

# Occupational Therapy and Primary Care: Updates and Trends

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As our health care system continues to change, so do the opportunities for occupational therapy. This article provides an update to a 2012 Health Policy Perspectives on this topic. We identify new initiatives and opportunities in primary care, explore common challenges to integrating occupational therapy in primary care environments, and highlight international works that can support our efforts. We conclude by discussing next steps for occupational therapy practitioners in order to continue to progress our efforts in primary care.

Halle, A. D., Mroz, T. M., Fogelberg, D. J., & Leland, N. E. (2018). Health Policy Perspectives—Occupational therapy and primary care: Updates and trends. *American Journal of Occupational Therapy, 72*, 7203090010. <https://doi.org/10.5014/ajot.2018.723001>

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Occupational therapy practitioners have actively pursued initiatives in primary care environments for many years (Bumphrey, 1989; Devereaux & Walker, 1995). Because of renewed emphasis on primary care driven by the Patient Protection and Affordable Care Act of 2010 (ACA; Pub. L. 111-148) and other national initiatives, interest in occupational therapy's role in primary care has intensified since 2012 (Metzler, Hartmann, & Lowenthal, 2012; Muir, 2012). Since that time, occupational therapy providers have seized opportunities in primary care and worked to resolve numerous barriers in this area—notably, reimbursement and recognition. However, as health care continues to transform and innovative models are tested, occupational therapy practitioners must identify new opportunities and rapidly adapt to changes.

This column builds on previous work first by defining primary care, identifying existing initiatives, and highlighting new opportunities created by innovative care delivery models. It then explores how to situate occupational therapy to support expansion in primary care, examines common challenges and solutions to integrating occupational therapy in primary care, and identifies international evidence

for occupational therapy in primary care. Last, it examines next steps for occupational therapy to achieve a prominent place in the evolving primary care arena.

## Defining Primary Care

The definition of primary care has been an area of contention since the term was introduced in 1961 (Institute of Medicine [IOM], 1994). Although several definitions are currently used, the most common definition is the one created by the IOM (1994), which defined *primary care* as “the provision of integrated, accessible health care services by clinicians who are accountable for addressing a large majority of personal health care needs, developing a sustained partnership with patients, and practicing in the context of family and community” (p. 1). In comparison, the term *primary health care* is more holistic and has a different intent from primary care, one that is based on more of a social model of health (Keleher, 2001). The terms primary care and primary health care are often used interchangeably, and although primary care was redefined and expanded in response to recent health care changes, this term is often used to refer to

services provided only by physicians, nurse practitioners, and physician assistants (Keleher, 2001; Metzler et al., 2012; Vanselow, Donaldson, & Yordy, 1995). Occupational therapy's objective has been to challenge that narrow view of primary care and expand it to include many other services, including occupational therapy.

## Primary Care Innovation: Models of Service Delivery

The emergence of alternative payment models (APMs) provides a key opportunity for occupational therapy to move further into primary care. APMs are payment approaches that give added incentive payments to practices that take on some risk related to patient outcomes to encourage provision of high-quality and cost-efficient care. The Centers for Medicare and Medicaid Services (CMS) in particular supports many efforts to advance quality and innovation in primary care through APMs to incentivize providers to engage in high-quality care by linking payment to processes and outcomes (e.g., preventive care screenings, care planning and coordination, functional status assessment, readmissions).

Key models of primary care service delivery and innovation include the Comprehensive Primary Care Plus (CPC+), Next Generation Accountable Care Organization (ACO), Federally Qualified Health Center (FQHC), and Patient Centered Medical Home (PCMH; CMS, 2018a):

- The CPC+ model is a 5-year, multi-payer initiative to improve primary care that will target 20 U.S. geographic regions and 20,000 doctors and practitioners (CMS, 2018b).
- ACOs are groups of doctors, hospitals, and other health care providers who come together voluntarily to give coordinated high-quality care to their Medicare patients (CMS, 2017b). The Next Generation ACO model provides greater opportunities for shared savings to create increased incentives for experienced ACOs (CMS, 2018c).
- The FQHC is a reimbursement designation from CMS for safety net providers who provide comprehensive services to a medically underserved area or popu-

lation and have ongoing quality assurance programs (CMS, 2017c).

