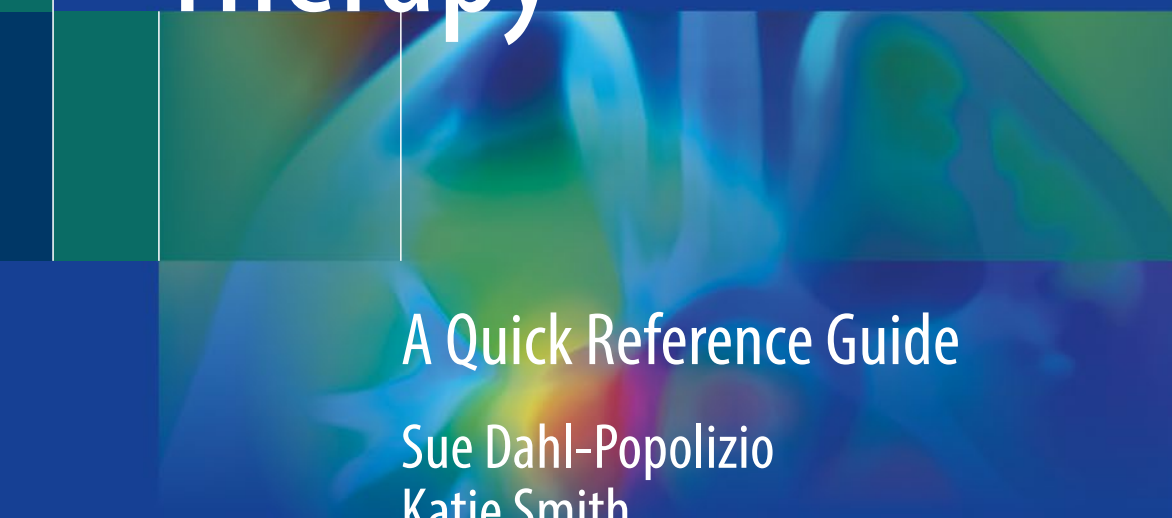
Primary Care Occupational Therapy



A Quick Reference Guide

Sue Dahl-Popolizio
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Editors

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User Guide

Throughout this text, the authors will be using the following abbreviations, to maximize brevity of the overall text.

Most Commonly Used Abbreviations Throughout the Text:

ADL	Activities of Daily Living
CDC	Centers for Disease Control and Prevention
CPT	Common Procedural Terminology codes (billing codes used in practice)
EHR	Electronic Health Record
HTN	Hypertension
IADL	Instrumental Activities of Daily Living
ICD-10	International Classification of Diseases
OT	Occupational Therapy
OTP	Occupational Therapy Practitioner
PC	Primary Care
PCP	Primary Care Provider

Abbreviations Specific to Musculoskeletal Issues:

CMC	Carpometacarpal joint
DIP	Distal interphalangeal joint
FMC	Fine motor coordination
GMC	Gross motor coordination
IP	Interphalangeal joint (can be either PIP or DIP or both)
MCP	Metacarpal phalangeal joint
PIP	Proximal interphalangeal joint
ROM	Range of motion (A/AA/PROM active/active assist/passive ROM, respectively)

Additional Terms:

The use of the term ‘client’ versus ‘patient’ was determined by the authors of each chapter. The term chosen is used consistently within the chapter. This reflects the use of both terms based on the preference or industry standard of the setting in general or the practice site.

Additional Note Regarding Resources:

The authors have provided assessments, patient handouts, and other resources whenever possible. When they could not provide the actual resource, they provided links to the online resource whenever possible for ease of access for the reader. The reader is responsible for obtaining any necessary permissions for use. As links can break over time, the authors have included the name of the resource so the reader can find it online.

Social Networking:

For connection with OTPs and other professionals who are passionate about the topic of PC OT and related progressive concepts of prevention and health promotion, please visit https://www.facebook.com/groups/323579324877922/

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Part I
General Topics for Primary Care Occupational Therapy

Chapter 1
Introduction

William Manard

When I was in medical school, knowing how therapies integrated into my practice was clearly defined by my instructors. If a patient had a lower extremity or back complaint, you sent them to physical therapy (PT); if a patient had an upper extremity complaint, you sent them to OT. This simple algorithm helped a forming physician understand what therapists did without engaging with them to determine exactly how they participated in patient care. Although I had some interactions that made this appear less than complete, this was the framework with which I entered into postgraduate training.

During residency training, I discovered that these divisions were not always so clear; I also learned that perhaps there were broader services that differing therapists could provide. This is when I first learned that, although physical therapists often performed assessments prior to discharge for adaptive equipment, OTPs often had a broader view on overall patient safety at home, including the impact of cognitive impairment on potential readmission or appropriate level of care. At this point, I started reconsidering my initial learning, which positioned me for my next experience.

