For me, the concept that occupational therapy belongs in primary care began to form slowly, with those brief, casual conversations that practitioners have every day in their personal lives, such as at a school or community event, offering small pieces of advice about how to adapt an activity, explaining a medical diagnosis or clarifying a physician’s recommendations, and suggesting how those recommendations can be reasonably incorporated into daily life. So often the person would respond, “Why didn’t someone explain this to me at the doctor’s office? I would have done it if I had just understood better.”

During intervention sessions across a variety of settings, occupational therapy professionals working with a client with a specific injury or diagnosis naturally expand the occupational profile to gain a complete picture of the client, to understand his or her roles and responsibilities, and to determine what challenges limit his or her full participation in important and valued occupations. As professionals, we treat the problems for which our clients were referred, and we also address many other issues that are causing them difficulty, often resulting in changes across multiple areas of occupation and performance patterns.

Over more than 20 yr of practice, as I have observed numerous occupational therapy professionals in a variety of settings, I have begun to believe that occupational therapy has a unique approach to patient care. This holistic approach, delivered with respect and caring, results in the development of a strong client–therapist alliance. According to Morris (2011),

The first step to help a patient change a habit is to establish a meaningful, trusting, and supportive environment so that the patient feels comfortable enough to discuss and consider changing himself or herself. The patient must know that the clinician, without question, is a trusted source of help and is aligned with the patient’s best interests. People are more likely to change when they are given respect, understanding, and compassion. (p. 2)

Establishing this type of supportive and trusting relationship is challenging in a typical (or should I say “traditional”?) primary care practice in which the focus is frequently on symptom reduction, disease management, and basic prevention—not on the pursuit of long-term health.

However, as the U.S. health care system is evolving to provide quality health care with positive outcomes, it is becoming clear that the provision of primary care must change to best use health care dollars. Having the opportunity to receive professional guidance for lifestyle modification and the development of healthy habits early on could prevent patients from having a significant medical or emotional event. This type of intervention would
truly support achieving health and wellness rather than waiting for inevitable illness or accident. I argue that it would likely be a better utilization of health care dollars.

**Health Care Services Fragmentation**

In the United States, patients typically visit their primary care physician as the first step when issues arise in their lives that cause concern or discomfort or that impair participation. According to the Commonwealth Fund (n.d.), physicians spend, on average, 19–20 min with their patients during a visit, and neither patients nor physicians feel that this is adequate time. The Commonwealth Fund postulated that the interaction feels inadequate to the participants because of “the need to do more during a patient visit, including provide preventive care and more fully explain a larger number of treatment options as patients ask more questions” (para. 5).

Primary care physicians understand that they are not meeting all of the needs of their patients, so they often refer patients to other services, which generally and often leads to a fragmentation of care. This fragmentation is not unique to the United States. According to Montenegro et al. (2011), high levels of fragmentation characterize health systems in the Americas. Fragmentation . . . can lead to difficulties in access to services, delivery of services of poor technical quality, irrational and inefficient use of resources, unnecessary increases in production costs, and low user satisfaction. . . . Fragmentation manifests itself as lack of coordination between the different levels and settings of care, duplication of services and infrastructure, unutilized productive capacity, and health care provided at the least appropriate location, especially hospitals. Furthermore, in fragmented systems, users experience lack of access to services, loss of continuity of care, and the failure of health services to meet their needs. (p. 5)

The World Health Organization (WHO; 1978) has been promoting changing the conceptualization of primary care to include health, preventative, and curative services provided by rehabilitation professionals for several decades. This larger conceptual framework provides many opportunities for inserting occupational therapy directly into primary care.