- The PCMH is a care delivery model focused on reducing costs by providing care that is comprehensive, patient and family centered, coordinated, accessible, and accountable (National Committee for Quality Assurance, 2015).

Although each model has slight differences, the common goal of all models is improved primary care service delivery.

## Situating Occupational Therapy to Support Expansion in Primary Care

Although many observers may believe that primary care is a new practice context for occupational therapy, history and precedent exist for the profession's role in this area. Moreover, occupational therapy practitioners have addressed health management, wellness, and prevention—common concerns in primary health care—as well as the role of occupational therapy, as generalists or specialists since the early years of the profession (Devereaux & Walker, 1995; Foto, 1996).

Given the profession's long-standing interest in these areas related to primary care, we occupational therapy practitioners must reflect on what makes this point in time any different from the past. Since the passage of the ACA, policies and prospects to include occupational therapy in primary health care have increased at seemingly exponential rates. Similarly, payment for health care practitioners appears to be constantly changing. The opportunities include notable trends toward behavioral health, mental health, prevention and wellness, team-based care, chronic care management, value-based payment, and care coordination (CMS, 2017a; DeVore, 2018; Substance Abuse and Mental Health Services Administration, 2017). The American Occupational Therapy Association (AOTA) Commission on Education highlighted that although our profession has not always specifically referred to our role in primary care, the work we have been doing in primary care settings is not new or significantly different from what we have been doing for generations (AOTA, in press). Models and

research for specific settings are still emerging in the United States, but we have multiple examples from other countries that can guide our pioneering work in the U.S. context.

Occupational therapy can be an active contributor to national efforts to improve population health through the delivery of high-quality, safe, and efficient care (Berwick, Nolan, & Whittington, 2008; Hildenbrand & Lamb, 2013). For example, occupational therapy providers in primary care can help achieve these goals by addressing patients' risk of hospital readmission, assisting patients with adherence to treatment regimens, helping people maintain independence, identifying the need for early intervention, promoting management of chronic conditions, delaying long-term institutionalization, and assisting patients' transitions through the care continuum (AOTA, 2014; Hooper, Delosh, Parsons, & Trudeau, 2017; Leland, Fogelberg, Halle, & Mroz, 2017; Rogers, Bai, Lavin, & Anderson, 2016; Szanton et al., 2015). Achieving such outcomes is key to successful implementation of primary care as a component of a revised and more successful health care system. And occupational therapy, if used well, can help to achieve these goals.

## Challenges to Integrating Occupational Therapy in Primary Care

Although it is important to highlight the ever-changing opportunities in primary care, it is also critical to be realistic about the barriers. Key areas to consider relate to reimbursement, narrow or unclear vision of the value of occupational therapy in primary care, interprofessional and team-based considerations, and current educational preparation for entry-level occupational therapists and occupational therapy assistants (Wood, Fortune, & McKinstry, 2013).

### Reimbursement

The logistics of the U.S. health care system present unique challenges related to reimbursement for occupational therapy in primary care. Funding sources include both traditional (e.g., existing *Current Procedural Terminology* [CPT<sup>®</sup>] codes; American Medical Association, 2018) and

alternative models. For instance, *CPT* code 97535, self-care/home management training, might be used for an intervention for a client with diabetes who has difficulty with the scheduling and mechanics of insulin use. In contrast, alternative solutions involve inclusion in bundled encounter payments. For example, an FQHC can renegotiate a higher encounter rate to cover additional costs associated with providing occupational therapy services (Murphy, Griffith, Berkeridge, Mroz, & Jirikowic, 2017). Within the PCMH model, occupational therapy practitioners have been able to include a portion of their salary under the health education component of the medical home services.

In the context of APMs and other health care initiatives, a business argument may be effective. Return on investment (ROI) is a way to measure profitability and benefit resulting from an investment. In this case, an organization's "investment" in occupational therapy produces desired outcomes ("returns"), thus demonstrating the value of the profession in primary care. For example, by augmenting the physician-patient interaction, occupational therapy practitioners can help facilities or entities meet quality standards, improve patient satisfaction, achieve quality reporting metrics, or enhance referrals to other service lines.