I was fortunate to work in a Program of All-Inclusive Care for the Elderly (PACE) as my first position after residency. In this setting, we were able to provide holistic services, across the entire continuum of care, for a population of frail elderly persons. Freed from reimbursement considerations, each professional on the care team was able to provide any services within their experience and licensure. Because of this, I first learned the full extent of services that OTPs could provide our patients in a PC setting. I didn't have to use simplistic algorithms to determine potential home safety or potential issues with motor vehicle operation (simply because my services would be reimbursed); I could instead rely on my professional colleague to

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complete a more comprehensive evaluation and provide recommendations for patients and families in a more robust fashion than I could ever hope to do. With each member of the care team able to provide any services within their skill set, patients and families received more comprehensive primary care (PC) and were generally more satisfied with care versus that provided in a more traditional PC setting.

Upon moving into a more academic setting, I again had an opportunity not offered to many PCPs. As part of a patient-centered medical home transformation project, we were able to offer non-traditional services, including workplace and home ergonomic evaluations, behavioral health services, and integrated holistic person-centered care, again without direct concern to existing payment structures. In this environment, I again increased my appreciation for the services that OTPs could offer our patients in the PC setting, as I gained a greater understanding of the cognitive services available to help our patients struggling with behavioral health issues. Again, although other professionals, including myself, could provide some of these services, the holistic approach of OT seemed a natural fit for the holistic nature of family medicine, and this experience has made me an advocate for expanding the role of OT in PC, including enhancing our reimbursement structure to support these services.

This need for additional professionals to enhance services to our communities has an even more acute importance at this time. Professional and popular media are replete with stories of shortages of PCPs, both currently and, more worrisome, as our current population ages. In a 2020 study commissioned for the American Association of Medical Colleges (AAMC) [1], it was estimated that by 2023, there will be a shortage of PCPs between 21,400 and 55,200. This potential shortage is accelerated by increasing age of existing PCPs, and it could be exacerbated if payment structures were improved to remove barriers to care for historically underserved persons.

The COVID-19 pandemic may have worsened this potential shortage, and these fears are being presented in recent news stories. As an example, a survey published in the Washington Post in 2021 reported that a significant fraction of physicians who ceased or reduced providing care during the pandemic do not anticipate returning to their prior level of practice, for those who return to practice at all [2]. This will likely make it more difficult to receive PC for all segments of the population in the future.

Because of the broad array of services that OTPs are able to provide to our communities, I am happy to introduce this practical guide to the provision of these services in the PC setting. As OTPs become more integrated members of the PC team, the value of the care we provide people will continue to increase. Additionally, by increasing the number of professionals in the care of our patients, the workforce strains that are anticipated in the coming years will be somewhat blunted; this will help allay some of the concerns described above. Beyond all of this, providing a broad array of services in our communities, especially in the setting of the patient's medical home, will help improve the overall health of our communities and make our society a more holistically healthy place in which we all live.

Thank you to my colleagues for preparing this important guide to help our fraternity better understand how to integrate their valuable services into community PC practice. Thank you to those who read this and apply its principles to your own practice. Finally, thank you for taking this newly developed knowledge and applying not just to patient care but to also advocate for broadening the integration of OT services in the provision of PC within our communities.

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Chapter 2
Overview of Occupational Therapy in Primary Care

Katie Smith, Sue Dahl-Popolizio, Lydia Royeen, and Brenda Koverman

Introduction

In the United States, primary care (PC) is gaining recognition as the key setting where patients can receive accessible and integrated care to address the majority of their healthcare needs in one setting [1]. With the integration of preventative services and behavioral health into PC practices, the focus of PC is shifting from a reactive approach to illness and disease, to a more proactive approach that empowers and engages the patient as an active participant in their healthcare and overall health and wellness. This approach includes a care spectrum ranging from preventative strategies to acute and chronic condition management, with a population-focused approach to care, and an awareness of underlying or comorbid behavioral health issues, available resources, cultural customs, and all other social determinants of health [1, 2]. This approach to PC provides an opportunity for early detection of acute illnesses and chronic disease onsets, chronic disease management, a triage system for connecting patients to specialty resources as needed, and a focus on increasing patient self-management of health and wellness [1, 3–5]. This approach encourages active patient involvement and planning and reduces the

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dependence on emergency rooms and hospitalizations for conditions that can be proactively managed by the patient and their primary care team.

