The Role of Occupational Therapy in Primary Health Care

Elizabeth B. Devereaux, Robert B. Walker

Recent statements from the National Commission on Allied Health (1993) and the Pew Health Professions Commission (1991, 1992) have made it clear that allied health has a dramatically increasing role to perform in the delivery of health care, now and in the future. The way in which occupational therapy defines its role in community-oriented primary health care and the length of time it takes to implement changes will determine its ability to take a leadership position in such a complex effort.

Traditionally, the practice of occupational therapy has focused on the restoration and rehabilitation of function, with some venturing into the areas of health promotion, wellness, and prevention, although these areas have not received major impetus throughout the profession. The time has come when they should.

According to a recent report from the National Commission on Allied Health, efforts to reform the nation’s health care system must include careful consideration of allied health workers, since they play a critical role in the provision and support of primary care. Allied health workers are diverse in their work, amount of education required, and regulatory control of their activities. Provider agencies may increasingly rely on these types of services as alternatives to more costly forms of treatment under a managed competition framework. (1993, p. 6)

In 1991, the Pew Health Professions Commission published a report entitled Healthy America Practitioners for 2005—An Agenda for Action for U.S. Health Professional Schools. The following year, that Advisory Panel for Allied Health distributed its Final Draft Report, Healthy America Practitioners for 2005—A Beginning Dialogue for U.S. Schools of Allied Health (1992). It noted that a number of emerging trends identified in the Commission’s Agenda for Action, such as access, cultural values, medical information and technology, and quality of care would have “major consequences” (p. 4) for the allied health professions.

The Advisory Panel’s Draft Report (Pew Health Professions Commission, 1992) briefly analyzed the issues within each of the trends, the possible involvement of allied health in responding to these trends, and the resulting effect on health care, as well as some of the changes that must occur within the allied health professions to permit or enable these responses to occur. This analysis was followed by a particularly pertinent section titled “Missing Links”:

A number of trends of particular relevance to allied health were not given emphasis in the Commission’s Agenda for Action. Among these, health promotion and disease prevention, informal caregiving, mainstreaming of people with disabilities, and the rapid globalization of our society are worth mentioning. (p. 7)

The section concludes with the statement “Allied health professionals will play a greater number of roles of growing diversity in the implementation of these new practice models, and are likely to be among the major beneficiaries of further experimentation in services delivery” (p. 8).

Primary Care and Primary Health Care

The Institute of Medicine (IOM) Committee on the Future of Primary Care recently adopted a provisional definition of primary care to accommodate several dimensions of health care that were not included in their earlier definitions in 1978 and 1984 (IOM, 1994, p. 3). The provisional definition states that:

Primary Care is the provision of integrated, accessible health care services by clinicians who are accountable for addressing a large majority of health care needs, developing a sustained partnership with patients and practicing in the context of family and community (p. 1).

The American Journal of Occupational Therapy

Downloaded from http://ajot.aota.org on 05/02/2019 Terms of use: http://AOTA.org/terms
Each phrase or term in italics is defined within the IOM report, along with the critical assumptions on which the provisional definition is based, including the quality of interactions between patients and clinicians, integrated delivery systems, and areas of special emphasis. It is not clear in the preliminary report just who should provide primary care, but it is an issue to be addressed in the full report. Those providers must frequently associated with the concept of primary medical care are primary care (generalist) physicians in areas such as family medicine, general internal medicine, and general pediatrics. Some definitions included obstetrics and gynecology physicians, physician assistants, nurse practitioners, and nurse midwives. The Pew Commission refers to allied health professionals as part of the primary health care team, but does not consider them to be primary health care providers, however, the distinction between the two terms needs to be made (S. Hertfelder, personal communication, October 26, 1994) for purposes of role definition, curriculum development, and reimbursement. Various configurations may be tried in the future and the determination as to usage may in actuality be made by a particular practice, based on function or setting regardless of the way these two terms are defined.

The Opportunity

In crisis and in chaos, there is opportunity. The crisis, of course, is health care for the American people; the chaos is that created by the health care reform efforts and the implementation of those reforms once a plan is adopted. But major changes in the health care system have been occurring, and are continuing to occur, while the plans are being debated. Those of us who are involved in the health care system are struggling not only to keep up with the rapidly occurring changes, but to predict the effects of these changes on our ability to deliver services and our attempts to minimize the resulting confusion for the consumers of our services.

