Interprofessional Collaborative Practice in Care Coordination

The Patient Protection and Affordable Care Act of 2010 (ACA; Pub. L. 111–148) supports patient-centered primary care through the creation of authority for the Centers for Medicare and Medicaid Services (CMS) to develop new models of interdisciplinary team practice, payment reform, and increased use of information technologies (Berrymen, Palmer, Kohl, & Parham, 2013). Occupational therapy practitioners need to assess how the profession fits within these new models of care and must be involved in studying the impact of these new models on key health care outcomes related to the “Triple Aim” of lowering costs, improving patient experience, and managing the health of populations (Berwick, Nolan, & Whittington, 2008).

Care Coordination in the New Models

In practice and policy, care coordination is an integral component of the new models and is defined as (i) Promoting broad payment and practice reform in primary care, including patient-centered medical home models for high-need applicable individuals; . . . (iii) Utilizing geriatric assessments and comprehensive care plans to coordinate the care (including through interdisciplinary teams) of applicable individuals with multiple chronic conditions; . . . (v) Supporting care coordination for chronically-ill applicable individuals at high risk of hospitalization through a health information technology-enabled provider network that includes care coordinators, a chronic disease registry, and home tele-health technology; . . . (vii) Utilizing medication therapy management services; . . . (viii) Establishing community-based health teams to support small-practice medical homes by assisting the primary care practitioner in chronic care management, including patient self-management activities.

A critical issue will be monitoring the hundreds of CMMI projects to promote the role of occupational therapy in these demonstration programs.
Without care coordination, pitfalls exist that can lead to fragmented care and resulting negative outcomes, such as medication errors and avoidable hospitalizations and emergency department visits (National Quality Forum, 2010). Understanding the impact of fragmented care becomes easier when one considers that nearly 70 million Americans are projected to be eligible for Medicare in 2023, a significant increase from the current 50 million (Blumenthal, Stremikis, & Cutler, 2013). Eighty percent of Medicare beneficiaries do not have access to care coordination (American Geriatrics Association, 2011), even though patients with five or more complex chronic conditions account for more than 75% of total Medicare spending. Medicare beneficiaries enrolled in Medicare Advantage plans are the 20% who are required to receive care coordination services as necessary.

Barriers affecting care coordination include lack of patient access to a range of needed health and social services and the resulting difficulty care coordination teams have in managing scarce resources in health care systems (Walsh et al., 2010). As a result, lack of care coordination is a key driver of increased costs and problems in patient experience. Many organizations across the health care system have undertaken quality improvement initiatives to develop care coordination models to reduce rehospitalizations and emergency room visits.

Occupational therapy practitioners are grounded in the critical skills and competencies necessary for effective team management and implementation of care coordination. The occupational therapy profession must promote its education and skills in interprofessional collaborative practice and highlight the way in which these team-based skills position the profession as key in the design and implementation of care coordination models.

**Care Coordination Models**

Care coordination models depend on improvement in team-based approaches that support a patient- and family-centered focus, multidisciplinary communication, coordination of work and roles among team members, and measurement of team-based outcomes of care (Cipriano, 2012). Care coordination also extends to coordination with other service providers, including hospitals and postacute care providers. Many models of care coordination have been developed. The CMMI is providing funding for a variety of care coordination efforts, including the development of Accountable Care Organizations (ACOs), promotion of community-based care transition programs, and enhanced primary care (CMS, n.d.).

A common principle that undergirds all care coordination models is that of the patient-centered medical home (PCMH). This model was first developed by the American Academy of Pediatrics (AAP) in the 1990s (AAP, 1992) and has subsequently been adopted by other physician societies. PCMH is an approach to providing comprehensive primary care for people of all ages and with all medical conditions. Although this term is often used to describe a particular model, it is in many ways the foundation of the framework of ACOs and other managed care approaches. Several PCMH elements are important, including team-based care, information technologies, and payment incentives for value-based care (Scholle, Saunders, Tirodkar, Torda, & Pawlson, 2011).

Typically, the PCMH approach is used in a primary care setting under supervision of physicians, nurse practitioners, and physician assistants. This hierarchy may need to be challenged if the range of skills on the team is to be fully used. Some research shows that if other professionals are used appropriately, 24% of the physician or related professionals can be freed up, making better use of resources and competencies (Bodenheimer, 2006).

Redefining the leadership and players for the PCMH and the other models built around this core will be required if occupational therapy practitioners are to be a part of the team-based care process. How occupational therapy practitioners may function as lead care managers in models using the PCMH approach will require further delineation of occupational therapy’s skills because these roles are typically filled by nurse practitioners and social workers. Also, occupational therapists, rather than business-trained professionals, could serve as practice facilitators in the PCMH to drive quality improvement and build a team orientation.