In 2010, the passage of the Affordable Care Act provided more Americans with insurance coverage to increase access to PC services. This influx of patients into PC resulted in an increased shortage of PCPs and provided an opportunity to rethink our approach to PC [3–5]. As a result, the concept of an interprofessional team approach has gained popularity to offload work from the PCP, while meeting the needs of the patient population in PC through the more holistic provision of services from prevention, to acute illness, and chronic condition management of individual patients, and patient populations [3]. With an interprofessional team, each provider practices at the top of their license, using the skills most unique to their profession [4]. This approach improves job satisfaction and can also reduce provider burnout due to overwork or the requirement to complete tasks that do not require the provider's unique skills or interests. Burnout is a growing concern among PC practices [3, 7]. The specific professionals comprising these interprofessional teams vary across PC practices. Considering the whole person approach to care of the OT profession and their broad training in medical and behavioral health conditions, the integration of OT into the PC setting is a natural fit [8, 9]. With their lens of treating all issues within the context of the patient's habits, roles, and routines, OTPs can maximize the patient's experience with care and offload patient visits from the PCP that do not require the PCP's skill set, but do require behavioral or behavioral health intervention [3, 4, 7–9]. This can reduce PCP burnout, reduce healthcare costs, improve health outcomes, and meet public health goals while demonstrating how OT functions as a member of the PC team [7, 8]. With their patient-empowering approach, having an OTP available on a PC team is an opportunity for OTPs to have a positive impact on the lives of patients, populations, other team members, and also the overall management of health and health care.

Defining PC

As defined by The Institute of Medicine [1, 5], PC "is the provision of integrated, accessible health care services by clinicians who are accountable for addressing the large majority of personal health care needs, developing a sustained partnership with patients, and practicing in the context of family and community." The increasingly interprofessional team of clinicians who deliver services in a PC context may include PCPs, behavioral health providers, medical assistants, pharmacists, social workers, and more [3]. A team-based approach occurs when at least two healthcare professionals collaborate with each other, patients, and their caregivers, to achieve shared goals while striving to provide high-quality care [10]. An effective team-based approach includes clear roles, effective communication, shared goals, mutual trust, and measurable processes and outcomes [10].

PC is an umbrella term that includes many different practice types, such as family practice, internal medicine, pediatrics, and more [7]. The specifics of OT

practice within a PC setting depends on the specific focus of the clinic, the physical and operational requirements of the setting, and the conditions commonly seen in the specific PC clinic. See the ***Conditions Addressed by Occupational Therapy in Primary Care*** section for condition-specific considerations for PC OT practice. There are a variety of business organizational arrangements that can all be considered PC. Ideally, PC settings have all clinicians on the interprofessional team operating within the same physical clinic [5, 7]. This arrangement is optimal for increasing patient engagement with interprofessional services and in supporting clinician communication. If sharing a physical clinic location is not possible, PCP referrals to an offsite OTP may still be considered PC OT, as the key quality of team-based integrated PC is the overall collaborative approach to care with effective communication among providers and a plan of care that includes and empowers the patient.

OT Theory in PC

OT is a whole-person oriented profession, and OT training addresses the biomechanical, psychological, social, spiritual, and environmental factors that are directly applicable to addressing the broad needs of the diverse population that comes to a PC site for care [5]. OTPs are skilled in addressing physical dysfunction, and also behavioral and mental health issues. OTPs work with individuals across the lifespan to maximize function and participation [6, 8] and improve health outcomes. The preventative focus of PC is well aligned with OT philosophy that supports patients in independence and self-efficacy with managing their health and engaging in self-determined, value-driven tasks that bring meaning to their lives. The population-focused approach of PC is also reflective of OT values of addressing relationships and the social and environmental contributors to health outcomes, such as the built environment, economic stability, education, access to food, healthcare, and other factors and available resources that affect overall health and wellness [5, 6]. The alignment between PC goals and OT philosophy reflects a natural and mutually supportive fit with the shared interest among team members of preventing negative health outcomes, optimizing independence, and improving wellness and quality of life for as many individuals and communities as possible.

OT Practice in PC

The PC setting is fast-paced and broad. The OTP is likely to encounter many different patient needs across the lifespan and across a wide breadth of presenting conditions. It is important to consider the limitations of the PC setting and the function of the OTP within this setting. Consider approaching PC OT as a triage role. If the patient's occupational deficits could be best addressed in one or a few sessions, this

reduces the need for the patient to go to a separate clinic and prevents the risk of the patient being unable to follow through with a referral to access those services. However, PC is not the setting within which to conduct extensive treatment plans or to address significant occupational deficits. This would diminish the OTP's availability to best serve the patient population and the interprofessional PC team with more brief interventions for more patients. If, after an initial OT screening or OT evaluation, it is determined that the patient's needs would be better addressed through outpatient OT or by referring to a different profession, the OTP can make that suggestion and help with that referral process to an offsite provider. PC OT is a practice of brevity and breadth; offsite referrals will be necessary for more involved cases or conditions.