From General Systems Theory, this confusion or altered state could be called "unfreezing" or "disequilibrium." Though it could differ in degree of severity from the examples just given, Norris Hensell (1976) described a similar state called the "adaptive interval" which occurs with individuals in connection with a crisis: this is a time when there is great motivation for change, when the individual is most out of balance, but able to make adaptations to behavior (Devereaux, 1990, p. 6).

The adaptive interval is actually a period of time during which both the individual and the group can change a great deal; we all strive constantly to stay in balance or to get back into balance because it is what we know and so it is more comfortable for us.

In the process of achieving that balance, we can shift the where, how, and when of our practice and end up in a different place. We can stop doing only more of the same and make a logical jump to a greatly increased involvement in primary health care (Devereaux, 1993a, 1993b; Watzlawick, Weakland, & Fisch, 1974). Such an expansion of this area of practice in no way reduces the necessity of our continuing involvement in current areas of practice. It is, however, a major paradigm shift. Using a greater percentage of occupational therapy personnel in one area of practice will reduce the percentage of therapists being used in other areas of practice, so that it also becomes an internal systems shift.

A major thrust of the health care reform movement means a role and function redefinition for all health care providers and delivery systems toward "making health, rather than illness, the central, organizing concept. The aim of treatment, then, becomes [the maintenance or] restoration of health rather than curing illness; illness, or pathology, becomes a relative concept" (Bennett, 1993, p. 30). Certainly, illness, injury, and disabilities will continue to be treated, but many more resources will be shifted to health promotion, wellness, and disease and disability prevention. More than 10 years ago, Tarlov (1983) wrote that "the central objective in the coming era will be the maintenance or improvement of individual patient functioning in the patient's normal environment while he or she performs usual activities" (p. 1240). He further stated that what the patients and society most wanted in treatment outcomes was "the ability to function at a high level in personal activities" (p. 1240). These activities, of course, include activities needed for the individual's occupational performance: mobility, the ability to care for self and others, and the ability to perform work and leisure roles. He predicted "that process and coverage will assume less attention in the benefit-cost equation of the future, whereas improved patient functioning per unit cost of services will be highlighted" (p. 1240). This concept is important for occupational therapists in particular; our ability to do what we do best, taking the time to provide services in the way we know gets the best results, which helps to make a difference in the lives of those we treat, is dependent on this kind of thinking and payment for services. With an increasingly greater percentage of the population of all ages living longer with or without disability, Tarlov's comment deserves even greater attention.

The movement from an acute to a chronic disease burden for the nation will become even more evident in the early years of the next century. The health care system, which has been focused largely on treatment of acute disorders or the acute manifestations of chronic disorders, will move gradually toward a system that delays the onset of inevitable chronic disorders through prevention and education. Accompanying this change will be a general shift from care to care as the health care needs of the population change (Pew Health Professions Commission, 1991, p. 10).

Such a major shift that takes the long-term view in the way health care is delivered and paid for may very well become the most important element in the reduction of overall health care costs. The initial result of this change might well be a sharp increase in costs, followed by gradually decreasing expenditures to a point lower than that of today.

A worthwhile goal in primary health care is that "patients should be treated at the lowest level of care clinically appropriate to their particular disorder" (Klerman, 1980, p. 26). This level of care is determined by both "humanistic concerns" (Klerman, p. 26) and realistic cost containment. "Occupational therapy costs are insignificant when compared with overall healthcare costs (less than one tenth of one percent)" (American Occupational Therapy Association [AOTA], 1987, p. 114). Those served by occupational therapy include persons with disabilities, elderly persons, and a large proportion of the
pediatric population, all of whom frequently need longer term care than the general treatment population. Thus, the illusion is created that they are using a large amount of the health care dollar, which is simply not true. "A therapist could see a caseload of approximately 120 home care patients for an entire year for $22,000, or about the cost of two surgical procedures for myocardial infarction" (AOTA, 1987, p. 114). Because those figures were from a 1987 report, it will certainly be more costly today for 120 visits from the occupational therapist, but so will the cost of the surgical procedures. Percentage comparison of the occupational therapy services to the surgical services would probably remain either much the same or have an even wider variance today.

If we, as a nation, are serious about providing community-oriented, client-centered primary health care through coordinated services that focus on health promotion and prevention of disease and disability, maintaining and improving occupational performance, and quality of life, then we must develop "a better scientific data base to show what community responsive practice can do to improve human welfare" (Rogers, 1982, p. 1625). We must also be prepared to pay for this model of health care, according to the results of outcome studies that indicate what it is that we do that makes the difference.

All of these theories about what health care should be make it clear that what has been described is a setting perfectly tailored for occupational therapy. The treatment outcomes desired are goals occupational therapists work with every day, and we know how to structure for their successful achievement. Occupational therapy can be a major force in the delivery of primary health care.

