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## ACCOUNTABLE CARE ORGANIZATIONS AND MEDICAL HOMES

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### HEALTH CARE REFORM

The Patient Protection and Affordable Care Act of 2010 (ACA) is designed to change the way health care services are delivered and reimbursed in the United States. Health care reform efforts stemming from the ACA will introduce important changes for providers and consumers that are expected to unfold over the next decade.

### ACCOUNTABLE CARE ORGANIZATIONS

The Accountable Care Organization (ACO) is a new type of health care entity established by section 3022 of the ACA. ACOs will be integrated networks of providers (hospitals, outpatient clinics, primary care centers, community clinics, inpatient rehabilitation facilities, long-term care hospitals, physicians and physician groups, private practitioners—such as occupational therapists—and others) that agree to work together to improve individual and population level health outcomes, coordinate care, and share accountability for the quality, cost, and outcomes of their patients. ACOs able to address rapidly rising health care costs and related inefficiencies (*e.g.*, acute readmissions, duplication of services) while meeting quality standards will be financially rewarded with a share of the savings. To participate in the program, a prospective ACO must accept responsibility for at least 5,000 beneficiaries; establish a governing body that includes patients and providers (possibly occupational therapy practitioners); develop a plan for routine self-assessment, monitoring, and reporting of care; agree to participate for a period of 3 years, and take responsibility for each patient's entire continuum of care. Patients retain their choice of provider and are not required to see only providers within the ACO, although care may be more easily integrated when all providers function on the same team.

Payment for ACOs will be based on a benchmark amount set for specific outcomes, instead of the current system in which each service is reimbursed on a fee-for-service basis. The goal is for the provider network to achieve an outcome at a cost less than the defined amount. A share of the financial savings that are achieved by the coordinated providers—through mechanisms such as prevention of a condition, improved self-management, reduced hospitalization and rehospitalization, decreased length of stay, and/or successful and effective discharge planning and transitions—will be shared among all providers. Financial disincentives will apply when quality targets are not met. ACOs are being initiated under Medicare, but the model is poised to potentially become a standard approach to health care delivery when state-based insurance exchanges are established in 2014.

Occupational therapy practitioners can play an integral role in ACOs by utilizing their unique skills and qualifications: Assessments can focus on the improvement of a patient's quality of life and include evaluations of home safety, ADL and IADLs, participation\*, vision, ergonomics, driving, fall risk, swallowing, pediatric, and mental health. Practitioners can also pursue education and training in certain specialized areas by accessing AOTA resources, for instance, additional certification may be obtained as recognition of your advanced knowledge and expertise (see [www.aota.org/Practitioners/ProfDev/Certification.aspx](http://www.aota.org/Practitioners/ProfDev/Certification.aspx)). The profession has much to offer, and we must be ready and prepared to demonstrate all we have to offer in order to maintain a place in this new and exciting health care model.

## MEDICAL HOMES

Central to the ACA health care reform initiative is the development of innovative models of health care delivery systems that will reduce fragmentation of care, improve efficiency and outcomes, and reduce health care costs. Separate from ACOs, the Patient-Centered Medical Home (Medical Home or PCMH) is a primary care model based on patient-centered, coordinated, team-driven care and supported by strong health information technology (HIT). Although the ACO structure houses many practices under one umbrella, the Medical Home is centered on a single practice: Each patient is assigned to a physician-directed practice and a personal physician, and the two are jointly held accountable for providing and coordinating the entire spectrum of that patient's care needs, including physical and mental health, prevention and wellness, acute care, and chronic disease and disability management.

To accomplish this goal, Medical Homes are designed to embody the following attributes:

