Achieving the Goals of Health Care Reform:

Introduction to Occupational Therapy in Primary Care

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Building Health Enhancing Communities

**Beneficence**  
**Nonmaleficence**

**Autonomy**  
**Social Justice**

* Darrell G. Kirch, MD  
  David J Vernon, BA  
The Ethical Foundation of American Medicine: In Search of Social Justice  
JAMA April 8, 2009, Vol 301, No. 14: 1482-1484
2011: BAD MEDICINE IN AMERICA

- 2011: More than 50 million uninsured in the US.
- 2011: The US spends 17% of GNP, and $7,000.00/capita on healthcare, but ranks less than 20\textsuperscript{th} in the world on healthcare quality.
  Compared to 5 nations- Australia, Canada, Germany, New Zealand, UK.
  The US ranks last in 5 dimensions of “high performance health systems.”
  1. Last in “Quality.”
  2. Last in “Access.”
  3. Last in “Efficiency.”
  4. Last in “Equity.”
  5. Last in “Healthy Lives.”
Walking in the Shoes of Our Providers and our Patients...

• The Providers work within a “Frantic Bubble.”

• The Patients are in “Limbo.”

1992: Barbara Starfield, MD/MPH

*Primary Care: Concept, Evaluation, and Policy*

“The Four Pillars of Primary Care”:

- Personal Relationship with a Physician and Physician-Led Care Team Over Time.
- Immediate Access to the Right Care, at the Right Time, at the Right Place.
- Care is Comprehensive.
- Care is Coordinated.
Health Delivery System Transformation

Acute Health Care System 1.0
- High quality acute care
- Accountable care systems
- Shared financial risk
- Case management and preventive care systems
- Population-based quality and cost performance
- Population-based health outcomes
- Care system integration with community health resources

Coordinated Seamless Health Care System 2.0
- High quality acute care
- Accountable care systems
- Shared financial risk
- Case management and preventive care systems
- Population-based quality and cost performance
- Population-based health outcomes
- Care system integration with community health resources

Community Integrated Health Care System 3.0
- High quality acute care
- Accountable care systems
- Shared financial risk
- Case management and preventive care systems
- Population-based quality and cost performance
- Population-based health outcomes
- Care system integration with community health resources
The “Medical Home”

- Personal Physician: **Longitudinal Relationship**
- Care Team: ”**Team Organized Care**”
- Primary Care: **B. Starfield’s “4 Pillars”**

Whole Person Orientation
Coordination/Integration of Care
Quality/Safety
Enhanced Access
Financing
Payment for Medical Home

• Enhanced *Fee-for-Service* payments for E&M.
• Additional *E&M Codes for Medical Home activities*.
• *Per patient per month Medical Home payments* to augment Fee-For-Service payments.
• *Risk-Adjusted Comprehensive* per patient per month payments.
February 17, 2009: Congress defines “Meaningful Use”
The Patient Protection and Affordable Care Act...

http://healthreform.kff.org/the-animation.aspx

1. Health Insurance Exchanges and New Market Rules
2. New Nonprofit Plan Choices
3. Minimum Medical Loss Ratios (80-85%)
4. Incentivizing **Primary Care and Prevention**
5. Innovative Provider Payment Reform: **Payment for PCMH**
6. Creating **Accountable Care Organizations**
7. Spending Growth Control: Independent Payment Advisory Board
8. **National Strategy to Improve Health Care Quality**: QI Reporting
9. Medicare Private Plan Competition
10. Promotion of Consumer Cost-Consciousness
How Do We Define, “Success” in Healthcare Reform?

Healthcare Value = Quality/Cost

• Increased **ACCESS** to high value care
  (Enhanced Patient Experience/Improved Care Processes)
• Increased **QUALITY** of the care provided.
• Decreased **COST** of the care provided.

*The Institute for Healthcare Improvement, [www.ihi.org]: “THE TRIPLE AIM” is...
*Better Care, Better Outcomes, Decreased/Stabilized Costs*
2007: Thomas Bodenheimer and Kevin Grumbach
Improving Primary Care

PROBLEM:
US Population Increase 18% and >65 73% by 2025
27% shortage of adult primary care physicians by 2020
65,000 primary care physician shortage by 2025

SOLUTION:
Interprofessional Care Teams to improve care and lower costs
for patients with chronic disease.