The Generalists

There is an interesting and fortunate parallel between the family practice physician and the occupational therapist when they complete their education and training and first enter practice. They are both generalists. Each may choose to specialize at some point in his or her career, but in the beginning they have wide general knowledge and varying levels of depth in their areas of study.

It has long been my contention (Devereaux, 1978, 1991) that occupational therapists should maintain their skills as generalists. "In addition, the generalist may become a specialist in a particular area of practice, as the two are not mutually exclusive, and those therapists with special expertise are also needed. However, the generalist can move freely between practice areas (1991, p. 945) and can give direct treatment to many as well as screen and refer others to the proper specialists, disciplines, or services. A positive result expected from this type of functioning would be decreased overall health costs with a higher quality of care provided" (1978, p. 668). For the occupational therapy practitioner who practices in primary health care, continuing to strengthen generalist knowledge and skills becomes that therapist's specialty. The job to be done in this area of practice will require therapists with a wide variety of experiences of some depth. Entry-level therapists wishing to work in this area of practice should plan to prepare themselves for this specialty in general practice as they would for any other specialty area.

The Job Description

Every patient entering the primary health care system should be screened by an occupational therapist and scheduled for assessment, periodic reassessments, and treatment as indicated. Just as a history and physical examination are required for each patient, followed by routine blood tests and X-rays so that a database may be established to guide future care, so additional information from the occupational therapist's screening or assessment would add a valuable dimension to a more comprehensive database. This information could include the psychosocial implications of disabling for each patient and enhance holistic treatment. If the initial screening reveals no apparent performance dysfunction, this too is important information to have on record.

In 1979, Vandallam predicted that by the year 2000 "persons will be evaluated for an activity history paralleling the medical history of the physician and a performance evaluation similar to a physical examination used by medical doctors" (p. 54). It now seems possible that her predictions could be realized.

Consider how valuable to comprehensive care it would be to know the patient's current functioning in various performance areas, especially the ability to perform daily roles. A decrease in ability to perform daily activities is often an early sign of increasing depression. At a cognitive level, can the patient follow directions regarding medication? Given the combined functioning of various performance components such as neuromuscular, sensorimotor, and cognitive areas, can the patient still drive a car safely? Can the patient return to work safely? Can the patient work in the same job, or another job that uses his or her skills but does not require lifting or standing or other contraindicated activity?

Think of the parent who tells the child's physician that there is something wrong because the child is not developing as he or she should. The physician may tell the parent that everything is just fine, but the parent continues to worry anyway. Using knowledge, skills, and assessments that may overlap but are different from those used by the physician, the occupational therapist may find data that reaffirm what the physician told the parent or data that reveal a developmental delay or functional deficit that indicates a need for treatment. Parents with whom I have worked over the years, almost without exception, want to know one way or the other. Even if the news is not good news, it is a relief to know that their judgment is valid.

More than 57 million people in the United States have some form of arthritis. (National Center for Medical Rehabilitation Research, NC/MRR Report, 1995, p. 24). Nearly 19% report varying degrees of limitation of their activities due to arthritis (NC/MRR, Report, 1995). Detection at an early stage of this disease would enable measures to be taken toward preventing deformities and their effects on limitation of activities. Such interventions as patient education regarding joint protection and energy conservation, medication, and splinting, if indicated, could contribute much to the prevention of further disability.

With the occupational therapist working in collaboration with the primary care physician, these are just a few examples of the types of patient and family-centered, community-oriented in-
Interventions that fit into wellness, health promotion, and prevention models of health care delivery. The interactive communication in these models encourages the expression of consumer preference in the selection of lifestyle and treatment choices, and commitment by the patient and family to doing those things that enable him or her to maintain and improve functional ability. This model of partnership between patient and clinician empowers the person to take responsibility for his or her own health. Delivering services as part of an interdisciplinary team would further move comprehensive, coordinated health care delivery toward integration of services rather than the fragmentation that exists all too often. This kind of restructuring of service delivery also lends itself to treatment in groups when appropriate, again stretching the health care dollar.

