Occupational Therapy Plans of Care Affecting Chronic Condition’s Outcomes
(Not Just Upper Extremity Strengthening)

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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

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International Classification for Functioning, Disability and Health

- World Health Organization (WHO) family of international classifications
- Conceptual basis for the definition, measurement and policy formulations for health and disability.
- From emphasizing people's disabilities, we now focus on their level of health.
- ICD-10 is based on ICF.
International Classification for Functioning...

Body Function
- Upper extremity range of motion
- Upper extremity muscle strength
- Fine/gross motor coordination
- Breath capacity
- Pain

Activity
- Reaching for clothes, brushing hair
- Picking up a pan full of food, using a can opener
- Opening pill containers, buttons, zippers, snaps
- Meal prep w/o SOB
- Any activity restriction

But the home health population needs more than this....
Home Health Population

- Older
- Homebound
- Exacerbation or new (additional) diagnosis
- Chronic condition(s)
  - Cardiac/circulatory/CHF
  - Diabetes/diabetic complications
  - COPD
  - Neuromuscular or orthopedic conditions

**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>Osteoarthritis 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><strong>Total</strong></td>
<td></td>
<td><strong>37.6</strong></td>
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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.”
  -Bodhener, Lorig, Holman & Grumbach, 2002.

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)
- 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>
</thead>
<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>
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<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</td>
<td>• Role-related activities and habits</td>
</tr>
<tr>
<td>encounters</td>
<td></td>
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</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.
### The Domain of Occupational Therapy

"With what is OT concerned?"

#### Supporting Health and Participation in Life through Engagement in Occupation

<table>
<thead>
<tr>
<th>Areas of Occupation</th>
<th>Performance Skills</th>
<th>Performance Patterns</th>
<th>Contexts &amp; Environment</th>
<th>Activity Demands</th>
<th>Client Factors</th>
</tr>
</thead>
<tbody>
<tr>
<td>ADL, IADL, Rest &amp; sleep</td>
<td>Motor &amp; praxis skills</td>
<td>- Habits</td>
<td>- Cultural</td>
<td>- Objects &amp; their properties</td>
<td>- Values, beliefs &amp; spirituality</td>
</tr>
<tr>
<td>Education, Work, Play, Leisure, Social participation</td>
<td>Sensory-perceptual skills</td>
<td>- Routines</td>
<td>- Personal</td>
<td>- Space demands</td>
<td>- Body functions</td>
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<tr>
<td></td>
<td>Emotional regulation skills</td>
<td>- Rituals</td>
<td>- Temporal</td>
<td>- Social demands</td>
<td>- Body structures</td>
</tr>
<tr>
<td></td>
<td>Cognitive skills</td>
<td>- Roles</td>
<td>- Virtual</td>
<td>- Sequence &amp; timing</td>
<td></td>
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<td></td>
<td>Communication &amp; social skills</td>
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<td>- Physical</td>
<td>- Required actions &amp; performance skills</td>
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- ADL: Activities of Daily Living
- IADL: Instrumental Activities of Daily Living

**Occupational Therapy Practice Framework: Domain and Process, 2nd ed., AOTA, 2008**
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

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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 measureable 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).
Translating Jimmo to careplan

- Relevant factor is *need for skilled occupational therapy*
- Goals and care plan should make the need and the outcome explicit.
- Focus on how performance will be affected (quantitatively or qualitatively) as the result of OT intervention. (Don’t get hung up on maintenance).
- Outcomes framed in terms of performance.

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)

Therapy re-assessment = Intervention Review

- Re-evaluate the plan
- Modify the plan
- Determine need for continuation or discontinuation
- Re-evaluate the plan, not the patient
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
- 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 (attached)
  AOTA Role of OT in Diabetes Management Fact Sheet (attached)
  Other AOTA resources (see AOTA booth in the expo)
• Role of OT in Medication Routines (attached)

Outcomes in the Context of Home Health

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

Occupational Therapy is Outcomes!
Occupational therapy practitioners are effective and important components of any home health agency's patient care and administrative teams. Occupational therapy practitioners can have many roles in improving efficiency, implementing new administrative requirements, and optimizing outcomes for patients.

**Occupational therapy can perform admission visits.** Occupational therapists can conduct the initial assessment visit and the start of care comprehensive assessment on therapy-only patients for whom occupational therapy “establishes eligibility” (Conditions of Participation, 42CFR484.55). For many payers (e.g., Medicaid, private insurance), occupational therapy does establish the initial eligibility for home health, even though Medicare restricts occupational therapy as a qualifying service only to when there is a “continuing need” (see below). But agencies and consumers should not restrict options for initial visits for non-Medicare beneficiaries. Occupational therapy can be a valuable resource to conduct the initial visits, increasing the number of available staff to conduct initial visits, addressing home safety issues earlier and identifying established routines to share with team members for improved participation by the patient in the plan of care.

