With the passage of the Patient Protection and Affordable Care Act (ACA) on March 23, 2010, preventing chronic disease and improving the health of the public became a centerpiece of health reform. Upheld largely by the Supreme Court on June 28, 2012, legislation and funding to ensure focused attention on prevention initiatives remain intact. The reelection of President Obama, the originator and prime supporter of the ACA, further solidified momentum for implementation of health care reform. Poised to expand health coverage and health services for all Americans, the ACA proposes changing a health care delivery system that limits access to care, compromises provision of quality services, increases costs as a result of system inefficiencies, and lacks attention to basic prevention and wellness supports.

The ACA is built on many concepts, including the Triple Aim (Berwick, Nolan, & Whittington, 2008) to control costs, improve quality, and increase efficiency. The Triple Aim originated from the Institute for Healthcare Improvement and has influenced new regulations, programs, and efforts to reform the U.S. health care system. The Triple Aim is largely anchored in wellness and prevention as a foundation for improving our ailing system and the overall health of Americans.

As described by Kingdon (2002), the policy “window of opportunity” has been opened by the elements of three merging streams—the recognition of a problem (i.e., the need to dramatically reform our health care system), political events, and the presence of policy proposals. We are looking squarely at a time when all the right elements are converging to make prevention and wellness a prime area for action. Occupational therapy professionals can play a key role in improving the health of a population through prevention and wellness by reaching out to communities and organizations and by working with clients in managing chronic conditions. Unfortunately, occupational therapy professionals are seldom recognized as prevention players, past or present. To better establish our role in prevention and seize this opportunity, we must consider these questions: Is occupational therapy prepared for or positioned to be present in the prevention arena? How can we position ourselves for success to engage with other professional partners in prevention? Collectively, are we ready to extend our reach into the prevention and wellness arena during this distinct window of opportunity created by health care reform?

The Prevention Foundation Is There . . . Are We There Yet?

Achieving health should be a central responsibility of health care and has always been a focus of occupational therapy. Health promotion and disease prevention are not new ideas, nor do they represent health aims outside the occupational therapy scope of practice. Historically, the Progressive Era (1890–1920) provided the context for the birth of occupational therapy and foundational work in the area of prevention. Through the passionate labor of Jane Addams and Eleanor Clarke Slagle in Chicago-area settlement houses such as Hull House, community workers assisted newly arrived immigrants as they tried to acclimate to new routines in different surroundings (Loomis, 1992; Stivers,
During the same period, collective groups of civic-minded women organized as “municipal housekeepers” to engage in reform movements targeting sanitation, transportation, and work conditions that created health-compromising environments and were negatively affecting the health of individuals and communities (Hill, 1938; Stivers, 2000). In both cases, prevention was at play in the establishment of health-supporting lifestyles or health-promoting contexts or systems consistent with occupational therapy principles and practices.

Philosophically, occupational therapy is steeped in health-promoting constructs and behaviors such as using time in meaningful and productive ways, “doing things” or engaging in occupations as part of an active lifestyle, and maintaining social connectedness (Meyer, 1977). Moreover, the intersection of the individual, environment, and tasks or activities is a place where health can happen; “participation in meaningful occupation is a determinant of health” (American Occupational Therapy Association [AOTA], 2011, p. S65; Meyer, 1977). As a profession, occupational therapy traditionally lays claim to meaningful occupations as its core and has included health promotion and wellness in its scope of practice. However, it seems we are less clear on how to engage as a discipline in the emerging role of prevention.