Example: The PCP referred Emily to the OTP for a fall risk assessment. Emily is a 56 year old woman who lives alone, reports difficulty sleeping, has high health literacy, high baseline health, and high motivation to implement OT strategies. The OTP provided sleep hygiene education during the same session as the initial evaluation, including environmental modification education. The OTP and Emily set up four, once weekly follow- up appointments. Emily also reports knee pain, and the OTP consulted with the PCP to suggest that a PT referral may also be beneficial.

Referral: Any condition or diagnosis that impairs function or involvement in daily activities may prompt an appropriate referral to the PC OTP. Educating providers is an important part of receiving appropriate referrals. OT referrals may reach the OTP via the Electronic Health Record (EHR) or by the PCP directly introducing the patient to the OTP. A direct introduction is called a "*warm handoff*" or a "*hallway handoff*" and is one of the benefits of being located in the same clinic [7]. There are times the warm handoff process interrupts an ongoing OT session, allowing the OTP to determine, based on the issues of the current patient and the new patient, if the OTP will address the new patient's issues immediately, wait a few minutes until the current session is done or have the patient return for a separate visit. No matter which of these approaches is chosen, the relationship has already been established

due to the warm handoff from the PCP to the OTP. That significantly increases the likelihood that the patient will return if not seen immediately.

Example: Dr. Ling's patient Elaine expressed interest in support with smoking cessation. Dr. Ling excused herself and knocked on the door of the exam room where the OTP was in session with another patient to make a request that the OTP meet with Elaine. The OTP excused herself from her session, to go with Dr. Ling to meet Elaine. The OTP provided a brief overview on OT intervention for smoking cessation, and Elaine expressed interest in working with the OTP. Elaine made an OT evaluation appointment with the front desk for another day, and the OTP returned to her session that had been temporarily interrupted by the warm hand-off referral.

Evaluation: Consider the specific populations and conditions most frequently seen at your PC site and tailor your evaluation tools to assess for occupational deficits that are related to those conditions and populations. Be mindful of the time required for assessment tools and use brief assessments when possible. Clinicians may treat patients within their own offices, or in shared treatment rooms, in which case the PC OTP may need to have portable access to assessment and intervention tools. Document OT evaluation in the EHR as soon as possible, to ensure that communication flow with other providers involved in the patient's care is current, as face-to-face communication with providers may not be possible given the potential space and time constraints.

Example: An OTP integrated into an internal medicine PC clinic is working with Garret, a 79 year old man who lives with his wife in a one-story home and is interested in information on falls prevention and home safety. The OTP

Fig. 2.1 Common interventions of OTs in PC
Note: Fig. 2.1 reproduced with permission from Smith, K. & Day, M. (2018). Primary care OT: clinical and administrative templates. Pacific University doctoral thesis.

Intervention: In addition to focusing on brief evaluation processes, seek to optimize impactful interventions that require less time investment and maximize the patient's ability to utilize strategies on their own. There are many clinical services that an OTP may choose to offer to the PC team and ultimately the patient. OTPs in PC can address conditions including acute musculoskeletal injuries, developmental delays, and mental health needs [8, 9]. See Fig. 2.1 for an overview of common interventions that are often appropriately delivered in a PC OT context. See the ***Conditions Addressed by Occupational Therapy in Primary Care*** section for condition-specific intervention strategies for PC OT practice.

Example: The OTP met with Carol, a 23 year old coffee barista developing initial symptoms of carpal tunnel syndrome. The OTP worked with Carol for four sessions in total, and at the end of the OT plan, Carol was able to independently demonstrate job-specific activity modifications and ergonomics and reduce her overall experience of carpal tunnel syndrome symptoms.

Communication: Consistent communication with the interprofessional team is essential in PC, as the PCP will be generating referrals to all available providers, including the PC OTP, and the PCP is ultimately responsible for directing the patient's plan of care. PCPs often work closely with a medical assistant (MA), who supports the PCP in patient communications, referral flows, patient rooming, and documentation. As mentioned above, there may be other professions who will also be working together in PC, and the PC OTP must understand the roles and scopes of practice of the various professionals located at the specific PC clinic where they are working. This serves to ensure patient needs are met by the most appropriate provider available.

Example: The OTP walked past a MA typing in the EHR. The MA asked the OTP if OT would be beneficial for a patient experiencing stress and anxiety. The MA explained that the PCP was hoping to connect the patient to the PC psychologist, but that the psychologist was out at meetings today. The OTP briefly explained the OT role in stress management including self-management routines, pacing, and energy conservation. The MA suggested that OT may be an excellent fit for the patient's needs, as the patient's stress is related to their challenges with managing their chronic lupus independently while feeling successful at work. The MA communicated to the PCP and the patient was able to initiate services with the OTP that day.

