Primary care is a key theme in the Patient Protection and Affordable Care Act (ACA; 2010). But what does the term mean? Is there a difference between primary care and primary health care? Does primary care encompass occupational therapy? What are the possible roles for occupational therapy in primary care and in achieving primary health care goals?

This column defines the terms, provides questions for occupational therapy professionals to consider in connecting the domain of practice to primary care and primary health care, and suggests some possible connections between the definitions and practice.

**Definition of Primary Care**

The ACA addresses primary care in several ways, but the definition is usually construed as limited, even as the descriptions of what primary care should be and should accomplish are expansive. Is this a problem of expectations—that primary care should address a “large majority of personal health needs” (ACA, 2010) or that it should address a plurality of care? In defining primary care practitioners, the ACA identifies physicians, nurse practitioners, and physician assistants.

This definition may be a carryover from the language that defines services provided by community health centers (CHCs). Occupational therapy is identified as a “supplemental service” along with all other rehabilitative services (42 C.F.R. § 51c.102(j)(4)); CHCs refer their clients to other providers of rehabilitative services because the federal funding provided to CHCs through the Health Resources and Services Administration is to be used only for basic services.

In the ACA, primary care is defined with similar constraints:

- the provision of integrated, accessible health care services by clinicians who are accountable for addressing a large majority of personal health care needs, developing a sustained partnership with patients, and practicing in the context of family and community. (§ 3502)

Therefore, the exact definition of primary care in the ACA is limited by who can provide it (physicians and physician extenders), but it is intended to address most of the needs of patients over a period of time, including family and community. Are these contradictory requirements?

There are high expectations for primary care as expressed in a description of supports for the primary care workforce:

- The Obama Administration believes that strengthening and growing our primary care workforce is critical to reforming the nation’s health care system. Increasing access to primary care physicians and nurses can help prevent disease and illness and ensure
all Americans—regardless of where they live—have access to high quality care. It can also reduce costs by increasing access to preventive care. (healthreform.gov, n.d., para. 2)

But how can primary care achieve these lofty goals if it is not viewed more broadly? Are there conflicting concepts in these definitions and in the expectations? If certain care is primary, then what is the rest of care? Answers to these questions are critical to ensure quality of health care. But who will answer these questions, and when?

Can we as a profession mobilize and promote a broader discussion of the concept and the actualization of primary care with occupational therapy as a critical element? Some have indicated this as a possibility. A rethinking of what specialist and supplemental services are and how they can achieve the “triple aim” of health care may be one avenue to promote occupational therapy.

The triple aim of health care as conceived by the Institute for Healthcare Improvement, founded by Donald Berwick, who served as the administrator of the Centers for Medicare and Medicaid Services from July 2010 to December 2011, provides a link to be considered:

Improving the U.S. health care system requires simultaneous pursuit of three aims: improving the experience of care, improving the health of populations, and reducing per capita costs of health care. Preconditions for this include the enrollment of an identified population, a commitment to universality for its members, and the existence of an organization (an “integrator”) that accepts responsibility for all three aims for that population. The integrator’s role includes at least five components: partnership with individuals and families, redesign of primary care, population health management, financial management, and macro system integration. (Berwick, Nolan, & Whittington, 2008, p. 759)

This description of a new and more effective health care system recognizes primary care, but Berwick et al. (2008) also recognized that primary care may need to be redefined and reconceived:

We believe that any effective integrator will strengthen primary care for the population. To accomplish this, physicians might not be the sole, or even the principal, providers. Recently, physicians and other clinicians have proposed principles for expanding the role of primary care under the title of the “medical home.” This expanded role includes establishing long-term relations between patients and their primary care team; developing shared plans of care; coordinating care, including subspecialists and hospitals; and providing innovative access to services through improved scheduling, connection to community resources, and new means of communication among individuals, families, and the primary care team facilitated by a patient-controlled personalized health record. (p. 759)

Barbara Starfield is sometimes referred to as the “pathfinder of primary care” because of her attempts since the early 1990s to redefine primary care (Stange, 2011, p. 292). The four pillars of primary care she defined continue to be cited: “first contact care, continuity over time, comprehensiveness, and coordination with other parts of the health system under the practice of the future” (Starfield, 1998, as cited in Margolius & Bodenheimer, 2010, p. 779).