In recent decades, occupational therapy visionaries have persistently asserted the value of meaningful participation in daily life tasks as a means to support health while also challenging the discipline of occupational therapy to respond to the changing health care landscape and population health needs. During the 1960s, prevention began to emerge as a significant professional issue through the voices of occupational therapy’s top leadership. West (1968) called on occupational therapy practitioners to develop a “professional consciousness” able to recognize shifts in health care and in the demands of individuals and populations regarding service delivery. Wiemer (1972) identified preventive health as a continuum that starts with the promotion of health and wellness and moves toward the reduction of limitations and elevation of strengths through adaptation of tasks and environmental modifications. Moreover, she charged that simply including preventive methodology in curative treatment or focusing prevention efforts largely at the rehabilitative end of the prevention continuum does not serve occupational therapy well if there is a need or intention to develop our role in prevention and community health. Rather, rehab- or curative-focused prevention “establishes a head-in-the-sand posture for occupational therapy, making impossible the expansion of its responsibility beyond that exercised in the treatment of pathology” (Wiemer, 1972, p. 2). Indeed, prevention requires a “commitment to wellness equal to that for illness” (Wiemer, 1972, p. 3) and a greater focus on the strengths of and possibilities for an individual or community instead of the concentrated attention to deficits and limitations that in some ways restricts the public’s image and understanding of occupational therapy.

In addition to the direction provided by researchers and thought leaders, AOTA professional publications, official documents, and reports from working groups provide a framework for involvement in prevention arenas. In 1986, the American Journal of Occupational Therapy (AJOT) published a special issue on health promotion (White, 1986). Twelve years later, the AJOT special issue on community health provided evidence specific to service provision in the community—a service delivery context where there is support for health promotion and disease prevention efforts (Baum & Law, 1998).

Broadly, the Occupational Therapy Practice Framework: Domain and Process (2nd ed.; AOTA, 2008a) delineates our profession’s “contribution to promoting health and participation of people, organizations, and populations through engagement in occupation” (p. 625). Specifically, the framework outlines two intervention approaches central to health promotion, wellness, and disease prevention efforts: (1) the “create/promote” (health promotion) approach, designed to enhance strengths and performance for everyone within authentic contexts and (2) the “prevent” (disability prevention) approach designed to prevent barriers to performance through focus on contextual supports and challenges, activity demands, or client needs regardless of their state of health or disability (pp. 657–659).

The AOTA statement Occupational Therapy Services in the Promotion of Health and the Prevention of Disease and Disability replaces earlier versions of health and wellness documents spanning three decades (AOTA, 2008b). AOTA’s (n.d.) Occupational Therapy’s Role in Health Promotion fact sheet was developed for use with internal and external audiences seeking to understand and advocate for occupational therapy as a prevention partner. Each of these public documents seeks to highlight our philosophical base and preparation to support participation in health promotion and disease or disability prevention arenas.

In 2006, the AOTA Task Force on Health and Wellness, commissioned by AOTA’s President Carolyn Baum, produced a comprehensive report detailing our profession’s state of readiness for participation in health and wellness arenas along with targeted recommendations to enhance our capacity and establish our presence in this area. The full report summarized the key and often untapped potential of occupational therapy. Occupational therapy can contribute through its distinct perspective on participation in daily activities situated within authentic occupational contexts, particularly in relation to chronic disease management and fostering health-promoting lifestyle behaviors to support overall health and well-being. Additionally, the report exposed prevention and health promotion deficits in the occupational therapy educational curricula and outcomes research, restrictive language in practice guidelines and documentation for reimbursement, limited internal perceptions by researchers and practitioners of occupational therapy as players in health and wellness, minimal practitioner participation in advocacy and policy work related to public health, and an important but narrow national policy agenda grounded in traditional medical models and systems and bound by finite lobbying resources.

The report proposed the following action items:
- Engage in image promotion connecting occupational engagement and health.
- Use language familiar to consumer and health promotion audiences.
- Incorporate prevention and population health into curricula.
Develop partnerships to lead and influence policy and programs related to health and wellness.

Identify occupational therapy experts in health and wellness.

Support practice and disseminate research related to health and wellness.

(AOTA Task Force on Health and Wellness, 2006, pp. 4–5)

The message was clear: Occupational therapy has much to offer, but we are missing opportunities in health and wellness venues because of internal and external barriers.