Summary

The holistic and contextual OT philosophy and the evolving PC approach share many common goals and interests. When delivering OT services in PC, be mindful of the overall preventative and population-health perspective, as well as the importance of addressing patient needs in the context of their communities. The importance of interprofessional collaboration and communication cannot be overstated as this is critical to ensure the needs of patients are expeditiously and effectively addressed, while at the same time ensuring the providers are all working at the top of their license. All OTPs are prepared through their training to practice as PC OTPs if they choose to do so, and this book will support OTPs in tailoring their services to the needs identified at their specific PC site.

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Chapter 3
Administrative and Operational Considerations

Katie Jordan and Ashley Halle

Strategic Plan: Needs Assessment of Site, Population, and Stakeholders

Whether you are already engaged in PC or PC-related services or looking to get started, it's important to first consider the strategic priorities of your plan. Because of the breadth and depth of people, populations, and stakeholders in PC, it is vital to reflect on your strategic priorities for engaging in PC settings. Below is a list of considerations when reflecting on your strategic plan.

- Business plan or proof of concept plan
  - There are numerous tools available to support developing a business plan that will prompt and guide you through the process. While a formal business plan may be needed for contracting, negotiating for space, or acquiring a business loan, a proof of concept plan can sometimes be a more logical and accessible place to start. Generally, a proof of concept plan involves research to determine the viability of your ideas, testing those ideas by talking with stakeholders, and then involving stakeholders in the development of your plan. One way to approach your plan is by using a SWOT (Strengths, Weaknesses, Opportunities, and Threats) analysis to discover the needs of your site(s), population(s), and stakeholder(s). A SWOT analysis template can be found online.

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  - SWOT analysis online resources:

    MindTools.com SWOT Analysis https://www.mindtools.com/pages/article/newTMC_05.htm
    LivePlan.com What is a SWOT Analysis and How to Do It Right: With Examples https://www.liveplan.com/blog/what-is-a-swot-analysis-and-how-to-do-it-right-with-examples/

- Vision and mission
  - A vision document contains current goals but also inspires a path forward toward your ideal future state. A vision document can be exhaustive or short and to the point, depending on the current stage of development you are in for your PC practice. It should set achievable aspirational targets and must be a reflexive document that you continue to refine over time.
  - A mission statement explains your purpose, explaining what you are currently doing and why.
  - The vision and mission of your practice may be combined into one document, but it's important that you clearly define each and that you continue to modify the document(s) when making strategic decisions as circumstances or priorities change.
- Learn your stakeholders, what matters to them and why
  - PC is a broad practice area, and there are many stakeholders whose interests must be considered. Below is Table 3.1: *Stakeholder Interests*, which includes

Table 3.1 Stakeholder interests

Stakeholder	Considerations
Consumers of the service (patients)	Experience, access (to providers, space, and support), cost, quality/outcome
Families/caregivers/ significant others	Caregiver support and resources, access, experience
Referring providers (DO, MD, PA, NP, optometry, etc.)	Internal and external providers that refer (or do not refer) to OT, perceived barriers and supports, workflow and clinical pathways, space
Health system and/or facility ownership/leadership	Integration into a health system vs. standalone practice, leadership expectations and vision, risk tolerance, culture
Payers	Payer policy, payer mix, access to payers (billing, coding office support), documentation requirements
Students and volunteers	Experience, educational goals/requirements, strengths and skills
Researchers	Current and potential collaborations, opportunity for synergies, how research will be used
Professional and support staff	Clinical and operational workflow, culture of the team(s), perceived needs/supports
OTPs	Current or previous attempts to connect OT services, desired future state, employment options and benefits, advancing OT practice

initial stakeholders but depending on your setting, there may be others. After listing all invested stakeholders, the next step is to engage them. Your site might already have an advisory group of some kind or you might need to reach out to individuals to begin building relationships to help you understand what is important to each stakeholder and why, especially regarding PC access, services, workflow, and operations.

Resources

- General business plan free online resources:
  - U.S. Small Business Association website https://www.sba.gov/business-guide/plan-your-business/write-your-business-plan
  - SCORE is another organization that offers information regarding writing business plans:
  - https://www.score.org/business-plans-startup-assistance-resources
- Specific OT in PC business plan development resource:
  - Developing Tailored Program Proposals for Occupational Therapy in Primary Care [1]. https://scholarworks.wmich.edu/ojot/vol8/iss1/11/
- Vision statements:
  - TopNonProfits.com 30 Example Vision Statements https://topnonprofits.com/examples/vision-statements/
  - ProjectManager.com A Guide to Writing the Perfect Vision Statement https://www.projectmanager.com/blog/guide-writing-perfect-vision-statement-examples
- Mission statements:
  - https://www.missionstatements.com/

Understand Your Environment

The physical, policy, temporal, and cultural environments in which your target PC practice is located adds important context for planning. Below are some key areas for reflection. Building expertise in these areas can take time. Practitioners should use resources, if available at your clinical site, such as legal counsel, compliance officers, and billing and coding experts for support and guidance. While professionals in these offices may not be familiar with OT's role in PC, they can serve as subject matter experts and can advise you on questions related to regulatory, compliance, and reimbursement issues.