Occupational therapy education in team dynamics, leadership, and outcome effectiveness creates skills required for practice facilitation (Taylor, Machta, Meyers, Genevro, & Peikes, 2013). Occupational therapy practitioners must not only delineate how they can fill these new roles but also push and advocate for maximum use of their talents and capabilities.

CMMI is conducting several other primary care initiatives, including efforts in collaboration with Federally Qualified Health Centers to provide primary care and Multi-Payer Advanced Primary Care Practice (CMS, n.d.). These and other grants and projects promote care coordination, improved access, patient education, and other services to support chronically ill patients and those who have multiple or complex conditions.

**Occupational Therapy’s Role in Care Coordination**

The American Academy of Nursing (Cipriano, 2012) recommended the following guiding principles for implementation, evaluation, and payment for care coordination and transitional care models:

- Models are patient and family caregiver-centered in concept and design that support shared decision-making.
- Interprofessional teams match services to patient and family needs to gain the highest value.
- Team leadership shifts according to patient and family needs, preferences, and expertise of team members.
- Existing and new payment mechanisms recognize evidence-based models led by any discipline that are associated with improved quality outcomes and cost reduction.
- Explicit and seamless links connect patients, providers, and caregivers to community resources.
- Teams have high reliance on the expertise, skills, and services of registered nurses.
- Care coordination and transitional care provide seamless transition experiences for patients and family caregivers.
- Ongoing quality measurement and comparative effectiveness research are needed to test these assumptions and define best practices. (p. 331)
These principles of care coordination are consistent with the values and philosophical underpinnings of the occupational therapy profession related to patient- and family-centered care. The central principle supporting involvement of occupational therapy in care coordination is the concept of team leadership shifting according to patient and family needs and preferences and the expertise of team members. Occupational therapy practitioners have considerable expertise with populations experiencing functional limitations and participation restrictions that, if ignored, may cause the patient and family to face reductions in income, institutionalized living, caregiver burden, and further preventable health, cognitive, and mental health declines.

Occupational therapy education focuses on patient and caregiver education; psychosocial, physical, cognitive, cultural, and environmental supports of function; quality assessment and improvement; and collaboration with other providers. Occupational therapy practitioners are therefore well equipped to create and assume lead roles within the PCMH or other primary care or coordinated care models. In addition, occupational therapy practitioners can fill the gap left by the growing shortage of traditional primary care providers, including nurse practitioners, physician assistants, and physicians. Finally, the long history of occupational therapy practitioners in fostering evidence-based practice through practice guideline development and systematic reviews serves the profession in terms of the quality improvement skills required for care coordination.

Promoting Interprofessional Education and Collaborative Practice for Better, More Coordinated Care

To develop adequately functioning health care teams, bridges must be built across professions beginning with professional, postprofessional, and continuing education. Historically, health profession entry-level education has occurred and, in many cases, continues to occur in discipline silos. As a result, the separate functioning of practitioners is perpetuated in spite of the demand for team collaboration as a major component of patient-centered care. According to the World Health Organization (WHO; 2010), “Interprofessional education [IPE] occurs when two or more professions learn about, from and with each other to enable effective collaboration and improve health outcomes” (p. 13). In contrast to siloed curricula, IPE provides for sharing skills and knowledge among health care professions and promotes respect for other health care professionals.

The focus of IPE is on helping students build a basic value of working within interprofessional teams before they engage in traditional clinical education experiences. Interprofessional education is the foundation for interprofessional collaborative practice, which the WHO (2010) defined as “occurring when multiple health workers from different professional backgrounds provide comprehensive services by working with patients, their families, carers, and communities to deliver the highest quality of care across settings” (p. 13). The Interprofessional Education Collaborative Expert Panel (2011) released a set of competencies designed to enable health profession schools to reshape their curricula to better prepare future clinicians for both collaborative and team-based care. These competencies for interprofessional practice include values and ethics, roles and responsibilities, communication, and teams and teamwork.

Confeerees at the Josiah Macy Jr. Foundation conference “Transforming Patient Care: Aligning Interprofessional Education With Clinical Practice Redesign” concluded that “educational reform must incorporate practice redesign, and delivery system change must include a central educational mission if we are to achieve enduring transformation” (Josiah Macy Jr. Foundation, 2013, p. 1). A consensus vision was created for “a healthcare system in which learners and practitioners across the professions are working collaboratively with patients, families, and communities and with each other to accomplish the ‘Triple Aim’” (p. 2). On the basis of this shared vision, conference participants crafted recommendations for immediate action in five areas:

1. Engage patients, families, and communities in the design, implementation, improvement, and evaluation of efforts to link interprofessional education and collaborative practice.
2. Accelerate the design, implementation, and evaluation of innovative models linking interprofessional education and collaborative practice.
3. Reform the education and lifelong career development of health professionals to incorporate interprofessional learning and team-based care.
4. Revise professional regulatory standards and practices to permit and promote innovation in interprofessional education and collaborative practice.
5. Realign existing resources to establish and sustain the linkage between interprofessional education and collaborative practice.