**Occupational therapy qualifies a Medicare patient for continued home health eligibility.** A continued need for occupational therapy can extend eligibility under Medicare because the need for occupational therapy alone qualifies Medicare patients for continuation of the home health benefit and thus for any dependent aide and medical social work services the patient needs (Medicare Benefit Policy Manual, Chapter 7, Section 40.24). Occupational therapy may be the only continuing service needed by patients, but it is sufficient to qualify for continued coverage of Medicare home health services. “Subsequent to an initial covered occupational therapy service [visit], continuing occupational therapy services which meet the requirements of §409.44(c) are considered to be qualifying services” (Beneficiary qualifications for coverage of services, 42CFR409.42(c)(4)).

**Occupational therapy can collect OASIS data at any time point subsequent to the start of care.** OASIS accuracy ensures that payment is appropriate and outcomes are accurate, benefiting the agency and the patient. Occupational therapy practitioners can contribute to this process. Once competency is established, occupational therapists are well prepared to perform assessments collecting OASIS data at resumption of care, other follow up, recertifications, and discharge time points (OASIS Guidance Manual). Furthermore, occupational therapists can help other agency staff understand the most effective techniques to assess patient needs, activities of daily living (ADLs), and instrumental ADLs to more correctly complete the OASIS and develop a plan of care. Occupational therapists can provide this guidance based on their unique training and perspective, which focuses on functional capabilities.

**Occupational therapy can assist in aide supervision and in training of aides** to maximize effectiveness and promote patient recovery. An occupational therapist may supervise the home health aide when nursing services are not on the plan of care, but occupational therapy is on the plan (Conditions of Participation, 42CFR484.36). (Note: Some states require nursing to always supervise aides; check your state regulations.) Whether supervising or not, occupational therapy can “fine tune” the aide care plan so that aide services help to move the patient toward independence in self-care, potentially speeding progress while reducing needed aide visits and the length of the home health episode.
Occupational therapy contributes to stronger outcomes—for your patients and your agency.

Patients and their families are concerned about your patients’ abilities to take care of themselves and to manage at home safely. Some patients have the potential to regain skills affected by their conditions. Other patients need strategies to prevent further loss of abilities. Regardless of specific diagnosis or condition, occupational therapy practitioners offer strategies for your patients to manage daily activities while reducing the risk of injury or further decline (Goldberg, 2009; Ryan, 2006). Occupational therapy practitioners find the right fit between patients’ abilities, needed and desired activities, and their home environment so patients can manage safely and productively—at home.

You are also concerned about your patients’ ability to manage their conditions. Management of chronic conditions is in large part management of daily activities. Occupational therapy brings expertise to help patients translate “doctor’s orders” to manageable daily habits and routines (Bondoc & Siebert, 2010). Occupational therapy can strengthen outcomes related to:

- **Medication management**: Occupational therapy addresses strategies to enhance medication adherence and integrate medication management into patients’ daily routines (Sanders & Van Oss, 2013, Touchard & Berthelot, 1999).
- **Daily management of conditions such as**:
  - **Diabetes**: Occupational therapy addresses the many aspects of diabetes management that must become daily routines: blood sugar monitoring, hygiene and foot care, meal planning and preparation, healthy coping strategies, and physical activity. Occupational therapy practitioners can also train patients with diabetes to use compensatory strategies for vision, sensory, or motor loss that may interfere with their daily activities (Sokol-McKay, 2011).
  - **Heart failure**: Occupational therapy addresses strategies to conserve energy and reduce the demands of activities, while integrating appropriate physical activity and self-monitoring. Occupational therapy practitioners can assist patients to master new activities—daily weights, modified diets—and incorporate these activities into regular routines (Branick, 2003; Norberg, Boman, & Lofgren, 2010).
  - **Chronic obstructive pulmonary disease**: Occupational therapy addresses strategies to conserve energy, reduce the demands of activities, and self-monitor to avoid exacerbations. Occupational therapy practitioners can assist patients to incorporate pacing, planning, and stress management into daily activities (Branick, 2003).
  - **Cognitive and behavioral health conditions**: Occupational therapy addresses daily routines, medication adherence, self-management, and stress management strategies. With a core knowledge base in psychosocial issues, occupational therapists can also address behavioral health conditions and train caregivers to provide appropriate cues and support to patients with cognitive limitations to optimize performance and reduce agitation or confusion.