Home visits have long been an important part of occupational therapy practice and would continue to be so in the delivery of primary health care. The benefits to be gained from making home visits include:

- assessment of the patient's level of occupational performance in his or her most familiar environment. Empirical evidence has supported the belief that patients almost always demonstrate a higher level of ability in the most familiar environment, which is usually the home, than in the clinic. This belief is supported most recently by research comparing instrumental activities of daily living (IADL) - ability of persons with suspected dementia in the clinic and in their homes (Nygard, Bcrnsplng, Fisher, & Winblad, 1994, p. 689). This research suggests that "to know how a person with suspected dementia performs in IADL in a specific environment we should test him or her in that environment." (Nygard et al., p. 689). Another study (Park, Fisher, & Velizzo, 1994), which examined the effect of home versus clinic settings on the instrumental activities of daily living (IADL) performance of older adults, concluded that "process skill abilities are affected by the environment to a greater degree than are motor skill abilities and that for persons living in the community, the familiar home environment tends to support IADL performance." (p. 697)
- further assessment of psychosocial issues and support systems
- the opportunity to evaluate the home environment and recommend adaptive equipment and modifications aimed toward energy conservation and safety
- education, training, and support of caregivers
- the opportunity to observe family dynamics, particularly as they facilitate or impede the accomplishment of treatment goals
- the provision of access to care for many consumers who have difficulty getting to other forms of health care, and who otherwise might have to enter a long-term care facility, thereby diminishing their enjoyment of life and dramatically increasing the cost of their health care.

Practice Models

Undoubtedly models of care currently exist that contain several of the components described in this article as being an integral part of and supportive of occupational therapy's role in primary health care. One that contains many components of this type of program is the Rural Geriatrics Program in Huntington, West Virginia, which is a joint effort between Lincoln Primary Care Center and Marshall University School of Medicine, Department of Family and Community Health, funded by the Claude Bencedum Foundation (Walker, 1990). "This program seeks to provide comprehensive care for the elderly utilizing the home visit as the primary tool in geriatric care." (Walker, p. 3).

The first step is a complete in-home evaluation that "explores the patient's social network, economic condition, psychologic and physical disabilities, and environmental hazards." (Walker, 1990, p. 3), followed by a thorough physical exam conducted at the Lincoln Primary Care Center. An interdisciplinary team with training in geriatrics (consisting of a social worker, nurse, physician's assistant, and Geriatric Board Certified family physician or internist) gathers this information and develops a comprehensive plan of intervention and treatment.

Another home visit is made to present the plan to the patient and family. The team schedules regular follow-up home visits in advance that focus on preventive medical care. Community and family resources are used to address social and environmental problems (Walker, 1990).

After this program had been in operation for several years, a research protocol was developed for a project called "Fall Prevention in the Rural Elderly." At this point, funds were made available from the Dean's contingency fund, and later from the grant itself, so that it was possible to involve occupational therapy personnel approximately 1 day per week as part of this research program. The occupational therapists use biopsychosocial indicators from the research protocol in reviewing the medical record to select candidates for screening. They then complete physical, cognitive, and mental status testing on the patients selected. The occupational therapists function as part of the interdisciplinary team, make home visits, provide limited treatment, recommend adaptive equipment and environmental modification, provide education for the family and caregivers, and collect research data.

Another practice model is the U. S. Army's use of occupational therapists as orthopedic health care extenders since approximately 1979. Occupational therapists participated effectively "in a program of primary evaluation and treatment for clients with upper-extremity musculoskeletal disorders" (Jenik, Protzman, & McKenney, 1984, p. 383). The education and experience of the occupational therapist enabled "a smooth and rapid transition into this role as a case manager and definitive care provider." (Jenik et al., p. 383).

Results of a study conducted at Fort Knox, Kentucky, demonstrated "that the OTs were accurate in their diagnostic and X-ray interpretation abilities, and that they were efficient in providing definitive care" (Jenik et al., 1984, p. 383). During peacetime, these orthopedic occupational therapists could be used in the role of health care extender wherever there are large numbers of troops and a rapidly employed model during armed conflict (Jenik et al.)

There are a number of factors in-
Reimbursement Issues

Our viewpoint on the issues described in this article may seem idealistic to some of you, exciting, boring, or scary to others. But we firmly believe that this situation (or at least something similar) will eventually happen. When it does, where will occupational therapists work and who will pay for their services? Perhaps the real issue is not so much where we work, but how we work. It is a given that the major portion of payment will come from some model of managed care or managed competition, although it is always possible that those consumers who can afford to pay directly will choose to do so.

