AOTA Student Conclave
Primary Care: An Emerging Area of Practice for Occupational Therapy
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Occupational Therapy in Health Delivery Transformation

AOTA Annual Conference
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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
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Community Integrated Health Care System 3.0
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Network of Providers

Healthcare System of Delivery is focused on improving population health and cost of care

Delivery networks will:
• Optimize care within and across the continuum
• Focus on coordinated care

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Integration of Care and New Payment Models

Movement to Integrated Care—New Payment Models and “Shared Risk”

- Value-based Purchasing
- Bundled Payments
- Global Payments
- Reimbursement Cuts
- ACOs and Medical Homes
- Shared Savings

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Ambulatory Care refers to: services and programs provided in both community based and post-acute care settings

- Move from volume to value based care
- Connectivity and care coordination are important
- Population health strategies emphasize wellness as well as predictable, sustainable outcomes through evidence-based care (e.g. penalties for avoidable admissions and readmissions)
Ambulatory Care

- All providers must work as a team across the SYSTEM of CARE (Clinical Alignment and Resource Effectiveness) to ensure patients are treated at and transitioned between the most appropriate settings.
- Aims to improve patient satisfaction—better patient engagement and helping clinicians improve productivity and efficiency.
Accountable Care Organizations (ACOs)

- ACOs are groups of providers
- Accountable for the quality and cost of care delivered to a population
- Providers, a hospital, a group of primary care providers, specialists and, possibly, other health professionals
- ACOs have responsibility to provide good care, achieve outcomes and save money
- Share in savings
Value-Based Purchasing (VBP) program established by the Affordable Care Act creates a system of penalties and rewards for hospitals based on reportable performance metrics.

- VBP effective October 1, 2012
- Quality measures will be used for scoring the VBP program using quality measures
- Payments based on achievement and improvement—hospitals achieving high quality scores and/or by demonstrating year over year improvement
Section 3023 of the Affordable Care Act states

“HHS shall establish a pilot program for integrated care during an episode of care, provided to an applicable beneficiary around a hospitalization in order to improve the coordination, quality, and efficiency of healthcare services”
Bundling

Different Methods of Bundling
Super Bundling

- One payment to cover a patient’s health care
- Episode from 3 days prior to the inpatient hospital admission through 30 days post hospital discharge
- Reimbursement package includes **ALL** inclusive payment for acute hospital, physician, SNF, IRF, LTAC, outpatient services and home health services
- Large financial risk to providers
Global Payments

- Global payments defined as fixed-dollar payments for the care that patients may receive in a given time period

- Places providers at financial risk for both the occurrence of medical conditions and the management of those conditions
Redesigning Primary Care

- Primary Care defined in the ACA as: “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” (PL 111-148)

- Primary Care practices must be designed to achieve the **Triple Aim**:
  - Improved patient *experience* of care
  - Improved population level health *outcomes*
  - Controlled *cost*
National Committee of Quality Assurance
Patient Centered Medical Home

NCQA-Recognized Practices Across the United States.
Source: Analysis by the National Committee for Quality Assurance, June, 2013
The Robert Wood Johnson Foundation Commission to Build a Healthier America report (2009) highlights:

- The most effective prevention activities occur outside the traditional medical care setting, in the place where we live, learn, work, play, and worship
- The actions we take and the choices we make in the course of our daily lives have the greatest impact on health

In Medical Home models, can develop patient access models that reflect the occupational profile of our patients


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NCQA PCMH 2011 Standards

Standard 1: *Enhance Access and Continuity*

Standard 2: *Identify and Manage Patient Populations*

Standard 3: *Plan and Manage Care*

Standard 4: *Provide Self-Care Support and Community Resources*

Standard 5: *Track and Coordinate Care*

Standard 6: *Measure and Improve Performance*
Federally Qualified Health Centers (FQHCs)

“FQHCs qualify for enhanced reimbursement from Medicare and Medicaid, as well as other benefits. FQHCs must serve an underserved area or population, offer a sliding fee scale, provide comprehensive services, have an ongoing quality assurance program, and have a governing board of directors”

U.S. Dept. of Health & Human Services (2014)
FQHCs (cont.)

• Services are payable when provided at the FQHC, at client’s home, or elsewhere, as needed.

• OT not directly billable, but as “incident to” the physician.
Payment for OT Services

With health care reform, fee-for-service will become less common, but it is still most common payment model in U.S.

- Remember, most private insurance companies follow Medicare rules.
- “Incident to” services:
Incident to Services
Wier (2013)

- Bill for the services under the physician’s Medicare provider number, would receive 100% reimbursement from Medicare under the MPFS (Medicare Physician’s Fee Schedule).
- Physician must perform an initial visit to establish the physician–patient relationship.
- After the initial visit, the physician does not need to be involved in each patient visit, but must actively participate in the management of the course of treatment for the patient.
- Although not required by Medicare, some carriers require that the physician meet with the patient every third visit or when a new symptom or medical issue arises.
With Reform:

- Capitated payment; per patient per month (PMPM)
- Bundling
Healthcare Reform = Opportunities for OT

• Goals of healthcare reform fit perfectly within the scope & expertise of the OT profession

• OTs are the experts in roles, routines, and activity modification.

