Population Health and Occupational Therapy

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Occupational therapy practitioners play an important role in improving the health of populations through the development of occupational therapy interventions at the population level and through advocacy to address occupational participation and the multiple determinants of health. This article defines and explores population health as a concept and describes the appropriateness of occupational therapy practice in population health. Support of population health practice as evidenced in the official documents of the American Occupational Therapy Association and the relevance of population health for occupational therapy as a profession are reviewed. Recommendations and directions for the future are included related to celebration of the achievements of occupational therapy practitioners in the area of population health, changes to the *Occupational Therapy Practice Framework* and educational accreditation standards, and the importance of supporting, recognizing, rewarding, and valuing occupational therapy practitioners who assume roles in which direct care is not their primary function.

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Much has been written about the Triple Aim of health care since the Institute for Healthcare Improvement introduced the concept in 2007. It is often cited as a guiding principle of health care and health insurance reform, including the Patient Protection and Affordable Care Act of 2010 (ACA; Pub. L. 111–148). Berwick, Nolan, and Whittington (2008) defined the Triple Aim as "improving the individual experience of care, improving the health of populations, and reducing the per capita cost of care" (p. 760). Health care leaders, including those in the discipline of occupational therapy, have explored a range of issues and connections to the Triple Aim.

In January 2012, the *American Journal of Occupational Therapy* launched a new column, "Health Policy Perspectives." Since that time, most of the articles published in the column have directly discussed connections between occupational therapy and the Triple Aim. Examples of these discussions have included

- Primary care and value-based payment (Leland, Crum, Phipps, Roberts, & Gage, 2015; Stoffel, 2013)
- The role of healthy habits and occupational therapy's role in wellness and prevention as a strategy to maintain its relevance (Hildenbrand & Lamb, 2013; Persch, Lamb, Metzler, & Fristad, 2015)
- New models of interdisciplinary team practice and a vision of health care as "a coordinated system built on teams of professionals with many capabilities and varied scopes of practice all focused on achieving health" (Metzler, Hartmann, & Lowenthal, 2012, p. 267; Moyers & Metzler, 2014)
- Increased use of information technologies supported by the Centers for Medicare and Medicaid Services (CMS) and telehealth (Cason, 2015; Moyers & Metzler, 2014)
- The Triple Aim and client centeredness as providing "a compass for future research demonstrating occupational therapy's value through improved outcomes for health care recipients, increased efficiency of care transitions and prevention of hospital readmissions, and cost-effectiveness of interventions and programs when effectively and efficiently provided on the basis of best practice" (Lamb & Metzler, 2014, p. 9; Mroz, Pitonyak, Fogelberg, & Leland, 2015)

- Evidence and promotion of the distinct value of occupational therapy (Arbesman, Lieberman, & Metzler, 2014).

One of the three pillars of the Triple Aim is to improve the overall health of the population. Comparatively less has been written about occupational therapy and population health and the relevance of population health to the profession than about the other two pillars and occupational therapy. In this article, I explore the concept of population health and articulate the relevance of population health to occupational therapy. I conclude with a set of recommendations and possible directions for the future.

Defining and Exploring Population Health

Kindig and Stoddart (2003) provided one commonly cited definition of *population health:* "the health outcomes of a group of individuals including the distribution of such outcomes within the group" (p. 381). This definition has been cited and clarified by many. CMS (2014) named population health as a key goal of the State Innovation Models for health system transformation.

The Institute of Medicine (IOM) convened a Roundtable on Population Health in June 2013. Members of the roundtable noted that "while not a part of the definition itself, it is understood that such population health outcomes are the product of multiple determinants of health, including medical care, public health, genetics, behaviors, social factors, and environmental factors" (IOM, 2015, para. 4). These clarifying comments from the IOM roundtable both highlight the value of population health and provide a distinction from public health in that consideration of all major population health determinants such as health care, education, and income typically remains outside public health authority and responsibility, even in its assurance functions (Kindig, 2015).