References


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Occupational therapy practitioners can play a strong role in diabetes education and self-management for individuals who are likely to develop the disease as well as those who are already diagnosed.

Diabetes is characterized by hyperglycemia (high blood glucose) resulting from the body’s inability to use the sugar from food eaten for energy. It is a systemic disease that can affect the body on both an immediate and a long-term basis. The most prevalent acute complication is hypoglycemia or low blood glucose. Hypoglycemia is a potentially life threatening condition requiring immediate and appropriate treatment. When blood glucose levels are persistently high, a wide range of chronic complications can occur. These can include kidney disease, vision loss, heart disease, stroke, and neuropathy, among others. Many of these long-term complications can be barriers to performance of activities necessary to successfully self-manage diabetes. Diabetes is also frequently accompanied by depression and anxiety.

Occupational therapy practitioners are experts at analyzing the performance skills and patterns necessary for people to engage in their everyday activities (occupations). They can effectively educate and train persons at risk for or who currently have diabetes to modify current habits and routines and develop new ones to promote a healthier lifestyle and minimize disease progression. Occupational therapy practitioners can assist clients to develop simple, concrete, measurable, and achievable self-management goals consistent with the seven behaviors advocated by the American Association of Diabetes Educators (AADE). These AADE 7™ Self-Care Behaviors are: (1) healthy eating, (2) being active, (3) monitoring, (4) taking medications, (5) problem solving, (6) healthy coping, and (7) reducing risks. Some behaviors, such as healthy eating, are self-explanatory, whereas others are more involved. For example, monitoring includes not only blood glucose testing but also tracking blood pressure, weight, foot health, and “steps walked” to ensure the person is getting enough physical activity. Similarly, reducing risks encompasses a diverse group of behaviors including, but not limited to, smoking cessation; foot self-inspections; maintenance of personal health records; and regular eye, foot, and dental exams, creating a need for clients to track and diligently attend appointments with their diabetes health care team.

According to AADE’s disabilities position statement, occupational therapy practitioners are viewed as part of the diabetes self-care team. Occupational therapy practitioners are knowledgeable about the impact of medical conditions on an individual’s day-to-day and long-term functioning. Through their holistic approach they address the physical, cognitive, psychosocial, and sensory aspects inherent in the performance of everyday life activities. Occupational therapy practitioners develop a collaborative relationship with their clients to prioritize what they want and need to accomplish—which is critical in a disease requiring self-management 24 hours per day, 7 days per week. Occupational therapy practitioners can modify or adapt how their clients perform their desired self-care tasks to promote ease and success in achieving their goals in managing this disease.
What Can an OT Practitioner Do for a Person With Diabetes?
Occupational therapy practitioners can fill diverse roles when working with clients to prevent and manage diabetes, including those who have developed a disability. They can incorporate general diabetes information into their instruction or they can specialize by adapting information to a particular population (e.g., persons with vision loss or amputations) or to a particular topic (carbohydrate counting or physical exercise). By way of example, the occupational therapy practitioner can:

- Promote healthy food choices and safe cooking methods;
- Instruct in safe and appropriate ways to incorporate exercise and physical activity into daily routines;
- Provide techniques to organize and track medications;
- Instruct in the use of low-vision and nonvisual devices to draw up and measure insulin;
- Instruct and provide strategies to successfully use a talking blood glucose monitor or use any blood glucose monitor one-handed;
- Incorporate protective techniques and compensate for peripheral sensory loss in activities that involve exposure to heat, cold, and sharp objects;
- Educate in techniques to structure time and simplify activities to cope with depression such as breaking down dietary changes and an exercise program into manageable steps and incorporating them into present daily routines.3

Who Can Benefit, and Where Are Such Services Provided?
Persons who can benefit from occupational therapy range from those who would like to implement a lifestyle that reduces the risk of diabetes to those who already have diabetes and complications that interfere with their ability to complete self-care activities and manage the disease. Clients of any age with diabetes can benefit from occupational therapy to address their specific self-care needs and preferences.

Occupational therapy can be provided in a wide range of settings, such as a client’s home, an outpatient clinic, or a hospital. It can also be provided through a program that focuses on wellness and prevention or one that focuses on medical treatment and rehabilitation for complications resulting from diabetes. Sometimes occupational therapy is available in a more specialized setting such as a diabetes clinic or low vision program. Services can be provided on a one-to-one basis or within a group and, depending on the topic, can include oral instruction, demonstration, hands-on experiences, group activities, and role playing.