**Occupational Therapy in Primary Care**

Because occupational therapy professionals are broadly trained in human development (cognitive, physical, social, emotional), health promotion, disease process intervention, activity analysis and behavior modification, lifestyle interventions, and use of adaptive equipment, the profession could be fundamental to reducing fragmentation in health care. An occupational therapist in primary care can

- Assist the physician by means of early intervention to prevent disease or disability, reduce the impact of the disease process, and promote regimen compliance;
- Provide services that extend the ability of physicians, nurse practitioners, and physician assistants to provide holistic care, focusing on identifying how symptoms are actually affecting function and participation;
- Improve patient satisfaction by addressing a broader array of patient issues and thereby demonstrating a concern for more than symptom reduction;
- Provide simple interventions that can be done at home or with intermittent supervision before referral for extended interventions, thereby decreasing health care expenditures;
- Enable or improve participation in occupations through activity modification or adaptive equipment and techniques; and
- Provide group education or intervention sessions to address prevalent issues among the population served.

Effectively facilitating change requires being present at the moment the person is ready for that change, when he or she is receptive to intervention. This key time of intervention is likely to be when the patient is in the primary care physician’s office, because the issue was problematic enough for him or her to make an appointment to see the doctor.

Therefore, to be fully effective, an occupational therapy professional in primary care will be present full time in the physician’s practice. Initially, it is necessary for the occupational therapist to see every patient with the physician to gain an understanding of how each practitioner operates and to build the trust and respect that will be necessary for a seamless, fully integrated practice. The therapist will be comfortable with and encouraged by the physician to fully participate in the patient interview to gather a health history and identify the issues of concern.

The occupational therapist, the physician, and the physician assistant or nurse will work as a coordinated team (not necessarily all in the room at the same time) to assess the patient, identify relevant issues and symptoms, and develop and deliver the appropriate interventions on the spot, going well beyond the prescription of medication and referral to an outside provider, as is typically done now. The team would be responsible as a whole for the health of the person.

Over time, as trust between the team members is built, competencies are understood, and boundaries are delineated, the roles of the team members may shift to allow each professional to best use his or her skills and ultimately enable the primary care practice to better address each patient’s needs. This mature team will require less time to coordinate and delegate, eventually reaching a level of true integration.

There should come a time when the occupational therapist is the first professional to see some patients and begin the assessments, such as seeing those who have upper-extremity issues, musculoskeletal pain, or chronic disease management difficulties; beginning the well-baby checkups by assessing infant developmental milestones and sleeping and eating patterns; or seeing patients who have difficulty managing stress and depression. The therapist would then communicate findings and confer with the other team members. Each
could assess the patient further, using his or her expert knowledge, as needed.

The team would decide—either through brief face-to-face encounters or other coordinative strategies (e.g., secure text messaging or instant messages through the electronic documentation system)—on appropriate interventions, identify who will deliver those interventions, and execute the appropriate portions of that plan during this office visit. This seamless team approach would likely improve the efficiency of the entire practice, allowing more patients to be placed in rooms and assessed than could be done if only the physician did the majority of the clinical assessment. In addition, this distribution of assessment responsibilities can improve patients’ experience at the physician’s office, because there should be fewer patients waiting for extended periods for the physician or extenders who is spending more than the expected or allotted amount of time with a patient who has many needs.

Occupational Therapy and Health Care Reform

Braveman and Metzler (2012) provided an excellent overview of the Patient Protection and Affordable Care Act (ACA), with at least two areas relating to occupational therapy in primary care: accountable care organizations (ACOs) and patient-centered medical home (PCMH) models. Both will change medical practice dramatically, because the focus will shift from just treating people when they are ill to improving overall health and well-being.

A review of U.S. health care expenditures revealed that a small percentage of patients account for a significant portion of dollars spent on health care. Stanton and Rutherford reported (2006) that

- Five percent of the population accounts for almost half (49%) of total health care expenses.
- The 15 most expensive health conditions account for 44% of total health care expenses.
- Patients with multiple chronic conditions cost up to 7 times as much as patients with only one chronic condition. (p. 1)

In addition, “in 2001, 5 percent of Medicare fee-for-service beneficiaries accounted for 43 percent of total spending, with 25 percent accounting for 85 percent of all spending” (p. 7), and “the elderly and disabled, who constituted around 25 percent of the Medicaid population, accounted for about 70 percent of Medicaid spending on services in 2003” (p. 8).