Applying the definition of population health requires that we understand more about what the term *population* includes. Narrow definitions of what might constitute a population can be as limited as the patients covered by a specific health plan, such as Accountable Care Organizations in Medicare that attempt to improve the health of the population for which they are responsible. Broader, or more varied, definitions have been used as well. How *population* is defined has implications for health professionals, including occupational therapy practitioners, educators, and researchers. Kindig (2015) expanded on the explanation of populations by stating, "These groups are often geographic populations such as nations or communities, but can also be other groups such as employees, ethnic groups, disabled persons, prisoners, or any other defined group" (para. 3). Occupational therapy has opportunities to affect population health across all of these groups.

The official documents of the American Occupational Therapy Association (AOTA) have defined *clients* as persons, groups, and populations and clarified the term *population* as meaning "collectives of groups of individuals living in a similar locale—e.g., city, state, or country—or sharing the same or like characteristics or concerns" (AOTA, 2014a, p. S3). The third edition of the *Occupational Therapy Practice Framework* explicitly stated that organization- or system-level practice is valid, although occupational therapy practice models guiding interventions at this level are less well developed than are practice models at the level of the individual person or groups. However, there is much potential to refine appropriate models to guide practice applied to populations. Moreover, occupational therapy practitioners must analyze the principles of population health to draw clear connections to the basic principles of occupational therapy. There is general agreement that the basic population health principles are as follows (Kindig, 2010):

- that health outcomes were more than the absence of disease;
- that these outcomes were produced by complex interactions of multiple determinants (health care, behaviors, genetics, the social environment, the physical environment); and
- that in a resource-limited world, the relative cost effectiveness of these determinants was critical for policymakers. (para. 2)

One construct stated by a member of the IOM Roundtable may be a good framing device. Chang observed that population health can be approached in two ways:

> either by (1) starting from the community and thinking about the needs of populations and then integrating with clinical care, or (2) starting from the individual needs of patients and learning about the social or community factors that are impacting their health and addressing these needs through policy or systems change. (as cited in Alper, 2014, p. 26)

Both of these approaches are familiar to occupational therapy practitioners, and the occupational therapy literature contains many examples of the application of these approaches to population health, although they have not always been framed within a population health perspective. I provide three examples.

First, in the late 1990s Gary Kielhofner and I identified the needs of the population of people living with HIV/AIDS. Members of this population struggled with management of what was being recognized as a chronic illness and the resulting challenges to employment and independent living in the community. These needs, identified at the population level, were addressed through the development and delivery of two clinical care programs in the community and in supportive living facilities in Chicago (Kielhofner, Braveman, Fogg, & Levin, 2008; Kielhofner et al., 2004). These efforts in turn influenced Social Security disability policy through invited testimony provided to the IOM Committee on Social Security HIV Disability Criteria to include broader language regarding the involvement of multiple disciplines such as occupational therapy in disability evaluation and determination (IOM, 2010).

A second example is the recent work of occupational therapy scholars and colleagues to explore the role that built, social, and economic environmental factors play in facilitating or limiting health, disability, and rehabilitation outcomes of people with disabilities both as individuals and as a

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group (Magasi et al., 2015). A third example is the outcomes and quality measures work within the CMS Testing Experience and Functional Tools project. Occupational therapist Trudy Mallinson and others are collaborating with CMS to measure population health indicators in the population of individuals with disabilities served under certain Medicaid programs. The project will extend the standardization of functional status items to the state home- and community-based waiver programs by piloting how these self-care and mobility items work in populations who are aging or have disability, intellectual disability–developmental disability, traumatic brain injury, and serious mental illness (Medicaid.gov, 2015).

There are multiple examples of occupational therapy practitioners and of AOTA addressing individual patient and population needs through advocacy for policy or systems change. Recent examples include advocacy for mental health initiatives such as the Mental Health Awareness and Improvement Act (S. 1893) and success in having licensed occupational therapists listed as part of the suggested staff to be considered for inclusion in newly created certified community behavioral health clinics (AOTA, 2015a, 2015b). In essence, the latter approach identified by Chang (i.e., to start with the needs of individual patients and address population needs through policy or systems change as one learns about the social or community factors that are affecting their health; Alper, 2014) may be at the heart of efforts by those who see social justice as a relevant cause for occupational therapy and as a value that is congruent with the core values of occupational therapy practice as currently stated by AOTA (2015c).