- Regulatory

  Understanding regulatory constraints and supports is an important step in building a sustainable practice. Answering questions about the regulatory context of your target PC environment can help you construct the most sustainable model for your practice while also helping you avoid barriers (see Table 3.2).

Table 3.2 Regulatory considerations

Key questions	Key considerations
How is your space licensed and/or accredited?	Space where healthcare services are delivered is generally regulated by local, state, and/or national rules. A PC space may be licensed as a specific type of space that creates parameters around how services are delivered there. Additionally, PC sites may hold a special accreditation that designates the level of service that they provide
Who are the stakeholders that have knowledge regarding licensure and/or accreditation of your target PC practice?	Depending on the breadth and depth of your clinical site, the administration or leadership would typically know what licensure and which accreditations are active at your site. If there is a legal or compliance office, they would also be able to provide more information on this question
What impact might space licensure or accreditation have on your practice plan?	Licensure and/or accreditation set rules and parameters for service development, delivery, access, and outcomes. Understanding how these rules impact your strategic plan is important for building a successful and sustainable practice. For example, you planned to conduct a therapeutic group in the waiting room in the evenings but your site is restricted from providing clinical services outside of licensed patient room areas. Understanding these constraints and supports is important for building your program and your credibility with your site and referring providers
Are there carve-out spaces that are not licensed or are licensed differently to consider in your planning?	Understanding how space is allocated and for what purpose may take some time, but it's an important first step for sustainable program development
How are services furnished for different types of providers or in different service lines?	Depending on how a space is licensed and/or accredited healthcare professionals may fall into different categories. For example, in some spaces, an OTP may be considered part of the facility and not able to bill for professional services. In another scenario, the OTP may be able to bill fee-for-service the same way a physician would bill in many PC settings
Are certain services required and/or required in specific spaces?	Licensure and/or accreditation may protect access to certain services by supporting their availability. PC sites that are designated as a Federally Qualified Healthcare Center (FQHC), for example, often have access to population health funds that could potentially support program development led by an OTP
Are any services prohibited under existing licensure and/or accreditation?	Licensure and/or accreditation may protect consumers by limiting access to certain services by restricting their availability

Table 3.3 Reimbursement considerations

Key questions	Key considerations
How are services in your target setting funded? What are the current and prospective funding sources that you need to consider?	If your site is currently billing fee-for-service, consider which CPT® codes will be useful to describe your planned services. AOTA offers members a quick reference document for the codes most commonly used by OTPs (see the 2022 CPT® Codes for Occupational Therapy, at AOTA.org). There are other mechanisms by which your services as an OTP may be covered. Access your experts within your professional associations and at your site to discuss the ways in which services are developed and delivered to explore how OT might support or expand programs and services
What is the payer mix for the population(s) you are targeting?	If you are billing using fee-for-service, it's important to understand the payers that need to authorize and reimburse for OT services at your site. Each payer has their own policy and while there are some consistencies, it's important to appreciate the variability as there may be opportunities to innovate
Is there a contracting office that you need to meet with to discuss your plans?	There are often steps needed to establish a workflow plan for reimbursement. For example, OT may need to be added as a service to the site payer contracts, authorization may be required per those contracts before initiating OT services, and there may be limits (diagnosis, number of sessions, type of intervention) on the type of services that OT can be reimbursed for by that payer
What payment models are feasible in your setting? (fee-for-service, alternative payment models, grant funding, etc.)	Explore the possibilities and be open to trying new ideas. Reimbursement in health care is a moving target, which creates opportunities for innovation
What if reimbursement is denied?	Ensure you are notified if reimbursement is denied as you typically have the opportunity to appeal this decision. If denied, the responsible party (often the patient) may be billed for the total service or the practice may simply write off the billed charges without informing the billing provider. This can lead to consumer dissatisfaction and/or a large and often unnecessary loss of revenue

Reimbursement

Establishing and maintaining a sustainable practice requires attention and resources toward current and future reimbursement mechanisms. A successful practitioner must establish how the service will be funded in current and future states of the practice [2] (see Table 3.3).

Compliance

It is critical that you are aware of the rules and regulations that might impact the development, clinical offerings, and viability of your PC service line (see Table 3.4). In addition to ethical practice and high provider integrity, a strong compliance liaison or office can support and protect all stakeholders in complex healthcare settings.