Conclusion
Occupational therapy focuses on lifestyle modification, health promotion, remediation of physical and visual impairments, and maximizing self-care independence, all of which are directly and adversely affected by diabetes and its complications. Occupational therapy practitioners focus on helping clients take charge of their diabetes as opposed to being controlled by it, so they can participate in everyday activities.

References
The Role of Occupational Therapy in Assessing and Supporting Medication Routines

Medication routines (including administering and managing medications) are an Instrumental Activity of Daily Living (IADL) that is within the domain of occupational therapy (AOTA, 2008). Medication routines are a Self Care Activity focusing on looking after and maintaining one’s own health (World Health Organization, 2001).

The Occupational Therapy Process

Evaluation:
- Occupational profile: elicit history, strength, needs from perspective of the client
- Analysis of occupational performance
  - Observe client’s performance in activity
  - Note effectiveness of performance skills and patterns
  - Select assessments to identify factors (contexts, activity demands, client factors) that may be influencing performance patterns and skills
  - Employ activity analysis
  - Interpret assessment data to identify facilitators and barriers to performance
  - Collaborate with client to create goals

Intervention
- Establish/restore performance skills, performance patterns, client factors
- Maintain performance skills, performance patterns, physical environment, activity demands
- Modify performance patterns, physical environment, activity demands
- Prevent: performance skills, performance patterns, activity demands, client factors

Application of the Occupational Therapy Process to medication routines

Case example: Performance patterns:
Mrs. P reports that she forgets to take some of her medication. Analysis of performance indicates she understands dosing and is able to manage dispensing and administering. She seldom misses her medications in the morning. However, after a recent hospitalization, she was prescribed a new medication to be taken at bedtime, and an existing medication must now be taken twice a day. The OT works with Mrs. P to incorporate the sequencing and timing demands of the medication dosing into existing routines while maintaining the effective morning routine. Mrs. P reports she likes to read when she goes to bed. They collaborate on a plan: Mrs. P will maintain the container of nighttime medications along with a second container of the twice a day medication on her nightstand next to her book. Once a week she will place a bottle of water on her nightstand and will take her medications each night before she reads her book. Two weeks later Mrs. P reports she has missed her nighttime medications only once, on a night when she went straight to bed and did not read.

Case example: Activity demands:
Mr. J is experiencing problems managing his medications. He takes 9 different oral medications and has 4 different dosing times. His daughter has been dispensing his medications into a 7 day “mediplanner” in efforts to simplify the task, but over two weeks, he has missed many doses, sometimes dispensed doses from the wrong compartment and, in one instance, pulled the cover off the entire planner and spilled all the pills on the floor.
Analysis of performance indicates that Mr. J does not understand the organization of the mediplanner and that the fine motor demands required to open the compartments exceeds his pinch and dexterity capacity. The OT identifies an alternative 7 day mediplanner with fewer fine motor demands and a more intuitive organization to reduce the required actions of the task. The OT works with the nurse to create an instructional card that corresponds to the mediplanner to provide additional cueing and to allow Mr. J to track (cross off) each dose as he takes it through the week. On followup three weeks later, Mr. J reports that he has gotten used to the mediplanner and no longer needs the instructional card.

Case example: Activity demands, performance patterns and contexts:
Ms. L’s diuretic dose has been increased after a hospitalization for heart failure. However, Ms. L reports she had not been consistent in taking the dose that was previously prescribed. Ms. L is aware that the heart failure is very serious and she “should” be taking her medications as ordered. She reports that when she takes the diuretic as ordered, she has to get up to urinate at least 4-5 times each night, that she has soiled her clothing and her bedding, that she has fallen once rushing to get to the bathroom and she is afraid to go to church because she is afraid of having a voiding accident. Analysis of performance indicates that Ms. L has some limitations in fine motor skills due to arthritis. Her ambulation is stable but she uses a cane. Analysis of the physical environment indicates that there is one bathroom in her house and her bedroom is the farthest from the bathroom. The OT and nurse collaborate with Ms. L on an intervention plan which includes: 1) incorporating timed voiding into existing routines, 2) minimizing garment fasteners and optimizing easy to don/doff clothing to reduce fine motor demands, 3) using a bedside commode at night to reduce sleep disruption and risk of injury (prevention), 4) incorporating dietary restrictions into existing meal preparation routines and preferences. The goals of the intervention plan are to 1) reduce or eliminate unintentional voiding while 2) taking prescribed diuretic as ordered and 3) efforts to reduce need for diuretic by reducing dietary sodium.