This kind of broad thinking goes beyond the Minute Clinic concept of readily, easily available basic care to one that envisions a coordinated system built on teams of professionals with many capabilities and varied scopes of practice all focused on achieving health. This is where occupational therapy can contribute and enhance the approach to primary care, helping to achieve the triple aim of ensuring care, promoting true health, and using resources wisely to achieve that health.

Primary Health Care and International Models

Although the terms primary care and primary health care are nearly identical and influence one another, they differ in the purpose of their service. As previously described, primary care refers to the services provided by physicians, nurse practitioners, and physician assistants to address diagnosis, treatment, and management of illness. Primary health care focuses on ideal comprehensive health care that provides preventative and curative services that include the rehabilitation professions (World Health Organization [WHO], 1978). Through these services, the goal is to improve health—leading to a decreased occurrence of chronic diseases and injuries (which may lead to hospitalizations)—and support community development and chronic disease management (Fong, 2008; Leclair et al., 2005).

In addition, primary health care values interprofessional collaborative practice to improve health and access to services, more efficiently use resources, and increase satisfaction for clients and providers (Fong, 2008; Fong & Siu, 2007; Leclair et al., 2005; WHO, 2008). The nature of the core competencies for interprofessional collaborative practice address the critical need for health care personnel to work together as a team to meet the current and future demands that health care be affordable and high quality to meet the needs of all people (Interprofessional Education Collaborative Expert Panel, 2011). Thus, interprofessional collaboration may provide one method to connect occupational therapy to primary care to promote healthy living in a variety of settings, such as the workplace, the school environment, or the home (Fong, 2008).

International efforts support the need for primary health care. Both New Zealand and Manitoba, Canada, have developed charters that advocate for the need for health promotion for all people (Leclair et al., 2005; New Zealand Association of Occupational Therapists, 2009). These charters are founded on the principles from WHO (2008), which supports putting the public’s needs first to provide the most comprehensive care possible. These tenets are integral to occupational therapy. A person is not solely his or her physical or mental impairment; external factors and context variables can also hinder or contribute to success and quality of life.
Occupational therapists are skilled in evaluating all factors in a client’s life, leading to a comprehensive understanding of the link between occupation and health. The profession’s scope of practice goes beyond treating illness and can be incorporated into promoting healthy living and preventing disease and disability. Despite having the skills and knowledge necessary to get involved in the field of primary health care, there is a lack of support from practitioners. Many occupational therapists may actually feel as though they do not have competency-based training or knowledge readily available to provide preventative services (Flannery & Barry, 2003; Seymour, 1999). In addition to these internal barriers, there is a low rate of referral from professionals who are unaware that preventative care falls under occupational therapy’s scope of practice (Arsenault & Swan, 2011; Flannery & Barry, 2003; Leclair et al., 2005; Seymour, 1999).

Opportunities for Occupational Therapy in the ACA

Are there opportunities for occupational therapy in the system the ACA envisions? There are, but the envelope may need to be pushed. It is up to the profession and individual practitioners to create the research, to advocate for the changes, and to support what can be done by occupational therapy within a broadened, more expansive view of primary care and primary health care teams.

Several forms of health system design are supported by the ACA, such as the medical home concept, accountable care organizations, and other approaches. The ACA provided more funding to establish and support CHCs (healthcare.gov, 2011), but as noted earlier occupational therapy is only supplemental, not funded by the basic grants. Most of these systems are built on the more limited concept of primary care but also include the previously noted concepts of “large majority of personal health needs” and “plurality” of care.

Section 3502 of the ACA may provide a glimmer of hope. Grants are allowed for states to coordinate primary, acute, behavioral, and long-term supports and services for people eligible for both Medicare and Medicaid (Center for Medicare and Medicaid Innovation, 2012).

For the most part, however, the ACA seems to split care into primary and other. The ACA continues this bifurcation by focusing on physicians, nurse practitioners, and physician assistants. Loan programs and incentive payments under Medicare and Medicaid are restricted to these practitioners. Yet, the concept of a long-term relationship that is responsible for health care, health, and costs seems to run contrary to parts of how primary care is defined.

Can occupational therapy overcome these limitations and challenges? When comparing the concept of primary care in the ACA with some of the incentive programs for systems to provide coordinated care, one can see some overlap and potential. The role expected of occupational therapy in this context is not clear, but what the profession believes about the best and most important contributions it can make should be what guides the profession’s advocacy. Wellness, self-management, rehabilitation, screening, prevention, and patient education by occupational therapy practitioners who are part of the primary care team must be included.