The many variations suggested in the ACA on approaches to reorganizing health care delivery and payment (ACOs, PCMHs, bundled payment arrangements, and shared savings agreements) are attempting to facilitate the very kind of contextual, holistic, and coordinated care that is at the center of occupational therapy practice. However, as Braveman and Metzler (2012) pointed out, there are questions about who is going to lead the transition to these new models of care.

I propose that this could be a system for which occupational therapy professionals have been longing; instead of having our interventions limited by what we can get reimbursed for in the fee-for-service model, we could truly provide patient-centered and comprehensive intervention plans if payment for our services were embedded in a bundled payment or another overall payment methodology. This would be especially helpful to meet the quality measures that will surely be part of these new structural and payment systems. For every patient, occupational therapists could focus fully on improving health and function, participation, and quality of life. For example,

- Instead of waiting for elderly patients to fall and sustain a hip fracture, occupational therapists could do a physical assessment in the primary care clinic and complete a safety assessment in the home. Therapists could then provide a home exercise program, suggest home modifications, and recommend and train in the use of adaptive equipment to prevent an injury from a fall—and the related costs. These interventions would also likely help spouses and families be safer as well because they would see the changes and incorporate some of them into their own lives.

- While doing the initial assessment for a well 6-mo-old, a therapist notices some developmental delays in the child. The therapist could teach the parents focused intervention activities and ask them to return in a month for a follow-up. If appropriate progress has not been made, the therapist could go to the home or day care provider to provide additional education. With each interaction, the therapist is not only helping this child, his siblings, and his parents but is also reaching other children at the day care provider. The therapist would also provide a link to formal early intervention for those children who needed it.

The possibilities are endless, and the impact of occupational therapy would ripple out, improving the lives of many, especially if the profession is not limited by an overly restrictive fee-for-service model. Occupational therapists could do the kind of practice that many have only read about in histories of the profession, focusing on the individual needs of each patient and the contexts in which he or she lives. Therapists could identify common problems within a specific population (and their communities) and develop group education sessions to meet their needs.

I have had the opportunity to develop and conduct several targeted group education sessions with an interprofessional team at the SLUCare PCMH, and all sessions were considered beneficial by the professionals and patients, on the basis of feedback forms distributed immediately after the 7-wk courses and in conversations in the clinic months later. In the primary health care practice, I have a vision of weekly life skills groups in which the occupational therapist, in partnership with other professionals, addresses topics such as money management, nutrition and meal planning, inexpensive grocery shopping, time management, job skills, stress management, parenting skills, helping a child succeed in school, effective discipline, and a range of other issues related to achieving health but not now considered part of the health care equation.
Primary Care Is Not for Everyone

Primary care is not a practice area for all occupational therapy practitioners, as all practitioners have different talents to contribute, and it has unique challenges. Because the primary care physician is often a family physician, the one who initially addresses every need or issue that arises for all family members, his or her scope of practice encompasses "prechadle to postgrave" (Brian Prestwich, MD, personal communication, April 29, 2012). The family physician may assist with family planning prior to a pregnancy, care for the woman throughout her pregnancy, deliver the baby, and care for all members of the family across their lifetimes, including the remaining family members when one member passes away. Therefore, in a single day at a family practice, a primary care occupational therapist may be asked to screen a 2-wk-old baby and provide parent education, confirm and treat a new diagnosis of carpal tunnel syndrome, recommend activities to address depression and mild anxiety disorder, teach energy conservation or work simplification techniques to a young mother with chronic fatigue syndrome, teach a patient newly diagnosed with diabetes strategies for medication compliance, and assess the fall risk of an elderly person.