Growing Opportunities to Address Population Health

The ACA has been instrumental in bringing attention to population health. Provisions of the ACA have helped to expand the focus of health experts, policymakers, and the public beyond traditional health care delivery within the limits of the health care system to the broader array of factors that play a role in shaping health outcomes and the broader range of actors (e.g., community organizations) who can affect population health. Alper (2014) stated that

> the shift includes a growing recognition that the health care delivery system is responsible for only a modest proportion of what makes and keeps Americans healthy and that health care providers and organizations could accept and embrace a richer role in communities, working in partnership with public health agencies, community-based organizations, schools, businesses, and many others to identify and solve the thorny problems that contribute to poor health. (p. 2)

Occupational therapy practitioners are well established in each of these settings and could play a central role in developing and nurturing such partnerships to help shape health outcomes. Occupational therapy practitioners must use their position in these settings to clearly articulate the role of occupational therapy in working with populations and in addressing population health and also to expand their employment, presence, and influence in other types of settings, such as child day care, public clinics, homeless shelters, and aging centers.

Recent calls for increased involvement of occupational therapy in primary care also highlight opportunities to begin with individual patients and then have an impact on larger populations. AOTA (2014b) has asserted that occupational therapy practitioners are well prepared to contribute to interprofessional care teams addressing the primary care needs of people across the lifespan, particularly those with, or at risk for, one or more chronic conditions. This involvement can be an opening for occupational therapy to show its potential by incorporating a broader view of health that is not about just one person but rather about the entire system and how effective it is in total—which is the essence of the transformation envisioned by the Triple Aim. New primary care delivery models are shifting the emphasis of interventions to the management of chronic conditions with the goal of reducing costs and improving population health (International Education Collaborative Expert Panel, 2011; IOM, 2010). These efforts move from populations to individuals and from individuals to populations as described by Chang (as cited in Alper, 2014). Practitioners must understand and perform in ways that showcase how their perspective and approaches add distinct value to achieving population health as well as individual goals.

Relevance of Population Health for Occupational Therapy

Discussions of the relevance of population health to occupational therapy are not new, and occupational therapy practitioners in the United States are not alone in their interest (Scaffa, 2014). For example, the Canadian Association of Occupational Therapists (CAOT; 2008, 2009) has clearly articulated its position on the involvement of Canadian occupational therapists in population health efforts. A 2009 report by the CAOT executive director that included recommendations intended to improve health human resource planning for occupational therapy in Canada noted, "Occupational therapists' broad vision is to enable people who face emotional, physical or social barriers to develop healthy patterns of occupation, and the profession demonstrates an ability to meet the population health needs of the Canadian people" (CAOT, 2009, p. 5).

Wilcock and Hocking (2015) from Australia provided a thorough discussion of occupation as an agent of population health in the third edition of their textbook *An Occupational Perspective on Health*. They addressed perspectives of population health founded on World Health Organization policies and promoted the role of occupational therapy to "uncover a different way to understand health in the light of how, what, with whom, and why people spend time and effort in 'doing, being, belonging and becoming' through engagement in occupation" (p. xi).

Occupational therapy practitioners' clinical care of individual clients is commonly understood and embraced by members of the profession and the public.

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The health of populations is not as clearly understood by members of the profession, but it is a concept we must embrace, and occupational therapy practitioners must include the broad focus of population health in their practice. This approach is not always closely aligned with the entities, processes, and settings that provide direct clinical care and at this time encompass most occupational therapy provision. Although the applicability of population health and public health to occupational therapy has been questioned, I believe this is exactly where occupational therapy practitioners must cultivate their role, push research, and move toward the future.

As a profession, occupational therapy has moved beyond the question "Is that occupational therapy?" to the equally important questions of "Is that something that occupational therapy practitioners can do?" "Can occupational therapy make an important contribution in this area?" and "How can we demonstrate our distinct value through contributions to population health?" A growing number of occupational therapy scholars and practitioners are exploring these latter three questions as well as the connection between population health and individual occupational performance. The exploration of new roles for occupational therapy in population health complements efforts focused on understanding and promoting the importance of occupation to health outcomes, such as in the Well Elderly studies (Clark et al., 1996, 1997, 2001, 2012), and on research related to the provision, outcomes, and efficacy of occupational therapy services in traditional practice settings.

