

Primary Care for Underserved Populations: Navigating Policy to Incorporate Occupational Therapy Into Federally Qualified Health Centers

Aileen D. Murphy, Vanessa M. Griffith, Theresa Berkeridge,
Tracy M. Mroz, Tracy L. Jirikowic

Federally qualified health centers (FQHCs) provide low- or no-cost primary care to medically underserved populations such as homeless or low-income people, migrant workers, and members of marginalized cultural groups. Occupational therapy services have the potential to help improve the health and functioning of FQHC patients. Using a FQHC serving American Indian/Alaska Native populations as a case example, we describe how occupational therapy is well suited to help meet the needs of medically underserved populations. We then examine options for integrating occupational therapy into this unique primary care setting, discuss related administrative and policy considerations, and propose possible solutions to identified barriers.

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Aileen D. Murphy, MOT, OTR/L, is Occupational Therapist, Kline Galland Home, Seattle, WA. At the time of this research, she was Student, Division of Occupational Therapy, Department of Rehabilitation Medicine, University of Washington, Seattle.

Vanessa M. Griffith, MOT, OTR/L, is Occupational Therapist, Muckleshoot Early Learning Academy, Auburn, WA. At the time of this research, she was Student, Division of Occupational Therapy, Department of Rehabilitation Medicine, University of Washington, Seattle.

Theresa Berkeridge, MOT, OTR/L, is Occupational Therapist, Seattle Public Schools, Seattle, WA. At the time of this research, she was Student, Division of Occupational Therapy, Department of Rehabilitation Medicine, University of Washington, Seattle.

Tracy M. Mroz, PhD, OTR/L, is Assistant Professor, Division of Occupational Therapy, Department of Rehabilitation Medicine, University of Washington, Seattle.

Tracy L. Jirikowic, PhD, OTR/L, FAOTA, is Associate Professor, Division of Occupational Therapy, Department of Rehabilitation Medicine, University of Washington, Seattle; tracyj@uw.edu

Federally qualified health centers (FQHCs) provide primary and preventive health services to medically underserved areas or populations such as homeless or low-income people, migrant workers, or marginalized cultural and ethnic groups. More than 22 million patients received care at a federal health center in 2014 (Health Resources and Services Administration [HRSA], 2016). Primary and preventive care services help reduce hospital visits and decrease the overall cost of care for underserved populations (Laiterapong et al., 2014; Rothkopf, Brookler, Wadhwa, & Sajovetz, 2011). Because occupational therapy services may reduce the severity and complications of disease (Rexe, Lammi, & von Zweck, 2013), we propose that incorporating occupational therapy into FQHCs could help further the triple aim of improving health care (Berwick, Nolan, & Whittington, 2008). Comprehensive services could improve health outcomes, client-centered practices could improve the experience of care, and increasing early service provision could reduce the

overall cost of health care for medically underserved populations. However, in a comprehensive needs assessment to develop an occupational therapy position in a FQHC that serves an American Indian/Alaska Native (AI/AN) population, several challenges were encountered. Using this example, we discuss administrative and policy considerations for occupational therapy service provision within a FQHC and describe how occupational therapists could address the needs of underserved populations in this primary care setting.

Social Justice

The notion of social justice within health care is supported worldwide. Article 25 of the United Nations' (1948) *Universal Declaration of Human Rights* asserted that every member of a society has the right to a standard of living that promotes health, including medical care and necessary social services. Within the field of occupational therapy, social justice has informed the concept of occupational justice, which

addresses equity, access, and the right to engage in one's desired or needed occupations. The World Federation of Occupational Therapists' (2006) position statement related to human rights asserted that people have the right to participate in occupation and that this right is threatened by "poverty, disease, [and] social discrimination" (p. 1). The American Occupational Therapy Association (AOTA; 2010) noted that social justice as it relates to service delivery involves "fair treatment and an impartial share of the benefits of society" (p. S21) for both individuals and groups. Given the national and international support for incorporating social justice into the provision of health care, the profession has a duty to explore opportunities to better serve disadvantaged populations.