In 2011, the AOTA Ad Hoc Committee on Health Care Reform established the Prevention and Wellness Group and charged it with the task of identifying the role of occupational therapy in prevention and wellness through the opportunity lens of the ACA. The group’s analysis of recent AOTA documents such as Societal Statements and Fact Sheets and review of the literature regarding prevention and wellness-related topics indicated progress in the areas of fall prevention (Murphy, Lyden, Smith, Dong, & Koliba, 2010), ergonomics (Feingold & Jacobs, 2002), anti-bullying initiatives (Bazyk, 2011), and aging-in-place supports (Clark et al., 2012). Progress has been slow, however, with prevention efforts often restricted to the familiar level of tertiary prevention associated with rehabilitation services. Although the group’s work sheds light on the goodness of fit between occupational therapy and prevention, much work needs to be done as we stand tentatively at the edge of transitioning practice opportunities into realities (AOTA Prevention and Wellness Group, 2011).

Affordable Care Act and Prevention

The bold inclusion of preventive health in health care reform as defined in the ACA elevates the issues of an inadequate public health infrastructure, the cost of chronic health management, the disparate influence of social determinants of health, and long-standing inattention to prevention initiatives. As outlined in the ACA’s Title IV (Prevention of Chronic Disease and Improving Public Health), the legislation mandates that the nation (1) modernize disease prevention and public health systems, (2) increase access to clinical services, (3) create healthier communities, and (4) provide funding and support for prevention and public health innovations. As part of the ACA-directed prevention efforts, the law allocated $15 million in dedicated funds to support prevention work such as research, public health capacity building, and demonstration projects. In response to the ACA prevention directives, the Center for Medicare and Medicaid Innovation (Centers for Medicare and Medicaid Services, 2013), through its Health Care Innovation Awards, supports the vision of improved health care within a responsive system committed to lower costs and increased access for all who seek health care services. Further support for work generated by the ACA comes from the Centers for Disease Control and Prevention (U.S. Department of Health and Human Services, 2012) as it continues to target chronic disease prevention/management and invest in healthier communities through the Community Transformation Grant Program. This broad language and the related resource allocations serve as a guide and funding support for agency officials, the health care delivery system, and practitioners to emphasize wellness and preventive services.

Also created by the ACA’s Title IV, the National Prevention, Health Promotion, and Public Health Council (referred to as the National Prevention Council) was charged to plan and coordinate the national prevention work of 17 key federal departments and agencies, to oversee the newly established Prevention and Public Health Fund, and to craft a national prevention agenda to guide our population and health care system toward better health. Responding to this charge, the council released National Prevention Strategy: America’s Plan for Better Health and Wellness on June 16, 2011 (National Prevention Council, 2011). The document represents efforts to shift health policy and programs from a curative emphasis to a prevention and wellness focus aimed at establishing a healthier American population. The National Prevention Strategy provides a vision of established and emerging partnerships across multiple settings “working together to improve the health and quality of life for individuals, families, and communities by moving the nation from a focus on sickness and disease to one based on prevention and wellness” (National Prevention Council, 2011, p. 7).

The overarching goal to “increase the number of Americans who are healthy at every stage of life” (National Prevention Council, 2011, p. 7) requires the expertise of health professionals who understand and support participation in meaningful daily life for children, adults, and older adults as they seek to engage in active, productive, independent, and healthy lives. To guide these efforts, the National Prevention Strategy identified four strategic directions:

1. Healthy and safe community environments
2. Clinical and community preventive services
3. Empowered people
4. Elimination of health disparities

Whereas these strategic directions outline the underpinnings for broader, prevention-focused societal change supporting healthy people and health-sustaining communities, the strategy targets lifestyle choices and personal responsibility as a means to address health and well-being across the life course in the following seven priorities:

1. Tobacco-free living
2. Prevention of drug abuse and excessive alcohol use
3. Healthy eating
4. Active living
5. Injury- and violence-free living
6. Reproductive and sexual health
7. Mental and emotional well-being

Embedded in the identified strategic directions and priorities is the recognition that prevention and health promotion efforts require a comprehensive approach to population-based preventive services alongside targeted individual health management initiatives, particularly efforts to address prevention through lifestyle choices and management of chronic disease processes.