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Relationship to Home Health Drug Regimen Review and OASIS Items Pertaining to Medication

**42 Code of Federal Regulations 484.55 (c): Drug regimen review:** A review of all medications the client is currently using in order to identify any potential adverse effects and drug reactions, including ineffective drug therapy, significant side effects, significant drug interactions, duplicate drug therapy, and noncompliance with drug therapy. Must be completed each time the comprehensive assessment, including OASIS, is conducted.

### Application of occupational therapy process to the elements of the drug regimen review

<table>
<thead>
<tr>
<th>Review Element</th>
<th>Occupational profile/Analysis of performance</th>
<th>Example(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ineffective Drug Therapy</td>
<td>Does the client report symptoms or exhibit signs that current medication is ineffective?</td>
<td>Client takes medication for pain but reports breakthrough pain or pain that interferes with activity.</td>
</tr>
<tr>
<td>Significant Side Effects</td>
<td>Does the client report symptoms or exhibit signs of significant side effects?</td>
<td>Client is lethargic and unable to stay awake.</td>
</tr>
<tr>
<td>Significant Drug Interactions</td>
<td>Requires collaboration with another clinician and/or pharmaceutical software to identify interactions</td>
<td>Client reports dizziness when taking a specific medication.</td>
</tr>
<tr>
<td>Duplicate Drug Therapy</td>
<td>Are there redundant prescriptions? Also requires collaboration with another clinician and/or pharmaceutical software to identify duplications</td>
<td>Client is taking meds from two different bottles. Label instructions are identical but filled at different pharmacies and pills are different colors.</td>
</tr>
<tr>
<td>Noncompliance with Drug Therapy</td>
<td>Does the client report not taking ordered medications or report dosing that differs from what is ordered?</td>
<td>Label dosing is 3 times/day but client reports taking medication only once a day.</td>
</tr>
</tbody>
</table>

### Application of the occupational therapy process and professional interdisciplinary communication to complete OASIS Items pertaining to medication

| OASIS Item M2000 Drug Regimen Review: | Does a complete drug regimen review indicate potential clinically significant medication issues, e.g., drug reactions, ineffective drug therapy, side effects, drug interactions, duplicate therapy, omissions, dosage errors, or noncompliance? (Completed at start of care/resumption of care) | Record all medications being taken by the patient, including dosage and frequency. Communicate with designated agency staff re: drug regimen review findings, including any determinations of duplication or drug interactions identified by designated clinician. Answer yes if any clinically significant issues were identified. |
| OASIS M2002 Medication Follow-up: | Was a physician or the physician-designee contacted within one calendar day to resolve clinically significant medication issues, including reconciliation? (Completed at start of care and resumption of care) | If clinically significant medication issues were identified, communicate with designated agency staff to determine whether issues were communicated to physician or physician-designee and resolved within one calendar day. Answer yes if communication and resolution occurred within one calendar day. |
| OASIS M2004 Medication Intervention: | If there were any clinically significant medication issues since the previous OASIS assessment, was a physician or the physician-designee contacted within one calendar day of the assessment to resolve clinically significant medication issues, including reconciliation? (Completed at transfer of care and discharge) | Review patient record and confer with other members of patient care team to determine if any clinically significant medication issues were identified since last OASIS time point, and if the issues were communicated to the physician (or designee) within one calendar day of identification. Answer yes if communication and resolution occurred within one calendar day. |
| OASIS M2010 Patient/Caregiver High Risk Drug Education: | Has the patient/caregiver received instruction on special precautions for all high-risk medications (such as hypoglycemics, anticoagulants, etc.) and how and when to report problems that may occur? | Review patient record and own interventions, and confer with other members of patient care team to determine whether (since previous OASIS timepoint): 1) patient is taking high risk medications, 2) has received instruction on special precautions related to such medication, and 3) instruction included how and when to report problems. Answer yes of all 3 elements are true. |
| OASIS M2015 Patient/Caregiver Drug Education Intervention: | Since the previous OASIS assessment, was the patient/caregiver instructed by agency staff or other health care provider to monitor the effectiveness of drug therapy, drug reactions, and side effects, and how and when to report problems that may occur? | Review patient record and own interventions, and confer with other members of patient care team to determine if, since last OASIS data collection timepoint, patient was instructed to monitor medication effectiveness, drug reactions and side effects and patient was instructed in how and when to report problems. Instruction may be from agency staff or another health care provider. Answer yes if such education was provided. |