IMPLICATIONS: Occupational Therapy can have a foundational role
in Care Team design, improved patient experience, improved care processes, better outcomes
and lower/stabilized healthcare costs...“THE TRIPLE AIM!”
Redesigning Care to Create “Reflective Time”:

• *Time* to listen to our patient’s stories.
• *Time* for investigation, Care Team collaboration, and for laying on hands.
• *Time* for pondering the clinical implications.
• *Time* for searching the literature, consulting with our “Competent Community,” and for critical analysis.
• *Time* to integrate the best evidence with our patient’s unique values, their biology, and their situation.
• *Time* to walk along side our patients.
• *Time* to comfort.
• *Time* to equip our patients to operationalize the Wellness Plan in their unique biopsychosocial setting, in the context of their own community.
“Everybody Deserves a Family Doctor...
And an Occupational Therapist...
and an Adaptive Care Team...
Imbedded in a Health Enhancing Community.”
“A busy primary care office handles such a wide array of patients that it is difficult to routinize what happens each day. One elderly patient with six diagnoses, 11 medications, and cognitive dysfunction can disorganize a primary care clinic for a whole morning. A child having an acute asthma attack or an adult with new-onset chest pain can rearrange an entire afternoon’s schedule. With hundreds of diagnoses and the need to provide acute, chronic, and preventive care services, organizing primary care is a major challenge.”

(Bodenheimer, Building Teams in Primary Care)
USC Eisner Family Medicine Clinic at California Hospital

- Is a Family Medicine Residency Site
  - 3 Teams made up of 24 Residents
- California Hospital Medical Center
- On July 1, 2011 merged with Eisner Pediatrics and Family Medicine to achieve Federally Qualified Health Center (FQHC) status
- Undergoing National Committee on Quality Assurance (NCQA) Patient Centered Medical Home (PCMH) transformation
Patient Profile at USC Eisner

- 2,000 patients with 6,000 patient encounters
- 80% Medicaid
- More than 60% of households live on incomes less than 200% of the Federal Poverty Level
- Eighty-five percent of our patients live below 150% FPL
- Highest levels of non-elderly uninsured
- Four out of every ten adults did not finish high school
- More than 10% are unemployed
- 8% are unable to work due to a disability
- Patients live in areas of high population density, crime, sparse commercial services, high rates of unemployment, and low levels of education
- 38% percent do not speak English
- 82% Latino
Where does primary care practice fit?

• OT Practice Areas:
  – Children and Youth
  – Health and Wellness
  – Mental Health
  – Productive Aging
  – Rehabilitation, Disability, and Participation
  – Work and Industry
  – Primary Care?
Population Based Occupational Therapy

- Population based medicine
- Primary care clinics maintain large patient panels
- How define appropriate patients to receive OT services?
- Risk Stratification
  - Screen
  - Evaluate and determine risk
  - Determine and provide intervention bundles
  - Ongoing surveillance of patients
- Need to demonstrate cost effective application of OT
• We are not physician extenders and MD work is not being “unloaded” onto us
OT’s Role in Primary Care

• Seniors and Persons with Disabilities Pilot
• New Family Care Team Pilot
• Early Developmental Screening Initiative
• Interprofessional Approach to Pediatric Development and Family Well Being
Q: How is this all paid for?!

A: FQHC Cost Based Reimbursement

- FQHCs receive a standard reimbursement rate for each patient visit
- OT cost is included in total cost of clinic visit
- Every patient encounter allows for OT encounter—allows for direct access to OT
- Regardless of division of provider time, reimbursement rate is the same
- Improved efficiency of clinic visits
Challenges

• Primary care is not traditionally a culture of healing
• Scope of practice
• Undefined roles
• We don’t always assess patients before we treat
• Space
• Time
• Resistance from providers
• Changing continuity providers
• Overutilization of OT services
• Medicine problem list and OT problem list don’t always align
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Could OT fit into Primary Care?