Occupational Therapy Education to Support Interprofessional Collaborative Practice and Care Coordination

Accreditation organizations are creating standards for appropriate design and implementation of collaborative practice and coordination, mainly through certification of primary care medical homes. Two important accreditations are those provided through the Joint Commission and through the National Committee for Quality Assurance. The purposes of these recognitions are linked to the Triple Aim and other frameworks to improve health care. The accreditations bestow a “seal of approval” that providers can use in marketing and in securing contracts with insurance companies, public providers, and others.

The Joint Commission (2014) stated the primary tenets for collaborative practice and coordination as practiced in a primary care medical home as follows:

- **Patient-centered care**—Relationship-based care focuses on the whole person and understanding and respecting each patient’s needs, culture, values and preferences
- **Comprehensive care**—A team of providers (may include physicians, advanced practice nurses, physician assistants,
nurses, pharmacists, nutritionists, mental health workers, social workers, and others) work to meet each patient’s physical and mental health care needs, including prevention and wellness, acute care and chronic care.

- **Coordinated care**—Care is coordinated across the broader health care system, including specialty care, hospitals, home care, and community services and support. This is particularly critical during transitions between sites of care, such as when patients are discharged from the hospital.
- **Superb access to care**—Patients have access to services with shorter waiting times for urgent needs, enhanced person hours, around the clock telephone or electronic access to members of the care team, and alternative methods of communication such as e-mail and telephone.
- **Systems-based approach to quality and safety**—The PCMH uses evidence-based medicine and clinical decision support tools, engages in performance measurement and improvement, measures and responds to patient experiences and satisfaction, practices population health management, and publicly shares robust quality and safety data and improvement activities. (p. 1)

The National Committee for Quality Assurance (NCQA; n.d.) stated similar goals for its recognition of appropriate PCMH goals:

The Patient Centered Medical Home (PCMH) 2011 program is for practices that provide first contact, continuous, comprehensive, whole person care for patients across the practice. PCMH has at its foundation the Joint Principles developed by the primary care medical societies (American College of Physicians, American Academy of Family Physicians, American Academy of Pediatrics, American Osteopathic Association):

- Whole-person care;
- Personal clinician provides first contact, continuous, comprehensive care;
- Care is coordinated or integrated across the health care system;
- Team-based care.

Whole-person care includes provision of comprehensive care and self management support and emphasizes the spectrum of care needs, such as routine and urgent care; mental health; advice, assistance and support for making changes in health habits and making health care decisions. Preventive care is also a key component of the expectation for clinician focus. For purposes of this paper, certain standards of NCQA were reviewed for their relationship to occupational therapy education.

Professional education in occupational therapy includes some IPE and collaborative practice competencies as described in the Accreditation Council for Occupational Therapy Education (ACOTE®) Standards and Interpretive Guide (American Occupational Therapy Association [AOTA], 2012). The occupational therapy educational standards can be matched with the NCQA (2011) Standards for Patient-Centered Medical Home (Table 1).

The matching between the ACOTE and NCQA standards supports the inclusion of occupational therapy practitioners in care coordination roles in primary care. According to Leasure et al. (2013), occupational therapy practitioners, along with primary care providers, must develop skills in the following areas:

- **Team leadership**, the ability to coordinate team members’ activities, ensure appropriate task distribution, evaluate effectiveness, and inspire high-level performance;
- **Mutual performance monitoring**, the ability to develop a shared understanding among team members regarding intentions, roles, and responsibilities so as to accurately monitor one another’s performance for collective success;
- **Backup behavior**, the ability to anticipate the needs of other team members and shift responsibilities during times of variable workload;
- **Adaptability**, the capability of team members to adjust their strategy for completing tasks on the basis of feedback from the work environment; and
- **Team orientation**, the tendency to prioritize team goals over individual goals, encourage alternative perspectives, and show respect and regard for each team member. (p. 587)

In examining these collaborative practice team skills, it is clear that occupational therapy education should be intentional about the development of practitioner abilities in forming teams, leading teams, evaluating team performance and team member performance, recognizing perceptions of power differentials among team members, creating accountability for performance, and implementing quality improvement approaches to maximize team outcomes.