Evidence-based recommendations in the areas of policy, systems change, environment, communications and media, and program and service delivery, along with emerging approaches, provide crucial direction to support health, wellness, and prevention efforts. Closer examination of recommendations to address the four
strategic directions reveals opportunities ripe for occupational therapy to cultivate partnerships and seize leadership. Under “healthy and safe community environments,” the recommendation to “design and promote affordable, accessible, safe, and healthy housing” (National Prevention Council, 2011, p. 14) with a focus on universal design is consistent with work of occupational therapy practitioners serving adults with disabilities and the elderly population aging in place and with community-based fall prevention efforts. Recommendations under “clinical and community preventive services” include implementation of community-based preventive services, enhancement of linkages with clinical care, and reduction of barriers to health care access points, especially for at-risk and underserved populations. Partnering with primary care initiatives and involvement with safety net clinics allow occupational therapy professionals to actively collaborate in preventive care efforts and chronic disease management within the scope of meaningful life participation and overall health and well-being. In support of “empowered people” recommendations, occupational therapy can “provide people with tools and information to make healthy choices” (p. 22) in ways that people can use or understand. Occupational therapy can “promote positive social interactions and support healthy decision making” (p. 22) through social connectedness and environmental access. Occupational therapy professionals can be significant contributors in the “elimination of health disparities” through our roles as health practitioners, researchers, advocates, and community partners in prevention. Across all strategic directions, occupational therapy professionals and students are primed to “increase the capacity of the prevention workforce” (p. 26) and enhance collaboration across all public and private sectors.

**Prevention Agenda for Occupational Therapy**

Occupational therapy has much to contribute across the prevention continuum; however, we must make that potential for contribution clear to others by getting outside of ourselves and into the world and work of prevention. Participation in prevention has to start with an internal dialogue about our profession’s preparation for active engagement in health promotion, wellness, and disease prevention. Are we ready to seize the opportunities before us and establish a presence in the prevention arena? Externally, we have to examine the changing health care landscape and strategically identify our prevention opportunities and partners to favorably position ourselves in preventive health venues. Are we where we need to be to ensure a presence in policy, practice, and payment related to prevention services? Four areas—problems, payment, partnerships, and policy—demand consideration to ensure that as occupational therapy professionals, we are not our own obstacle but rather have a clear understanding of how we can insert ourselves and take advantage of the window of opportunity in front of us today.

**Problems: The Definition Matters!**

To remain relevant in this new health care world, we have to change how we view problems and how we contribute to solutions. Historically, our nation’s health care system has functioned as a “sick care” system working to address disease and illness rather than promote health or prevention of disease. Understandably, occupational therapy followed suit by gaining substantial professional legitimacy established through work in rehabilitative and habilitative services and other points of service related to chronic illness or living with disability. The ACA, in its embedded prevention language, speaks in terms of health, wellness, health promotion, and disease prevention with an eye to empowering individuals and populations to manage their health. It also seeks to establish health-promoting solutions through environmental and system change. The problem has shifted from treating disease after it happens to preventing its occurrence.

As part of this shift in the system’s problem identification, occupational therapy must reframe the problem of its future to embrace this new direction. Occupational therapy professionals need to align their view of individual and population health accountability and acknowledge the interconnectedness among health outcomes, systems, and society. Reframing the problem toward prevention provides an opportunity for us to remain relevant in health care and allows us to reinvigorate our approach and our roles by reaching to our core principles to ensure that we are part of the solution.

**Payment: Change the Funding “Master”!**

As a profession, we generally filter new practice venues and innovative practice ideas through one question: How will we get paid? Pragmatically, this question makes sense because we work to support our employers and our personal budgets; however, the payment solutions we lean on connect almost exclusively to public and private payment sources that are tied up in traditional insurance structures. Reliance on the reimbursement mindset and restrictive fee-for-service payment options limits our ability to embrace potential occupational therapy contributions possible through unfamiliar payment arrangements or atypical service delivery contexts. Admittedly, our professional lobbyists work diligently to successfully maintain our status as an essential and reimbursable service in school systems, habilitation and rehabilitation services, and mental health. Yet, even within traditional practice venues, payment streams are transitioning to bundled payments, episodic payments, and value-based purchasing, which shifts responsibility for health.

