routines to administer inhalers, nebulizers or other inhaled treatments
- Skills/routines to manage supplemental oxygen in routine environments
- Skills/routines to implement physical activity recommendations
- Skills to appraise effort, to pace and plan activity and to routinize energy conservation as lifestyle
- Skills/routines to recognize and respond to symptoms indicating need for urgent or emergent care

### Auto-immune conditions
- These conditions are routinely treated with both medications and disease-modifying agents (DMA) (biologics)
- “Non-adherence” with meds and DMAs can damage other body organs and systems
- Some meds and most DMAs also require bloodwork on a regular basis
- “Side effects” of medications and DMAs
- Energy limitations

### Supporting self management in other conditions more commonly seen by OT
- Auto-immune conditions associated with cycles of flares and remission
- MS
- Rheumatoid conditions

### Some examples
- Bernice
- Diane
- Leroy
- Charles
Connect the dots for ALL relevant audiences
- Communicate what you are doing in terms that are meaningful to those for whom chronic disease management is a priority
  - Physicians and other providers
  - Payers
  - Patients

What is primary care?
- “Primary care is the provision of integrated, accessible health care services by clinicians who are accountable for addressing a large majority of personal health care needs, developing a sustained partnership with patients, and practicing in the context of family and community.” Institute of Medicine, 1996
- “Primary health care is essential health care ... made universally accessible to individuals and families in the community ... through their full participation and at a cost that the community and country can afford.” World Health Organization, 1978

Convergence
- Strong emphasis in Affordable Care Act
  - Primary Care Medical Home
  - Chronic condition management as service and as outcome
  - Community-based care
- Jimmo v. Sebelius settlement
  - Do not have to “expect” or “show” improvement to receive Medicare-covered services.
  - Criterion: a skilled service is needed to sustain/maintain health or functional status.
  - What this means: “rehabilitation potential” is no longer relevant or applicable.
4 Cs
- First Contact care
- Comprehensive care
- Continuous care
- Coordinated care
- Context of family and community

New team
- Primary care medical providers*
- Nurses
- Dieticians
- Certified diabetes educators
- Health educators
- Lay or peer health supports
- Occupational therapy

Who are primary care medical providers?
- Doctors:
  - Family medicine (children & adults)
  - (General) internal medicine (adults)
  - Women’s health providers (adolescents & adults)
  - Pediatricians (children)
- Physician assistants
- Advanced practice nurses/Nurse practitioners
  - Family nurse practitioners
  - Pediatric nurse practitioners
  - Geriatric nurse practitioners

Convergence
- Growing body of evidence in primary care medical literature indicating that
  - Primary care physicians have little awareness of/pay limited attention to the functional status of their patients.
  - Functional/ADL status has an important role in the management and course of two high priority chronic conditions: diabetes and heart failure.
  - An interdisciplinary primary care team, including occupational therapy, can optimize support for chronic condition management.
Functional status in primary care

- A mixed history
  
  “... the clinician is often unaware of the full extent of a patient’s functional disability. Nelson and colleagues, for instance, found substantial disagreement between primary care physicians and their patients in assessments of patients’ functional limitations. Many patients rated themselves somewhat more disabled than did their physicians.” Jette, et al, 1986
  
  - Failure of Physicians To Recognize Functional Disability in Ambulatory Patients (Calkins, et al, 1991)

Physical functioning and chronic conditions

- Richardson, et al. 2012
  
  - Non physician providers, including OT, involved in multicomponent intervention in primary care.
  
  - Feasible to monitor physical functioning as a health outcome for persons with chronic illness in primary care.

Functional status and chronic conditions

- Stewart, et al, 1989
  
  - 9385 adults evaluated on measures of daily functioning and wellbeing at time of physician visits in 3 US cities. Patients with 8 of the 9 most common chronic conditions showed significantly worse physical, role and social functioning; mental health, health perceptions and bodily pain as compared to those with no chronic conditions.
  
  - Chronic conditions have a negative effect on functioning (except for hypertension).
  
  - Interventions directly targeting functional limitations may be beneficial to improve health management of those with chronic conditions.

Chronic conditions are a major focus of primary care
A role for OT

- Relationship of chronic conditions to physical functioning and functional status.
- Relationship of lifestyle/habits and routines to management of chronic conditions.

Primary care

- Longitudinal vs. episodic
- Intermittent encounters
- Incremental change

Primary care . . .

*is a marathon…
not a sprint!*

Opportunities

- Federally Qualified Health Centers
- Co-locating within primary care practices
- Referrals from primary care focused on support for primary care goals
Community Oriented Primary Care

“Community-oriented primary care is the provision of primary care services to a defined community, coupled with systematic efforts to identify and address the major health problems of that community through effective modifications in both the primary care services and other appropriate community health programs.” Institute of Medicine, 1984

In your community?

- Do you have a connection to primary care settings and providers?
- Are you providing OT to individuals with one or more chronic conditions?
- Where are the opportunities in your current practice to collaborate with primary care providers?
- Where are the opportunities in your community to provide primary care services?

Opportunity and challenge

- With our focus on daily activities and approaches which focus on client empowerment and sustained participation, occupational therapy is ideally positioned to address contribute to primary care services and outcomes?
- Are you ready?
- Are you willing?
Thank you!

Carol Siebert

carol@the-home-remedy.com