**Partnering With Key Organizations on Care Coordination**

The occupational therapy profession must directly and forcefully pursue advocacy for an occupational therapy role in care coordination. To become recognized as key stakeholders and providers, individual practitioners and professional associations such as AOTA must reach out to promote the fit of occupational therapy in the care coordination process. To begin this work, AOTA held a Forum on Interprofessional Team-Based Care in June 2013 involving several important professional groups, such as the American Academy of Family Physicians. Reports generated from this forum highlight roles and opportunities for occupational therapy (AOTA, 2013). The work must continue and include all levels of the profession in reaching out to speak for occupational therapy. As of this writing, the Representative Assembly of AOTA has approved an official document prepared by the AOTA Commission on Practice outlining the role of occupational therapy in primary care (AOTA, 2014).

For the profession, research on occupational science and occupational performance and its subcomponents has been invaluable to prepare occupational therapy for the health care reforms outlined in the ACA. Theories and research about how habits, routines, and engagement in meaningful occupation contribute to health have always united the profession in its scope and purpose. However, the terms of our profession...
Table 1. Matched ACOTE® (AOTA, 2012) and PCMH Standards (NCQA, 2011) Related to Collaborative Interprofessional Practice

<table>
<thead>
<tr>
<th>ACOTE Standard No.</th>
<th>ACOTE Standard for Master’s-Level Programs</th>
<th>ACOTE Standard for Doctoral-Level Programs</th>
<th>PCMH Standards (NCQA, 2011, p. 3)</th>
</tr>
</thead>
<tbody>
<tr>
<td>B.5.21</td>
<td>Effectively communicate and work</td>
<td>Effectively communicate, coordinate, and</td>
<td>PCMH 1: Enhance access to and continuity of care</td>
</tr>
<tr>
<td></td>
<td>interprofessionally with those who</td>
<td>work interprofessionally with those</td>
<td>PCMH 2: Identify and manage patient populations</td>
</tr>
<tr>
<td></td>
<td>provide services to individuals,</td>
<td>who provide services to individuals,</td>
<td>PCMH 3: Plan and manage care</td>
</tr>
<tr>
<td></td>
<td>organizations, and/or populations to</td>
<td>organizations, and/or populations to</td>
<td>PCMH 4: Provide self-care support and community resources</td>
</tr>
<tr>
<td></td>
<td>clarify each member’s responsibility in</td>
<td>clarify each member’s responsibility in</td>
<td></td>
</tr>
<tr>
<td></td>
<td>executing an intervention plan. (p. 27)</td>
<td>executing components of an intervention</td>
<td></td>
</tr>
<tr>
<td>B.5.27</td>
<td>Describe the role of the occupational</td>
<td>Demonstrate care coordination, case</td>
<td></td>
</tr>
<tr>
<td></td>
<td>therapist in care coordination, case</td>
<td>management, and transition services in</td>
<td></td>
</tr>
<tr>
<td></td>
<td>management, and transition services</td>
<td>traditional and emerging practice</td>
<td></td>
</tr>
<tr>
<td></td>
<td>in traditional and emerging practice</td>
<td>environments. (p. 27)</td>
<td></td>
</tr>
<tr>
<td>B.6.4</td>
<td>Articulate the role and responsibility</td>
<td>Advocate for changes in service delivery</td>
<td>PCMH 1: Enhance access to and continuity of care</td>
</tr>
<tr>
<td></td>
<td>of the practitioner to advocate for</td>
<td>policies, effect changes in the system,</td>
<td></td>
</tr>
<tr>
<td></td>
<td>changes in service delivery policies,</td>
<td>and identify opportunities to address</td>
<td></td>
</tr>
<tr>
<td></td>
<td>to effect changes in the system, and</td>
<td>societal needs. (p. 29)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>to identify opportunities in emerging</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>practice areas. (p. 29)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>B.6.5</td>
<td>Analyze the trends in models of service</td>
<td>Analyze the trends in models of service</td>
<td>PCMH 1: Enhance access to and continuity of care</td>
</tr>
<tr>
<td></td>
<td>delivery, including, but not limited to,</td>
<td>delivery, including, but not limited to,</td>
<td></td>
</tr>
<tr>
<td></td>
<td>medical, educational, community, and</td>
<td>medical, educational, community, and</td>
<td></td>
</tr>
<tr>
<td></td>
<td>social models, and their potential</td>
<td>social models, and their potential</td>
<td></td>
</tr>
<tr>
<td></td>
<td>effect on the practice of occupational</td>
<td>effect on the practice of occupational</td>
<td></td>
</tr>
<tr>
<td></td>
<td>therapy. (p. 29)</td>
<td>therapy. (p. 29)</td>
<td></td>
</tr>
<tr>
<td>B.7.6</td>
<td>Demonstrate the ability to design</td>
<td>Demonstrate leadership skills in the</td>
<td>PCMH 5: Track and coordinate care</td>
</tr>
<tr>
<td></td>
<td>ongoing processes for quality</td>
<td>ability to design ongoing processes for</td>
<td>PCMH 6: Measure and improve performance</td>
</tr>
<tr>
<td></td>
<td>improvement (e.g., outcome studies</td>
<td>quality improvement (e.g., outcome</td>
<td></td>
</tr>
<tr>
<td></td>
<td>analysis) and develop program changes</td>
<td>studies analysis) and develop program</td>
<td></td>
</tr>
<tr>
<td></td>
<td>as needed to ensure quality of services</td>
<td>changes as needed to ensure quality of</td>
<td></td>
</tr>
<tr>
<td></td>
<td>and to direct administrative changes. (p.</td>
<td>services and to direct administrative</td>
<td></td>
</tr>
<tr>
<td></td>
<td>30)</td>
<td>changes. (p. 30)</td>
<td></td>
</tr>
<tr>
<td>B.8.3</td>
<td>Use scholarly literature to make</td>
<td>Use scholarly literature to make</td>
<td>PCMH 6: Measure and improve performance</td>
</tr>
<tr>
<td></td>
<td>evidence-based decisions. (p. 31)</td>
<td>evidence-based decisions. (p. 31)</td>
<td></td>
</tr>
</tbody>
</table>