Although payment streams in the areas of health promotion, wellness, and prevention are not as familiar to occupational therapy, we have several options for potential payment, such as the Prevention and Public Health Trust Fund, Health Care Innovation Awards, and Community Transformation Grants. Payment by project or program will require occupational therapy professionals to think and respond differently from our response in a fee-for-service context, challenging us to clearly define the distinct value of occupational therapy services to a system in need. It also provides us with the opportunity to test new approaches to our service delivery to increase effectiveness and improve outcomes.
Interprofessional Partners: Reach Out!

As we stretch our professional reach, we must cultivate new relationships with new practice partners. Many prevention initiatives are possible when occupational therapy professionals extend beyond familiar rehabilitation disciplines or health service institutions to engage in interprofessional collaboration with government agencies at all levels and with private-sector organizations, charitable groups, and community- and faith-based agencies. Many of these organizations represent sectors very different from traditional health venues, yet all have a vested interest in ensuring a healthier United States. For programs targeting livable communities, for instance, we need to work with urban planners, community leaders, and transportation services to ensure safe and interconnected communities that support active living and reduced environmental hazards. For programs seeking to reduce youth violence, we must come together with after-school programs, the employer community, parents, and youth to ensure life participation options with less risk and greater individual and societal rewards.

Many of our potential partners use language different from the traditional medical and diagnostic language we use as occupational therapy professionals. Therefore, we must learn to engage in jargon-free dialogue that invites understanding and exploration of shared interests and goals. We must promote our services in terms of system needs such as improving quality, increasing efficiency, and decreasing costs. Like our patients and clients, we need to meet our new partners where they are, find common ground in the talk we talk, and then walk the walk with these new prevention partners. It is not necessary to abandon our traditional roles. In fact, it is of particular importance that we maintain our current roles in hospitals, long-term care and home health settings, and special education and mental health programs. In these current practice settings, we are rooted in our interprofessional partnerships with physical therapists, speech therapists, physicians, psychologists, special education teachers, and others. We can recognize that rooted does not translate into stunted by building on and expanding these professional partnerships to broaden the reach of our discipline.

Policy: Be There!

Whether you believe policymaking happens through rational problem solving to meet a new need or by attaching ready-made solutions to the salient problem of the moment, either process produces policy that is often incomplete, incongruent and, in a word, messy. Policymakers rely on experts to educate them about issues and present solutions that address points of concern while resonating with constituents and budgets. In health promotion and prevention efforts, policymakers want to hear about evidence-based strategies that are cost effective and efficiently use intervention resources.

Once policy is made, written regulations shape how policy is actually implemented on the front line of health care and public health environments. At the level of policy implementation, “all politics are local,” and every occupational therapy professional has opportunities to make a policy-guided difference in practice.

Historically, occupational therapy does not have a robust presence at policy tables where health and wellness discussions and decision making take place; our active involvement in prevention policy discourse is fairly recent, but there is room for growth and the development of power. Absence from the policy table equates to absence from policy itself. Internally, we know our discipline has much to offer, yet our external “prevention voice” has been relatively quiet in our own practice contexts, professional publications, and political lobbying efforts. We must be more visible and vocal in policy overall, and in health promotion and wellness policy specifically, to ensure inclusion of occupational therapy by name and function.

Open Window of Opportunity

Historically, the practice of occupational therapy has been positively defined by our profession’s response to political climate and policy shifts mandating health care delivery for certain populations in particular settings, directing reimbursement and funding streams, and dictating certain health professionals or related service providers as essential for the provision of health care or educational support services. It is possible that the policy decisions and ongoing debates securing our presence and identity as habilitation, rehabilitation, and mental health professionals and essential related service providers in schools have been to the detriment of ensuring our inclusion in areas of health promotion, prevention, and wellness. As occupational therapy professionals, we need not change direction but instead expand our approach to include these emerging practice areas.

Admittedly, agendas typically are reset by the volume or weight of pressing problems, by knowledge acquisition redirecting or reinforcing receptivity to policy, and by changing internal or external political climates. When they are open as a result of a hot issue, windows of opportunity are time limited. The time is now for the profession of occupational therapy and AOTA to commit to championing our contributions specific to the National Prevention Strategy and related health promotion and wellness initiatives. It’s our window . . . will we catch it open?

References