However, efforts to promote the profession, including arguments based on ROI and improved health outcomes, require that occupational therapy practitioners understand the context—more specifically, what primary care physicians and health care systems are held accountable for (e.g., mandated quality metrics) and the challenges they face, including primary care provider shortages and time constraints (Association of American Medical Colleges, 2016; Østbye et al., 2005; Yarnall, Pollak, Østbye, Krause, & Michener, 2003). The integration of other professions into physicians' practice can mitigate physician time constraints and improve patient and provider satisfaction, as well as improve their quality measures (Bodenheimer & Laing, 2007). Thus, occupational therapy practitioners should be articulating how we can ameliorate the primary care shortage and help primary care providers optimize patient and provider satisfaction and quality measures.

### *Narrow or Unclear Vision of the Value of Occupational Therapy*

If our profession is to be seen as a key member of primary care teams, we need to conceptualize a comprehensive primary care approach (Metzler et al., 2012). This vision would allow us to have more opportunities to articulate our role, actively engage in care delivery, and make an impact on health and lives. In doing so, we must learn from our past and avoid previous mistakes. The inability to clearly describe occupational therapy's unique value in the 1930s and 1940s and consequential detriment to the profession have been well documented (Levine, 1987; Reed, 1986). Although all occupational therapy students are currently prepared at a generalist level, primary care education is limited; thus, many students and practitioners are unable to elucidate our value in primary care. Yet, initiatives have been created to mitigate this gap. For instance, AOTA (in press) developed a white paper on this topic that may prompt curriculum adaptations.

### *Interprofessional and Team-Based Considerations*

The interprofessional literature emphasizes that effective team performance and integration are based on an understanding of other professions' roles (Green & Johnson, 2015; Reeves et al., 2008; Stenner & Courtenay, 2008). Thus, our success hinges on our ability to work successfully on teams with other professions. Not only should we understand the other team members' roles to function effectively and negotiate authority on the team, we must also effectively communicate our contribution. Evidence has shown that physicians are less likely to understand the occupational therapy role relative to other health professions (Donnelly, Brenchley, Crawford, & Letts, 2013). To successfully function in this context at the top of our license—doing the optimum work we are educated and trained to do—we need to ensure we have non-occupational therapy champions who understand our full scope of practice. It is up to us to educate interprofessional teams as part of our daily interactions. This education by each of us is critical to our future success.

### *Current Educational Preparation for Occupational Therapy Practitioners*

As we advocate for occupational therapy to become increasingly involved in primary care, our profession must be able to supply practitioners who can provide services in the primary care context. AOTA (in press) describes the necessity for occupational therapy educators to better prepare students to work in primary care environments. Although all occupational therapy graduates are qualified to practice in primary care environments, the AOTA paper highlights various areas of education that might require unique tailoring to better prepare graduates for changing and emerging roles. These areas would address the need to provide more explicit applications of knowledge and skills to primary care approaches and to educate students on particular characteristics of primary care settings. Topics recommended by AOTA include models of care delivery, clinical reasoning, documentation, and reimbursement.

Another area of educational preparation is the need to provide fieldwork experiences for students in primary care environments. Some occupational therapy practitioners working in primary care environments may feel unsure about taking a fieldwork student into an emerging area of practice; however, it is critical that we do so to provide students the opportunity to experience this area firsthand. Again, AOTA (in press) highlights examples of how to integrate Level I and Level II fieldwork opportunities in primary care. Occupational therapy practitioners working in primary care need to think creatively about how to provide experiences. Some strategies currently being used include sharing students, having students at multiple sites with coordinated supervision, providing remote supervision, and placing students with non-occupational therapy providers.