The passage of the Patient Protection and Affordable Care Act (ACA; Pub. L. 111–148) in 2010 helped to highlight the notion of social justice within health care. Indeed, Title I of the ACA is designated "Quality, Affordable Health Care for *All* [italics added] Americans." According to HRSA (2016), the ACA introduced many changes for the general public, including increased overall funding, expansion of mental health services, quality improvement incentives, and center-based enrollment assistance, among many others. Within the field of occupational therapy, the implications of this legislation are significant. For example, the ACA provided incentives to expand Medicaid coverage (Medicaid.gov, 2015) for low-income adults. As a result, in states that chose to expand Medicaid, many individuals who previously lacked access to occupational therapy services because of financial limitations or lack of insurance now have the means to use occupational therapy through Medicaid reimbursements. In light of the increased potential to access occupational therapy services, a practical matter needs to be addressed: How will these previously uninsured low-income Americans actually receive needed occupational therapy services? What service delivery models would be most effective for reaching previously marginalized populations? How do we achieve social justice in access to occupational therapy?

Occupational Therapy in Primary Care

A key direction the ACA has charted is toward an emphasis on prevention and a parallel resurgence in a broader, recrafted primary care. If access to occupational therapy is to be achieved, the profession must promote its role in primary care and in the related area of prevention. Title IV of the ACA is designated "Prevention of Chronic Disease and Improving Public Health," and it provides an unmatched commitment of funds to these areas (ACA, 2010). In particular, rehabilitation medicine is among the disciplines to be included in a newly created U.S. Department of Health and Human Services Advisory Group on Prevention, Health Promotion, and Integrative and Public Health (ACA, 2010). This inclusion of rehabilitation medicine within prevention and health promotion carries with it new possibilities for where and how occupational therapy might be delivered. In addition, rehabilitative and habilitative services are considered essential health benefits—1 of 10 service categories that the ACA requires certain health insurance plans to cover (ACA, 2010).

New models of primary care have emerged since the passage of the ACA, including exploratory models of occupational therapy service delivery in the primary care setting. All of these models build on a new and expanded view of a primary care that provides continuous, coordinated, and comprehensive care to effectively and efficiently meet the needs of patients. Historically, a typical primary care team has included a physician, physician assistant, or nurse practitioner; registered nurses, licensed practical nurses, or both; and medical assistants (AOTA, 2013). In recent years, reimbursement policies have contributed to increased productivity demands for physicians, resulting in decreased patient contact.

The current role of physicians is often limited to diagnosing conditions and providing medical management (Metzler, Hartmann, & Lowenthal, 2012). Under the supervision of physicians, other professionals are providing many services formerly provided by physicians. The

inclusion of occupational therapy practitioners on the primary care team could supplement the medical services already provided with occupation-based interventions, thus helping to achieve outcomes and use resources efficiently. Although some legal and reimbursement barriers have been encountered as a result of collocating additional providers with physicians, improved function and health for older adults and people with chronic conditions have been demonstrated (Donnelly, Brenchley, Crawford, & Letts, 2013).

In 2014, AOTA published a position paper that advocated for and highlighted how occupational therapy practitioners could bring a unique perspective to a primary care team (Roberts et al., 2014). One component of this perspective is the distinct knowledge of and skills in activity analysis and compensatory strategies that could contribute to patients' functional independence, including environmental modifications (AOTA, 2013). Because of these skills and unique knowledge set, areas of focus for occupational therapy practitioners include safety and falls prevention; modification of the physical environment to support participation; self-management of chronic conditions, including psychiatric or behavioral conditions; and driving and community mobility (Metzler et al., 2012; Roberts et al., 2014).

By including language regarding health promotion in the *Occupational Therapy Practice Framework: Domain and Process* (3rd ed.), AOTA (2014) has underscored the occupational therapy profession's commitment to prevention, wellness, and proactive steps to maintain health. Indeed, if the health care system is to be effectively reformed, it may be important to redefine the notion of health itself. Occupational therapy can be at the forefront of that redefinition process and infuse its perspective into the change.

Federally Qualified Health Centers

FQHCs are nonprofit health centers that aim to "treat the whole patient through culturally-competent, accessible, and integrated care" (HRSA, 2016, p. 1). These centers provide emergency medical

procedures and outpatient health services and thus serve as a safety net for underserved communities across the United States and its territories. FQHCs are funded in part by grants from HRSA via Title 42 of the U.S. Code (Chapter 6A, Subchapter 2, Part D, Subpart 1, Section 54b; formerly Section 330 of the Public Health Service Act; HRSA, 2016, p. 14). In 2015, a total of \$270 million was awarded under the ACA to establish 430 new health centers (HRSA, 2016).