• Traditionally, especially in medicine (vs school systems), OTs have worked with those who have been hospitalized or had a significant injury (CVA, TBI, THA, UE Injury)

• However, because OTs are so broadly trained in human development, health promotion, disease process intervention, activity analysis & modification, and use of adaptive equipment, we believe we can & should intervene sooner…
Could OT fit into Primary Care?

• Broad Training
  – Pediatrics-Geriatrics
  – Cognitive, physical, social, emotional
  – Health promotion
  – Disease/injury prevention
  – Disease process intervention
  – Activity analysis
  – Behavior modification/lifestyle adaptation
  – Use of adaptive equipment
  – Orthotics
OTs role in Primary Care

Three settings:
1. Patient Centered Medical Home (PCMH)
2. Family & Community Medical Residency Program
3. Geriatric Primary Care Clinic

Not meant to replace traditional OT practices, rather this is a new or expanded role for OT and can serve as a conduit for referrals.
PCMH Team

Billing Representative
Business Manager
Clinical Lab Scientist
Department Chair
Family Physician
Medical Assistant
Medical Family Therapist
Nurse Care Manager
Nurse Practitioner

Occupational Therapist
Outcomes Researcher
Pharmacist
Physical Therapist
Physician Assistant
Public Health
Registered Dietitian
Social Worker
OT in PCMH

• See patients one-on-one in the clinical setting for direct treatment.

• Lead and participate in health promotion group educational programs:
  – Healthy Lifestyles
  – Balancing Life & Work
Challenges at PCMH

- Lack of Physician understanding of OT
- “Credentialing”
- Billing
- Scheduling
- Different locations
- Space
- Boundaries
- Licensure laws in each state
SLU Family & Community Medicine Residency Program (civilian & military)

• > 20 Family physicians (MD & DO)
• > 30 Medical residents of all levels
• Federally Qualified Health Center (FQHC) => many who cannot pay
• 2 PharmDs
• 1 PhD Behavioralist
“Intrusionary OT”

One OTR every day & one or two Level 2 Fieldwork students daily for six months

“Intrusionary OT”

• Because physicians don’t know what we do, especially not family physicians, we cannot wait for them to invite us in.
• Attached ourselves to a doctor, and saw all of the patients with him/her.
• Asked questions, did assessments, offered suggestions, provided direct treatment, recap directly with doctor.
• Do EXCELLENT notes
Fieldwork Students

• Level 2 Fieldwork students were chosen very carefully
• Interviewed, looking for:
  – Mature & confident
  – Strong personality
  – Great people skills
  – Flexible & able to handle stress
  – Prior clinical/work service
  – Excellent academic performance
  – Demonstration of excellent documentation skills
FCM Clinic: Case Mix Summary

• Age Range: preemie to 98 y.o.
• Development screenings
• Physical complaints
• Mental health issues
• Chronic Pain
• Health and Wellness
• Preventions
• Referrals
SLUCare: Geriatric Clinic

• Intrusionary OT again
• Standardized Screenings
• Seeing patients with Doctors/Residents
• Direct treatment
  – ADL’s
  – Use of adaptive equipment
  – Home exercise programs
  – Cognitive tasks
  – Referrals for home health & out-patient
Physician Response to OTs in Primary Care

• Overwhelming positive!
• “OMG, I didn’t know ANYONE did that”
• “I love working with you. Now I feel like my patients are really getting the total care they need”
• “When I open my own practice, will you help me hire an OT?”
Obstacles to OT Tx in Primary Care

• Lack of space
• Lack of MD knowledge regarding OT
• Lack of evidence/outcomes:
  – Cost savings
  – Efficiency
  – Patient satisfaction
  – Effectiveness
• Insurance/Billing/Payment
Challenges for OTs
Treating in Primary Care

• Necessary skill set for OT in Primary Care
• Identifying appropriate screens/evals for this setting
• Having available handouts
  – Patient education/Instructions
  – Exercises
• Documentation
Who can be a primary care OT?

• Competent across the age spectrum
• A true “Generalist”- broad experience & skills
• OTs practicing with a specialized population could be the primary provider for that population (like ALS, hands, and primary care)
• Knowledgeable about our scope of practice
• Able to think on one’s feet and think outside the box
• Able to self-advocate
• Ethically sound
Questions?