Having occupational therapy in primary health care will likely require the profession to expand the concept of occupational therapy practice beyond interventions as they are currently practiced in other medical settings. This expansion may occur because it is necessary to evaluate and intervene nearly instantaneously, usually in a single, very short session. To be successful in primary care, an occupational therapist must be a true generalist who is competent across all age spans and the entire domain of occupational therapy practice as well as knowledgeable about the full scope of practice.

This role likely requires broad experience, advanced training, and the ongoing commitment to lifelong learning. In this setting, the occupational therapist will be asked to treat patients for diagnoses not typically seen in a single traditional rehabilitation setting, such as an outpatient orthopedic or community psychiatric clinic. In primary health care, the occupational therapist will see a patient for depression and another for arthritis. It is challenging to be knowledgeable about such a wide variety of problems and needs and also to extrapolate how those issues do or will affect engagement in occupations. In some cases, there may be resources to allow for multiple occupational therapy professionals, each with different expertise, working in large group practices that may include medical specialty providers and integrated networks that may include hospitals and other care settings.

An occupational therapist in primary care should
- Espouse an absolute belief that occupational therapy can benefit most every person and is able to address lifespan wellness and prevention, physical illness and injury, psychosocial issues, roles and responsibilities, and end-of-life preparation and concerns;
- Be able to self-advocate, because he or she will be educating physicians and other health professionals, as well as administrators, on what he or she has to offer and must sometimes stand firm, insisting on treating patients while they are in the office and likely more receptive to change instead of asking them to return another day for an appointment with the occupational therapist;
- Accept the ethical responsibility to carefully and honestly assess his or her own personal abilities and competencies, so that he or she knows who he or she is qualified to work with and which patients should be referred to another professional; and
- Have a good understanding of professional boundaries: what is appropriate (but not necessarily traditional) for occupational therapy intervention and when it is appropriate to refer to another professional and to which one.

Who Better Than Occupational Therapists?

Who better to lead a team of health care professionals to improve the lives of members of our communities than the one profession that has always known the critical importance of occupation and the absolute need of humans to be engaged and productive? Who better than occupational therapists?

It is critically important that research is now validating what occupational therapy has always known—that the therapeutic use of valued occupations (frequently called task-specific training in the literature) results in functional improvements in patients. Hubbard, Parsons, Neilson, and Carey (2009), in a review of the literature, stated that task-specific training in rehabilitation focuses on improvement of performance in functional tasks through goal-directed practice and repetition. The focus is on training of functional tasks rather than impairment, such as with muscle strengthening. . . . Neurophysiological evidence also supports the value of the object used or task undertaken in the organization of movement. . . . The evidence indicates that cortico-motor neuron pools are organized relative to specific tasks rather than specific muscles. Importantly, evidence suggests that motor skill learning capability may be retained in stroke survivors under similar conditions to healthy volunteers. (p. 176)

On the basis of health care spending data and patient perceptions, we know that the historic medical model is insufficient—that medication and exercise alone do not prevent disease and disability, remediate even most illnesses, or improve patients’ lives over the long term. I believe that the profession of occupational therapy needs to remind itself of its roots, reinforcing the founding principles of the value of occupation (“task-specific training”), and that people can be understood and helped only within the context of their lives.

Occupational therapy must be able to clearly, passionately, and precisely articulate its value. The profession must make a coordinated and concentrated effort to develop mechanisms to quantify
not only the positive effects that we have on a specific client but also the ripple effects that result when people and community populations change. Occupational therapy must confidently and firmly stand its professional ground to prevent encroachment from other professions that are less suited to provide the contextual and patient-centered health care that occupational therapy has provided since the inception of the profession. Most important, the profession must strengthen its alliances with physicians and physician extenders, demonstrating the commitment to an integrated health team, especially as other professions move toward more independent practice that may not fit well with a more integrated system.

The United States is on the brink of dramatic changes in how it views and delivers health care. Whatever happens on the political and policy fronts, occupational therapists have a window of opportunity to showcase the value of the profession when we are allowed to deliver truly holistic, integrated care before devastating illnesses or injuries occur.

References