FQHCs can provide services to patients covered by Medicaid, Medicare, and private insurance. Medicaid reimbursement methodology for FQHCs varies by state and includes forms of prospective payment, cost-based payments, negotiated fee-for-service schedules, and combinations (Kaiser Family Foundation, 2016). The Medicare prospective payment system was established by the ACA and uses an encounter-based daily rate adjusted for geographic region. An *encounter* is defined as a face-to-face visit between a patient and a FQHC provider (such as a physician or nurse), for which the FQHC receives reimbursement to cover the associated costs including “medical services, supplies, and the overall coordination of the services provided to the agency client” (Washington State Health Care Authority, 2016, p. 14).

In Washington State, each FQHC negotiates its own encounter rate, a “cost-based, facility-specific rate for covered FQHC services paid to a FQHC for each valid encounter it bills” (WSHCA, 2016, p. 12). At this time, occupational therapists are not considered FQHC-qualified providers and thus cannot bill for independent visits even through Medicaid or Medicare because overhead and other costs noted earlier are not covered. However, they can provide services in conjunction with a qualified provider—called “incidental to” services (WSHCA, 2016, p. 22)—but only in certain circumstances. These rules may differ from state to state.

American Indian/Alaska Native Populations and FQHCs

FQHCs support health care for many different culturally marginalized and medically underserved groups, including AI/AN

communities. In 2014, there were 5.4 million AI/AN residents in the United States, and that number is projected to increase to 11.2 million by 2060 (Colby & Ortman, 2015). Inequalities in education, employment, funding, nutrition, political representation, and poverty levels have resulted in marginalization and lack of access to essential health services (Jones, 2006). Additional geographic, financial, and cultural barriers have further decreased access to health care services by AI/AN communities (Lomay & Hinkebein, 2006).

Multiple studies have identified the largest obstacle to receiving all needed services and achieving a benefit from those services as the misalignment between AI/AN cultural values and traditional service delivery methods (Clark & Kelley, 1992; Lomay & Hinkebein, 2006). In 1992, Clark and Kelley stated, “It is paramount that attention be paid to the underlying values of Native American clients if rehabilitation goals are to be met” (p. 23). Although progress in health equity has been made, these rates of disparity continue to influence health care delivery. Occupational therapists have the potential to help to reduce this disparity by incorporating client-specific spiritual and cultural values into their holistic approach to treatment (Brach & Fraser, 2000), which is a foundational principle of occupational therapy.

Case Example: Seattle Indian Health Board

The Seattle Indian Health Board (SIHB) is a FQHC that provides culturally relevant, holistic health care to Seattle’s urban AI/AN population and the surrounding community. It provides primary medical services and chemical dependency treatment, domestic violence programming, elder care, mental health, prenatal and parenting classes, traditional medicine, veterans care, youth outreach, and much more. By linking primary care with specialty providers, SIHB provides a network of services that encourages and facilitates comprehensive care for patients. Without this network, patients would be required to make multiple appointments with different providers and navigate multiple

administrative policies, ultimately receiving duplicative or incomplete services, which has been termed *fragmented care* (Muir, Henderson-Kalb, Eichler, Serfas, & Jennison, 2014). By providing comprehensive health care, SIHB, like other FQHCs, attempts to partially bridge the gap created by economic, physical, and social barriers experienced by AI/AN and indigent persons.

As part of its efforts to provide comprehensive care, in 2014 SIHB expressed interest in hiring an occupational therapist to improve existing services such as chronic disease management, chemical dependency treatment, preventive primary care services, and elder care. At SIHB’s request, master of occupational therapy students from the University of Washington completed a needs assessment to determine how occupational therapy could be incorporated into the organization’s existing structure. Through this process, existing models of occupational therapy provision within a FQHC were reviewed. Other international or unpublished models, not reviewed here, may also provide guidance and examples (Donnelly, Brenchley, Crawford, & Letts, 2014; Garvey, Connolly, Boland, & Smith, 2015). Costs and benefits of these models were examined, and the implications of incorporating these existing models into SIHB’s current structure were considered. The following section details key considerations of the two main models reviewed.

Current Models of Occupational Therapy in Primary Care

University of Southern California Model

One of the models of a full-time occupational therapist embedded within a FQHC primary care team was developed at the University of Southern California (USC) Eisner Pediatric and Family Medicine Center (AOTA, 2013; Brown et al., 2014; Farmer, Prestwich, & Muir, 2013; Goldberg & Pillittere Dugan, 2013; Pezeshkpour, 2014). Clients were from underserved communities, and many had not previously had access to occupational therapy services (Pezeshkpour, 2014). The

occupational therapist supplemented the main provider teams of physicians and residents by participating in client visits and team meetings. When a need for particular services was identified, occupational therapy immediately intervened to meet that need, such as those of children at risk for developmental disabilities, adults with disabilities, and senior citizens (Pezeshkpour, 2014).