Note. ACOTE = Accreditation Council for Occupational Therapy Education; AOTA = American Occupational Therapy Association; NCQA = National Committee for Quality Assurance; PCMH = patient-centered medical home.

are typically unfamiliar to policy leaders, health care system leaders, and primary care practitioners who are building care coordination models. To ensure continued access to funding and reimbursement, occupational therapy practitioners must translate concepts of occupation in terms that clearly link them to disease management, population health, lifestyle and behavioral change, self-management, and reduction of caregiver burden. Outreach to critical organizations now proliferating to address components of the Triple Aim will be an important way to integrate occupational therapy–based concepts into developing frameworks for addressing improved care. Key care coordination organizations include the following:

- National Coalition on Care Coordination (N3C; http://www.nyam.org/social-work-leadership-institute-v2/care-coordination/n3c/about-n3c.html), with a particular focus on older adults, was formed in 2008 as a partnership between Social Work Leadership Institute, the American Society on Aging, and Rush University Medical Center. The N3C represents 37 organizations to advocate for enactment of public policies that support care coordination.
- National Transitions of Care Coalition (NTOCC; http://www.ntocc.org) was formed in 2006 to improve the quality of care coordination and communication when patients are transferred from one level of care to another. NTOCC works with more than 30 professional associations, medical specialty societies, standards bodies, regulators, and government organizations to develop, review, test, critique, and implement NTOCC-produced tools and materials supporting improved transitions in care.
- Patient-Centered Primary Care Collaborative (http://www.pcpc.org/) is a coalition of major employers, consumer groups, patient quality organizations, health plans, labor unions, hospitals, physicians, and others to develop and advance the PCMH. The purpose of the organization is to disseminate results and outcomes from medical home initiatives, advocate for public policy that advances and builds support for primary care and the medical home, and convene stakeholders to promote learning, awareness, and innovation of the medical home model.
• Partnership to Fight Chronic Disease (http://www.fightchronicdisease.org) is a national and state-based coalition of patients; providers; community, business, and labor groups; and health policy experts committed to raising awareness of chronic disease as the number one cause of death, disability, and rising health care costs.

Conclusion
Promoting occupational therapy practitioners as care coordinators and as critical, necessary leaders and members of interprofessional teams will require a cultural shift both within and outside the profession. Successful integration of occupational therapy into ongoing care coordination requires an examination of occupational therapy education, practice, and research. In education, the profession must expand the standards and expectations regarding interprofessional collaborative practice and teamwork. Additionally, there is a need to place a greater emphasis in education and research on the design of coordination and care provision models, monitoring of outcomes, and using quality improvement methodologies. The existing educational standards provide a firm basis for the future because they link closely to critical expectations now defined for PCMHs and related coordinated care models (see Table 1).

Practice, too, must evolve. Occupational therapy practitioners need to develop their expertise in using varied communication strategies and technologies, including electronic record keeping and telehealth, to work with other professionals to maximize the care of patients and their families, thereby truly enabling clients to live life to its fullest. ▲

References