### **What We Can Learn From International Programs and Research**

International primary care models that include occupational therapy have demonstrated

enhanced function, quality of life, satisfaction, and engagement for patients as well as reduced risk of adverse events (e.g., accidental falls; Garvey, Connolly, Boland, & Smith, 2015; Gonzalez Gonzalez, del Teso Rubio, Waliño Paniagua, Criado-Alvarez, & Sanchez Holgado, 2015; Mackenzie & Clemson, 2014; Mackenzie, Clemson, & Roberts, 2013; Richardson et al., 2010). Many countries have thriving primary care systems within coordinated national health care systems. International research has provided a growing body of evidence demonstrating occupational therapy's unique value in primary care, including improved activity engagement, quality of life, safety, satisfaction, and service utilization for patients.

International research also serves as a source of encouragement and guidance as the United States continues to more formally develop models such as those being developed through the Center for Medicare and Medicaid Innovation. In Canada, Donnelly and colleagues (2013; Donnelly, Leclair, Wener, Hand, & Letts, 2016) examined various models for bridging primary care and occupational therapy, which has resulted in an examination of existing models of occupational therapy in primary care. Findings indicate that a growing number of occupational therapy practitioners are working in primary care and providing a broad range of services for clients across the lifespan and that effective interprofessional skills (e.g., knowledge of professional roles, trust and communication) are essential for successful integration of occupational therapy in primary health care environments (Donnelly et al., 2013, 2016; McColl et al., 2009).

## Conclusions and Next Steps for Occupational Therapy

To echo the call to arms by Metzler and colleagues (2012), opportunities to develop occupational therapy's distinct value in primary care seem endless. However, although the opportunities are plentiful, they are not without expiration dates. Primary care in the United States is a confusing and complex system that is constantly changing. We cannot be paralyzed, waiting for oppor-

tunities to be offered to us. Instead, we need to seek out the opportunities, take action, and continue acting in times of constant uncertainty.

Occupational therapy practitioners need to take steps to establish a clear and valuable role in the current system and in emerging systems as health care transformation continues. This effort can be achieved by first reflecting on the profession's past, looking to our peers in other countries who have established roles in primary care, and clearly articulating the unique value of occupational therapy and the ways we can help primary care practices optimize their quality metrics (Devereaux & Walker, 1995; Donnelly et al., 2013, 2016; Foto, 1996; Garvey et al., 2015). We should also consider both formally and informally establishing communities of practice to support practitioners working in primary care environments or interested in working in this area. Continued efforts should be made to collaborate with and educate people unfamiliar with our distinct value in primary care. We must strive to disseminate occupational therapy's distinct value and roles in primary care beyond our profession to non-occupational therapy audiences to improve our visibility. Furthermore, occupational therapy practitioners interested in primary care should also look beyond occupational therapy-specific job positions. For example, practitioners can capitalize on their occupational therapy knowledge and skills in work as clinic administrators, case managers, and in behavioral/mental health systems.

If occupational therapy is going to situate itself successfully as part of primary care teams, this is the time to act. If not now, other professions will seize the opportunities. By integrating occupational therapy into primary care environments, we can best serve our clients, communities, and populations. ▲

## Acknowledgments

During the preparation of this article, Ashley Halle was supported by the Health Resources and Services Administration under the Geriatrics Workforce Enhancement Program Award, Natalie Leland was supported by the Agency for Healthcare Research and Quality (K01 HS 022907),

and Donald Fogelberg was supported by the Eunice Kennedy Shriver National Institute of Child Health and Human Development of the National Institutes of Health (K01HD076183). The authors thank Ashley M. Delosh, Payment Policy Specialist at AOTA, for her editorial assistance.

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## Designing Occupational Therapy Services in a Primary Care Setting: Successful Strategies and Lessons Learned

**AOTA**  
Continuing Education

*Presenters: Dragana (Anna) Krpalek, Ph.D, OTR/L, Heather Javaherian Dysinger, OTD, OTR/L*

The triple aim of health care reform has been the driving force in the area of primary care. Through the understanding of habits, roles and routines as well as the power of participation in daily activities, occupational therapy is distinctly suited to address several components of the triple aim such as improving the health care experience, improving population health, and decreasing health care costs. By accessing patients through primary care clinics, occupational therapists can assist in the early identification of problems, assist with prevention of problems, improve overall patient health, and decrease hospitalizations.

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