Saint Louis University Model

A second working model of occupational therapy embedded within primary care services was created at Saint Louis University (SLU; Farmer et al., 2013). In this pilot program, an occupational therapist and a Level II fieldwork student joined the teams at six different health care programs overseen by SLU. The patients ranged from premature infants to older adults, and occupational therapy interventions ranged from administering developmental screenings to providing mental health, chronic pain, prevention, and general health and wellness services (Farmer et al., 2013). At SLU, the occupational therapist accompanied physicians to all appointments. During each consultation, the occupational therapist was able to assess the impact that a patient's medical problems had on his or her daily functioning, implement treatment plans, and recommend additional rehabilitative services as needed (Farmer et al., 2013).

Funding Considerations

University of Southern California

The USC Eisner clinic is a FQHC operating under a prospective payment system (AOTA, 2013). The clinic renegotiated to a higher encounter rate to cover the additional costs associated with retaining an occupational therapist and providing occupational therapy services, therefore eliminating the need for the occupational therapist to bill separately for services. Not all FQHCs can renegotiate rates; SIHB cannot renegotiate at this time.

Saint Louis University

At the SLU FQHC, the occupational therapist was employed by SLU and was

granted 6 mo leave from teaching duties to subsidize free provision of occupational therapy services in SLU primary care clinics. Students also provided services with appropriate supervision. If SIHB were to use this model, occupational therapy education institutions would have to fund faculty mentors to supervise graduate students providing free services.

Barriers and Facilitators

The USC and SLU models have similar benefits. Both models made occupational therapy services available to all clients, some of whom had never encountered the profession. In the primary care setting, occupational therapists were able to incorporate immediate interventions in the context of ongoing primary care and with scheduling ease for clients. Both models provided a successful venue to inform and educate other medical providers about the value of occupational therapy.

If SIHB used either of these models, innovation and flexibility would be required on the part of the therapist to join the team and provide timely and effective services. Treatment space might need to be expanded to allow primary care providers and occupational therapists to simultaneously work with patients. Additionally, employees of the facility may require education on occupational therapy's scope and its possible contributions to maximize collaboration and facilitate optimal use of the occupational therapist's expertise.

In primary care centers, referrals for occupational therapy can be made in house by clinic physicians or physician extenders authorized to refer under state licensure, Medicaid, and Medicare. The use of general screening tools could help quickly and easily identify patients who could benefit from occupational therapy services. Integrated health centers in Canada found that educating team members on occupational therapy was critical to generating referrals (Donnelly et al., 2013). Referrers could be taught through staff training, service demonstrations, and case study presentations to recognize which patients would be good candidates for occupational therapy services.

Independent Billing Model

A third option considered was to have an occupational therapist contract clinic space from SIHB and see clients referred by SIHB providers. Contracts could be adjusted in response to growing or fluctuating caseload, and providers could gain familiarity with occupational therapy services and build up a referral base. This model could be a low-risk way to initially implement occupational therapy services. Medicaid may reimburse occupational therapists in Washington State for services rendered outside of eligible FQHC encounters via its fee-for-service outpatient rehabilitation schedule. Medicare and Medicaid have complex rules, regulations, and legal requirements regarding alternative providers at FQHCs that could limit the easy use of this option.

Conclusion

We explored the inclusion of occupational therapy in FQHCs as one example of integrated primary care services. This project also explored how occupational therapy practitioners can contribute to health equity, a basic tenet of ethical health care, by enhancing access and service provision for AI/AN communities. Clearly, both benefits and challenges of existing and proposed models need to be considered, as well as the administrative (e.g., financial) structure of FQHCs. Although this project was limited by time and could not implement occupational therapy services in SIHB, the clinic was left with a clear outline of the steps needed to integrate occupational therapy services into its existing health clinic. It will take work to advocate for the inclusion of occupational therapy in FQHCs across the United States. Gathering evidence on the effectiveness of occupational therapy within primary care is also of utmost importance. Trying alternative approaches to introduce occupational therapy to FQHCs and primary care will ultimately increase access to occupational therapy and achieve health justice. ▲

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