- Patient-Centered
  - Care is organized around a patient's core needs
  - Providers strive to understand and respect a patient's unique needs, values, culture, and preferences
  - Patients learn to manage their own care
  - Patients and their families are considered core members of the health care team.
- Comprehensive
  - Covers the entire spectrum of patient care
  - Patients have a core team of providers that can include occupational therapists and ranges from physicians, nurses, and physician assistants to care coordinators, pharmacists, nutritionists, social workers, and case managers
  - Care can be provided both on-site and by virtual teams.
- Coordinated
  - Care is coordinated across all elements of the health care system including hospitals, office settings, home health, specialist services, and community services and supports
  - Transitions across sites of care are managed (from a hospital to a sub-acute setting)
  - Open and clear communication between patients, their families, and other members of the broader care team.
- Accessible
  - Delivers accessible services with shorter wait times
  - Enhanced in-person hours of delivery
  - Provides around-the-clock telephone or electronic access to providers
  - Is responsive to patients' preferences regarding access to care.
- Focused on Quality and Safety
  - Demonstrates a commitment to quality and quality improvement
  - Utilizes evidence-based medicine and clinical decision support tools
  - Measures the patient experience and patient satisfaction
  - Practices population health management
  - Shares quality and safety data publically
  - Utilizes advanced HIT systems to support the entire process.

Not simply a place of care, Medical Homes seek to improve individual and population level health outcomes as well as the patient experience, and the potential exists for this model to be widely adopted by insurance plans in the exchanges.

## IMPLICATIONS FOR OCCUPATIONAL THERAPY

The occupational therapy profession can play an important role in both ACOs and Medical Homes, as many of the principles driving efforts to transform primary care through these integrated care systems align with traditional occupational therapy education, beliefs, and values. Practitioners are trained to improve quality of life, function, and participation. They provide team-based, coordinated care that is patient-centered, family-focused, and that treats the whole person within the meaningful context of his or her everyday life and across his or her lifespan. These core components of the profession are likewise core components of ACOs and Medical Homes.

Under the ACA—and thus under these two systems, as well—all providers, including occupational therapy practitioners, will be held accountable for providing high quality, patient-centered, evidence-based care at reduced cost. Occupational therapy practitioners must be able to clearly articulate their program of care, the cost of that care, their role on the team, and the expected outcomes of their care. Knowledge of existing effectiveness standards is essential. Along with traditional occupational therapy evaluation and treatment interventions, some examples of how occupational therapy can be an integral part of ACOs and Medical Homes include: screening for functional deficits upon entrance; addressing function and safety during discharge planning to prevent rehospitalization; managing care—especially for chronic conditions such as diabetes, neurological conditions, or mental illness—to promote self-management; screening and prevention in areas such as falls; and other wellness interventions that will help achieve quality outcomes at a reduced cost.

Below are some steps occupational therapy practitioners can take to get involved in the dialogue and process surrounding the development of integrated models of care:

- The ACO and Medical Home are appropriate venues for occupational therapy to demonstrate effectiveness with chronic conditions. Perfect your program materials and gather related effectiveness literature to advocate for occupational therapy's inclusion in disease and care management.
- At the local facility or program level, occupational therapy practitioners should seek out and become involved with ACO and Medical Home planning, including being on management teams that may be developing these new models.
- Occupational therapy practitioners can take a proactive role by developing collaborative relationships with core providers and demonstrating a strong presence on the health care team. Key contexts include pediatrics, rehabilitation, stroke, brain injury, and autism.
- Occupational therapy practitioners may consider additional certification—such as Low Vision, Driving Evaluations, and Home Safety Evaluations—to remain competitive and help establish their expertise.
- The Medicare Health Risk Assessment (HRA) authorized under the ACA is part of a required annual wellness visit (AWV) for Medicare beneficiaries and contains sections on activities of daily living (ADLs) and instrumental activities of daily living (IADLs). This assessment may be the basis for defining and improving health behaviors and chronic disease management within both ACOs and Medical Homes. Occupational therapy practitioners should become familiar with this benefit and work to ensure that during visits appropriate services are suggested and ultimately provided to address any health concerns.
- Occupational therapy practitioners should participate in the process of electronic health record implementation within their institutions and practices to ensure that the purpose and language of occupational therapy is articulated so that outcomes are properly identified with occupational therapy.
- Occupational therapy practitioners working for organizations already experienced in providing coordinated care across settings will likely be the first to be involved with an ACO. Coordinated care across settings, from wellness and prevention programs through care management for chronic conditions, will be important aspects for occupational therapy involvement. Talk with your administrators about the implementation process and find out how you can become involved.

## **Additional Resources**

\* Participation is a person's involvement in a life situation. It represents the societal perspective of functioning. World Health Organization (2001). *International classification of functioning, disability and health (ICF)*, 213.

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