Implications for Occupational Therapy

There are many implications for occupational therapy in terms of developing opportunities in primary care that advocate for the profession and enable significant contributions to client health. There are potential challenges to the profession as well.

The challenges are clear—occupational therapy is not listed as a primary care provider. As with other rehabilitation services, occupational therapy is considered supplemental, and its roles in the ability to procure grants or incentives programs is unclear. Despite these challenges, the language of the ACA does provide opportunities for the profession to align with the definitions of primary care, international models of this alignment with primary care do exist, and the broader definition of primary health care does include the domains of practice that are consistent with occupational therapy. What does the profession need to do?

First, we must collaborate with each other to become educated in the terminology of primary care and to merge our collective power to align our knowledge and skills with that terminology and the definitions. Second, we must strengthen alliances with the identified primary care practitioners (physicians, nurse practitioners, and physician assistants) through
interprofessional care teams and practices to ensure the inclusion of referrals in the processes of coordinated and integrated care (Peranich, Reynolds, O’Brien, Bosch, & Cranfill, 2010).

The connection of occupational therapy as more than a supplemental service but instead a key team member in ACA is clear when we match the components of ACA to the profession’s domain of practice. “Address a large majority of personal health needs” can be connected to areas of occupation, including activities of daily living, instrumental activities of daily living, rest and sleep, education, work, play and leisure, and social participation (American Occupational Therapy Association [AOTA], 2008). The domain of practice in and of itself meets the definition of addressing a large majority of personal health needs. Within these domains the roles of occupational therapy in functional mobility, lifestyle adaptation, medication management, and participation for health promotion have been building evidence to support their efficacy in health care.

“Coordinated and integrated care” aligns with practitioners being case managers and patient enablers in mental health, long-term care, and acute and rehabilitation settings. “Developing sustained relationships” can become a trait of occupational therapy in this component of the definition, because the profession promotes functional skills and services across all practice settings from initial screenings to patient education to hospital to outpatient to home and to work or participation in leisure pursuits.

“Practice in the context of family and community” connects to the profession’s ability to conduct activity analyses within the contexts of different environments that include home and social connections as well as the community. Programs related to wellness and lifestyle adjustments, fall prevention, and environment redesign are but a few areas that align with this terminology.

“Whole person orientation” is embedded in the occupational therapy scope of practice and skill set. The profession’s accreditation standards, scope of practice and other practice and official documents, and the Occupational Therapy Practice Framework (AOTA, 2008) all describe our skill set and practice in the holistic management of client factors, values, and body structures and functions to yield a complete client occupational profile in psychological, social, physical, and cognitive function as it relates to occupations.

“Chronic care coordination” connects with occupational therapy’s involvement in engaging the client in goal setting, which increases participation in activities to promote well-being. The prevention of reinjury and increased medical involvement is seen in environmental and ergonomic interventions. The use of the professional approaches to create, maintain, modify, and prevent addresses the needs of those who have chronic conditions for independent functioning. Not only the language of the profession but also its close involvement with clients meets the definition of primary care and the purposes of primary health care; occupational therapy does have roles to “support health and participation in life through engagement in occupation” (AOTA, 2008, p. 652).

Occupational therapy must also examine its literature and evidence and promote its role, showing how the triple aim can be addressed when the profession provides self-management to address chronic disease, health promotion to keep older adults independent, fall prevention in the home, participation in discharge planning from acute care, and the integration of mental health issues into overall care management. These are but a few of the areas of possible opportunity for occupational therapy.

Looking to existing models, such Kaiser Permanente of Northern California (Murphy, Greathouse, & Matsui, 2005) and its triage system to refer to physical therapy before a physician’s visit, may provide ideas for an occupational therapy triage focus. The University of Southern California Health Care System’s Eisner Family Medical System uses a broad team concept and integrates occupational therapy throughout family practice from initial patient contacts through treatment and management. This unleashes the power of occupational therapy within the context of primary care (Prestwich, 2012).

Preparing for the Future

The possibilities for occupational therapy in primary care are endless, but the opportunities must be seized. Research, interprofessional training and collaboration, education and lifelong learning, and a mindset that moves beyond the clinic walls will carry occupational therapy into primary care and perhaps transform primary health care into a system that encompasses the whole person, the family, and the community. ▲

References