Occupational therapists face a dilemma similar to that of psychotherapists; although based on somewhat differing and partially overlapping theoretical frameworks, both disciplines have conducted most of their practice through dyadic relationships—ones-to-one. According to Bennett (1993), the health maintenance organization (HMO) practice is likely to be a busy and demanding setting, with “high volume and high turnover.” The clinician must be adaptable and readily accessible. The practice is likely to involve following a panel of patients discontinuously over an extended period of time and offering active treatment at points of need (p. 29). Clinician continuity becomes more critical to providing quality service within this model of practice (ICM, 1994). Bennett explained that as managed care activity changes its focus to more open systems such as “loosely configured networks” (p. 29), the influence on practice patterns will affect what is now considered best practice. Greater efforts will be required to achieve collaboration, cooperation, and integration in service delivery as managed care networks assume responsibility for population-based care as well as that of the individual. Planning for these prospective patients as well as current patients will emphasize prevention, early and easy accessibility, and providing patients to stay healthy, functional, and out of the hospital. The clinician’s job is to be a change agent, to use many resources that promote health, and to facilitate for the patient to be a part of the health care team. This approach is a collaborative, multidimensional model in contrast to the dyadic model; it encourages in-depth patient education, discussion of half treatment options, and patient preferences. The guiding principles are parsimony, timeliness and specificity of intervention, and scrupulous planning and monitoring of care (Bennett, 1993, p. 30).

Dr. Bennett’s statement of “guiding principles” is a much more eloquent way of stating something written about previously:

The message to therapists will continue to be to do more and to do it better for less, and in the future, as now, innovative community programming will provide part of the response to this societal expectation (Devereaux, 1991, p. 94).

Occupational therapists could become members of managed care plan closed panels. A panel is composed of a group of various providers whose members will have their health care reimbursed only if it is provided by a panel member (e.g., hospital, physician, etc.). We might join the staff of an HMO, a preferred provider organization (PPO), or a group practice of some type. These types of organizations often receive funds up front (called capitation funds), so that any service provided in that practice becomes an expense, in which case the providers receive salaries rather than fees-for-service; if clinical services are delivered with great efficiency and low costs, staff bonuses are sometimes given.

Ideally, occupational therapists would work in a physical setting where organized groups of health care providers are located and where we could take full advantage of being a part of well-integrated interdisciplined team. Ideally, insurance, government payment, and other reimbursement would be effectively restructured to reinforce health promotion, disease prevention, and wellness programs.

Conclusion

More chaos than certainty reigns in the health care arena these days. Greta Garbo’s publicity agent was fond of saying, “Dissatisfaction and controversy always accompany great progress” (W. Heller, personal communication, 1966). In crisis and in chaos there is opportunity. We must constantly be looking for the opportunities, and we must retain our flexibility to be able to take advantage of the opportunities (J. Thomas, personal communication, September 19, 1994).

I have encountered people who are critical of occupational therapy’s expansion into new areas of practice, claiming that we think we can treat everyone: neonatal patients, those with spinal cord injuries, psychiatric patients, patients in work-hardening and stress management programs, and so forth. Perhaps the focus has been on the wrong units of measurement. No, we do not think that we can treat everyone, nor do we wish to treat those who do not need our skills. We only treat people who have deficits in some aspect of their performance ability. Unfortunately, there is no limit as to where these persons are found, the diagnostic categories within which they fall, or the types of deficits they experience, so that occupational therapy services can and do, cut across all other units of measurement.

In defining the problems we face and in designing the interventions, we need to rely on our skills as occupational therapists to analyze systems. Many others will approach these issues with linear thinking, a cause-effect-solution process (Devereaux, 1993a). It is not that simple. As we consider interventions, our ability to evaluate their effects throughout complex systems will guide us in the choice of strategies, methods, and timing.

In their book on change, Watzlawick et al. stated:

It is our contention that change can be implemented effectively, by focusing on minimal, concrete goals, going slowly, and proceeding step-by-step, rather than strongly, promoting clear and vague targets with whose desirability nobody would take issue, but whose attainability is a different question altogether (1974, p. 159).

Taking a long-term viewpoint, what is it that will satisfy our patients as consum-
ers of health care and contribute to empowering them to demand access to occupational therapy services as well as others with similar qualities? “I am convinced that a profession that consistently provides treatment giving patients a clear sense of having both their physical and psychological needs well tended and contributed to will not only survive, but will also experience an increase in demand for their services. Occupational therapy is such a profession” (Devereaux, 1984, p. 794). ▲

Acknowledgments

Presentations of earlier drafts of this article were made by the senior author in the Keynote Address to the West Virginia Occupational Therapy Association’s First State Conference, September 1994, Charleston, West Virginia; and to faculty members and students of the Department of Occupational Therapy at the University of Texas Medical Branch, Galveston, Texas, in November 1994. We acknowledge the comments of these participants and the reviews, comments, and assistance of Bimbi Bieler, MSW, LSW, and Sarah Henfeldt, MSl, MOT, OTR.

References