• Time Limited Opportunities
  – Need to be at the table during the planning process of new treatment teams and practice models
Envision the roles for OT in Primary Care Practice...

For certain populations or diagnosis:

- Principle provider
- Initial contact for office visit
- Case Manager
- Health Promotion
- Screenings (Developmental & Safety)
- Disease prevention
OT Roles (cont.)

- Chronic Disease Management
- Lifestyle Modification
- Mental Health Issues
- “Quick shot” intervention delivery

Not meant to replace traditional OT practices, rather this is a new or expanded role for OT and can serve as a conduit for faster referrals
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 (nicely assertive!)
• Ethically sound
Top Areas that Evidence Supports OT Evaluation and Intervention for Changing Health

- Pediatric
  - Developmental Interventions
  - Sensory Integration

- Upper Extremity Rehabilitation
  - Orthotic Interventions
  - Soft Tissue Management (Lymphedema, Circulation, Wounds, Edema, Tissue Balance)

- Mental Health
  - Internal Locus of Control (Empowering)
    - Anxiety and Depression
    - Stress
    - Pain
Top Areas that Evidence Supports OT Evaluation and Intervention within Primary Care

Basic Activities of Daily Living/Instrumental Activities of Daily Living

- Compensatory Techniques/Self-care Modification
- Adaptive Equipment
- Work Place Modification
- Ergonomics
- Positioning: Work, Sleep, Seating

- Joint Protection
- Energy Conservation
- Fall Prevention
- Community Participation
- Medication Management
- Vision Management

Patient Activation and Engagement

Chronic Care Management:
- Diabetes management
- Weight management
- Mental illness: symptom management
OTs role in Primary Care at SLU

Six settings:
1. Patient Centered Medical Home (PCMH)
2. Family & Community Medical Residency Program
3. Geriatric Primary Care Clinic
4. ALS Center for Excellence
5. Student Health & Counseling
6. Health Resource Center

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.
- Inter-Professional Care Management Team (asthma, diabetes, depression)
- Lead and participate in health promotion group educational programs:
  - Healthy Lifestyles
  - Balancing Life & Work
“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 nearly all of the patients with him/her.

• Asked questions, did assessments, offered suggestions, provided on-demand direct treatment, recap directly with doctor.

• Did EXCELLENT notes
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
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
Geriatric Primary Care Clinic

• In clinic every Friday
• “Intrusionary” OT again with physicians and all levels of medical students/residents
• Screenings and on-demand OT interventions
• Just gained the ability to do home safety evaluations
• Working to be able to schedule separate OT visits, prn
SLUCare: Geriatric Clinic

• Direct treatment
  – ADL’s
  – Use of adaptive equipment
  – Musculoskeletal injuries
  – Home exercise programs
  – Cognitive tasks
  – Safety
  – Balance & functional mobility

• Referrals for home health & out-patient
ALS Center of Excellence

• To receive certification, a facility must demonstrate the involvement of specially trained professionals from multiple healthcare disciplines in caring for ALS patients and their families. The center also must offer a team approach to patient care, conduct research and collaborate with other ALS centers.

• Team Members: neuromuscular clinical nurse, social workers, occupational therapists, physical therapists, speech-language pathologists, pulmonary care team, psychologist, spiritual care professionals, registered dietitians and neurologists.

• 2\textsuperscript{nd} & 4\textsuperscript{th} Fridays of each month
Student Health & Counseling

• Newer initiative
• College students who are having difficulty being successful at SLU
• Usually because of psychosocial, sensory, or substance abuse issues
• Currently individual treatments, but plan is to add group treatment
• Occurs in natural environments
• Occupation centered treatment
• OTeams- individualized for students
Health Resource Center

• Since 1994, free primary care clinic managed & run by SLU Medical Students
  – Regular Clinic
  – Pediatric Clinic
  – Well Woman Clinic
• OT faculty & students will begin interventions this month.
Barriers/Challenges to OT in Primary Care

• Lack of Physician understanding of OT
• “Credentialing”
• Lack of evidence/outcomes:
  – Cost savings
  – Efficiency
  – Patient satisfaction
  – Effectiveness
• Billing/Fee for service
• Scheduling
• Multiple practice locations
• Space
• Boundaries
• Skills/knowledge of the Occupational Therapist
Challenges for OTs Treating in Primary Care

• Time!!!
• Stress Level: constant state of uncertainty
• Necessary skill set/personality for OT in Primary Care
• Identifying appropriate screens/evals for this setting
• Having available handouts
  – Patient education/Instructions
  – Exercises
• Documentation
According to the Manitoba Society of Occupational Therapists (2005):

“How people perform their occupations is believed to be an important determinant of health and is influenced by personal factors, environments, and the occupations that people do. Occupational therapy is the only health profession whose education is entirely devoted to the study of occupational performance and its impact on peoples’ health and wellness”. (p. 2)
References


Questions?