The appropriateness of population-based approaches is clearly documented in AOTA's official documents. For example, AOTA's (2013) *Occupational Therapy in the Promotion of Health and Well-Being* includes a section on a population health approach and states, "In addition to providing occupational therapy interventions for individuals, occupational therapy practitioners can develop and implement occupation-based population health approaches to enhance occupational performance and participation, quality of life, and occupational justice" (p. S49). This statement further delineates the relevance of health disparities (an issue central to population health) to occupational therapy, stating, "The term *health disparities* refers to population-specific differences in disease rates, health outcomes, and access to health care services" (p. S48).

Recommendations and Directions for the Future

Thus far, I have explored population health and key related concepts and articulated the relevance of population health to occupational therapy. Here, I present a set of recommendations and possible directions for the future.

First, we should recognize the successes and achievements of occupational therapy practitioners and of AOTA in addressing the two approaches to population health described by Chang (as cited in Alper, 2014). We should clearly articulate how occupational therapy practitioners address population health to promote increased recognition and consideration of the profession in policy arenas. Moreover, a clear articulation of our role in improving the health of the population and achieving the Triple Aim will contribute to occupational therapy's becoming a more powerful profession and achieving our vision for our future.

To guide practitioners and researchers and to clarify future possibilities, we should identify specific competencies related to population health and public health and include them clearly in the *Framework*. The current *Framework* includes populations in its definition of clients but does not include the phrase *population health* and does not address the issue of population health directly. Interventions aimed at populations are addressed, however; for example,

> Interventions provided to groups and populations are directed to all the members collectively rather than individualized to specific people within the group. Practitioners direct their interventions toward current or potential disabling conditions with the goal of enhancing the health, well-being, and participation of all group members collectively. (AOTA, 2014a, p. S15)

Additional examples should be added, such as advocating for changes in policy and education, sitting on government planning commissions, and helping design new public spaces; these examples should be tied to advocacy and other practice roles described in the *Framework*.

A related recommendation is to examine how population health is reflected in our educational accreditation standards. Current screening, evaluation, and referral standards include populations as clients and state that the "process must consider the continuum of need from individuals to populations" (Standard B.4.0; Accreditation Council for Occupational Therapy Education [ACOTE], 2011, p. 21). However, the term *population health* does not appear in the accreditation standards, and only the standards for doctoral-level occupational therapist programs include population-based interventions specifically (Standard B.5.33; ACOTE, 2011, p. 28). Contributions to efforts to address population health by occupational therapy practitioners at all levels hold great opportunity. Our educational accreditation standards should reflect these opportunities by clear inclusion of the term *population health* in the standards for all levels of educational programs.

Perhaps most important is the recommendation that we actively support, recognize, reward, and value occupational therapy practitioners who assume roles in which direct care practice is not their primary function. In 2015, our profession grew to more than 213,000 occupational therapy practitioners and students in the United States alone. We have both maintained a strong presence in traditional practice settings and broadened our focus to include new areas such as population health. Both of these successes should be celebrated.

Population health spans both occupational therapy's traditional and its emerging practices. It encompasses the work practitioners do when they identify the health needs of populations such as people with autism, diabetes, falls, limited mobility, or cancer and address those needs through integration with clinical care

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providers in schools, hospitals, private businesses, and community-based organizations (Roberts & Robinson, 2014; Fisher & Friesema, 2013). It will also encompass expanded roles practitioners could adopt in the policy arena, in nonprofit organizational leadership in organizations such as the American Cancer Society or the Brain Injury Association of America, or in federal health agencies such as the Centers for Disease Control and Prevention or the National Institutes of Health. Considering the long-term impact for the profession of supporting, recognizing, rewarding, and valuing the contribution of occupational therapy practitioners working in organizations such as these moves us toward answering a question that will have a big payoff for the profession: How can we demonstrate occupational therapy's distinct value in improving the individual experience of care, improving the health of populations, and reducing the per capita cost of care? ▲

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