Table 3.4 Compliance considerations

Key questions
Does your site have a compliance expert or office that can provide guidance on regulatory, reimbursement, and legal questions?
Is there a risk officer or office that can support risk and liability issues and concerns?
Are there existing policies and procedures regarding who or what office has oversight of policy?
Are there employment and/or labor laws to consider at your site? A healthcare attorney can be helpful when determining the best structure for your status at your site (independent contractor, consultant, employee, etc...)
Is there a general counsel office or a consulting attorney with healthcare expertise where you can direct questions? • Potential Stark issues • Anti-kick-back violations • Conflict of interest and/or commitment • Privacy of protected health information (HIPAA concerns)

PC Populations

As mentioned in the section on stakeholders, understanding the details of your facility is essential to establishing OT services. PC can occur in many different locations and serve patients with a variety of different needs. In a 2018 study, the 10 most common clinician-reported reasons for visits in global PC were upper respiratory tract infection, hypertension, routine health maintenance, arthritis, diabetes, depression or anxiety, pneumonia, acute otitis media, back pain, and dermatitis [3]. While this global picture of the needs frequently addressed in PC is helpful to understand the variety of PC issues, it is critical to remember that PC clinics can look very different from each other. Oftentimes, PC is connected to Family Medicine, where the provider works with patients across the lifespan and across all healthcare-related needs. However, this does not capture all of PC. Some PC settings may be more focused on a specific age group, such as pediatrics or geriatrics. Others may be focused on addressing a certain diagnosis or concern, such as diabetes or homelessness. It is essential to understand the needs of your clinic, the population they serve, and their individual clinic priorities [4].

Regulatory Considerations

Health care is a highly regulated industry. There are regulatory support and constraints from local, state, federal, and private agencies to consider. Below is a list of some of the regulatory bodies that might influence the design and sustainability of your PC practice (see Table 3.5).

Note: The names of the organizations have been provided as well as the link to current resources. If the links provided become inactive, you can find the resources by searching the name of the organization.

Table 3.5 Regulatory considerations

Regulatory body	Key considerations
Centers for Medicare and Medicaid Services (CMMS) Regulatory guidance: https://www.cms.gov/Regulations-and-Guidance/Regulations-and-Guidance Manuals: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/index	CMMS is a federal agency that is part of the U.S. Department of Health and Human Services (DHHS). They have oversight of the Medicare and Medicaid programs and have a powerful influence over healthcare policy as more than 50% of health care is funded by this agency [2]
Federally Qualified Health Centers (FQHC) CMS guidance: https://www.cms.gov/Center/Provider-Type/Federally-Qualified-Health-Centers-FQHC-Center Health Resources and Services Administration: https://www.hrsa.gov/opa/eligibility-and-registration/health-centers/fqhc/index.html HRSA fact sheet: https://bphc.hrsa.gov/sites/default/files/bphc/about/healthcenterfactsheet.pdf	FQHCs are community-based healthcare centers that provide primary and preventive care services to under-served populations regardless of their ability to pay for care. FQHCs must meet strict regulatory standards, have an established sliding scale for payment, and be governed by a board that includes consumers. FQHCs are generally paid using a prospective payment system (PPS) that is based on their costs for medically necessary PC and qualified preventive care services
State Department of Health and Human Services National Conference of State Legislatures (NCSL): https://www.ncsl.org/	State health departments regulate offices to support health care, mental health, public health, social services, and other health-related services. In addition to regulatory oversight, state health departments often convene task forces and workgroups to create guidelines and enforce best practices in health and social service areas
Agency for Healthcare Research and Quality (AHRQ) is part of DHHS and defines the qualities of a Patient Centered Medical Home (PCMH): https://pcmh.ahrq.gov/page/defining-pcmh PCMH supports: https://pcmh.ahrq.gov/page/pcmh-foundations	A PCMH is a model for the organization of preventive and PC. A PCMH must achieve five main functions: comprehensive care, patient-centered care, coordinated care, accessible services, high quality and safety standards
National Committee for Quality Assurance (NCQA) payment methodology, grant funding, etc.) https://www.ncqa.org/	The NCQA collects data that measures the quality of performance for healthcare sites and providers. NCQA provides health plan accreditation based on quality indicators and PCMH certification based on meeting standard criteria and quality outcomes
The Joint Commission (TJC): https://www.jointcommission.org/ The Joint Commission Resources: https://www.jcinc.com	TJC is an accrediting body that provides standards for quality, performance, and environment. They accredit and/or certify healthcare organizations and programs including PC settings. To comply with Medicare's condition of participation, hospitals and other healthcare organizations may use an accrediting agency, like TJC, to meet the mandatory CMS evaluation

Setting Configurations

Using language from the Six Levels of Collaboration/Integration from the SAMHSA-HRSA Center for Integrated Health Solutions (CIHS) [5], below are examples of space configurations for PC settings. They are presented in order from most transformed/integrated practice to lowest, starting with Integrated, then Co-Located, and then Coordinated Off-Site.

1. **Integrated:** Providers work together in the same space, within the same facility, where some or all of the office/practice space is shared.
2. **Co-located:** Providers work in the same facility, but not necessarily the same offices. Space is shared by team members. Teams may be in the same room or within the same building.
3. **Coordinated Off-site:** This is a referral model where providers work in separate facilities and refer off-site. They may even have separate organizational and health record systems, and communication is minimal.

Pros and Cons (see Tables 3.6 and 3.7).

Table 3.6 Pros and cons of shared space configurations

Pros	Cons
Easier to communicate with team members	Personal space may be limited
Able to consult and problem-solve difficult cases with team members	Lack of privacy
Team cohesion and bonding	Volume of noise
Patients don't need to go to multiple locations	
Patients see providers working as a team which can improve patient confidence in their care	

Table 3.7 Pros and cons of separated space configurations

Pros	Cons
May have more space	Can be challenging to communicate with team
Space could be more tailored for OT use	Team can feel disconnected
More privacy	Volume of noise
	Patients need to go to multiple locations
	Increased likelihood patients will not be seen. As patients are sent out, the likelihood of them falling through the cracks in the system increases

Synchronous vs. Asynchronous Collaboration

Synchronous collaboration means that services from more than one team member are provided simultaneously, while asynchronous services are provided one team member at a time. Synchronous collaboration and sharing of space offers benefits to team members such as the ability to problem-solve in real time. However, if space is limited or schedules do not permit, this is not always feasible. Asynchronous collaboration and space utilization allows the same space to be used by multiple team members, but means that communication between providers does not happen in real time.

Reimbursement Models

- **Fee-for-service**: fee-for-service billing can include billing existing Current Procedural Terminology (CPT®) codes, as well as private pay rates for OT evaluation and services. Table 3.8: CPT® *Codes for OT* lists CPT® codes that are often billed by OTPs, but there are additional codes that can be used for other services provided in PC (e.g., wheelchair management, wound care, orthotic fabrication, and training). A comprehensive book of all CPT® codes may already be owned by the practice or can be purchased annually from the American Medical Association. In addition, AOTA generates an annual list of frequently used CPT® codes for OTPs that is accessible to members at AOTA.org

Table 3.8 CPT® codes for OT

CPT® codes often used by OTPs	Code number	Narrative description
Evaluation/ re-evaluation codes	**Untimed codes**	Level of complexity dictates code used
Occupational therapy evaluation, low complexity	97165	Requires low complexity clinical decisions based on a problem-focused assessment
Occupational therapy evaluation, moderate complexity	97166	Requires moderate analytic complexity required to make decisions, client may present with comorbidities that affect function
Occupational therapy evaluation, high complexity	97167	Requires high analytic complexity required to make decisions, multiple options to consider
Occupational therapy re-evaluation	97168	Re-evaluation requires assessment of changes in patient functional or medical status with revised plan of care

(continued)

Table 3.8 (continued)

CPT® codes often used by OTPs	Code number	Narrative description
Intervention codes	**Timed codes**—15 min increments	Most of intervention codes are timed
Self-care/home management training (ADLs)	97535	Self-care/home management training (e.g., activities of daily living [ADLs] and IADLs). May include safety training and education in use of adaptive devices
Therapeutic activities	97530	Therapeutic activities (i.e., functional activities used to improve functional/occupational performance)
Community/work reintegration training	97537	Community/work reintegration training (e.g., shopping, managing money, transportation, non-work and work-related activities and/or work environment/modification evaluation, work task analysis, use of assistive technology device/adaptive equipment)
Therapeutic procedure; therapeutic exercise	97110	Therapeutic procedure or exercise to develop strength and endurance, range of motion, and flexibility
Therapeutic procedure; group	97150 (untimed code)	Therapeutic procedure(s) group (2 or more) with constant attendance by the practitioner
Therapeutic interventions; cognitive function	97129	Therapeutic interventions that focus on cognitive function (e.g., attention, memory, problem solving, and other cognitive function skills). May include development of compensatory strategies to improve functional performance
Orthotic and prosthetic management and training	97760 (initial encounter orthotics) 97761 (initial encounter prosthetics) 97763 (subsequent encounters both orthotics/prosthetics)	Orthotics/prosthetics—includes assessment, fitting, training/management of orthotics/prosthetics for the upper/lower extremities, and trunk

– Be thoughtful in choosing your codes. To demonstrate your distinct skill set as an OTP, especially when using a code that other professions also utilize. Your documentation must clearly articulate the skilled OT perspective of your intervention. Your documentation must support why that code aligns with the diagnosis you are addressing and the treatment you provided. We've provided this guide to support choosing the most appropriate code for the activity they are doing. The documentation must support the code. Examples:

  If you use "therapeutic exercise," you should document how the exercise you are doing facilitates function and supports the functional goal in your intervention plan.