What Is the Role of the Occupational Therapist in Managed Care?

Julia Van Deusen

Julia Van Deusen, PhD, OTR/L, FAOTA is Professor, Department of Occupational Therapy, Box 100164 Health Science Center, University of Florida, Gainesville, Florida 32610-0164.

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Like it or not, managed care is here. Foresighted occupational therapists are addressing the issues involved. For example, the occupational therapist and other providers in the workers’ compensation arena are coping with managed care through cooperation with insurers and employers (Niemeyer & Foto, 1994). The managed system of health care, which emphasizes preventative care, is considered cost efficient (Levy, 1993). Because of cost containment trends, health maintenance organizations (HMOs) and similar programs are not going to disappear; they will expand in strength and number. The issue is— not whether we will accept managed care—but rather, how do we, as occupational therapists, fit with this kind of programming? Is there a general model that is applicable to all of occupational therapy?

First, consider the current managed care medical model. There is a primary physician who typically is a family practitioner, a pediatrician, or an internist. This primary physician gets to know each patient holistically, delivers needed treatment within his or her level of competence, and refers other required intervention to specialists as indicated. Thus, patients are treated by specialists such as the ophthalmologist, the cardiologist, and the neurologist only when recommended by the primary physician. The trend, then, in medical education is to increase production of the number of general practitioners as opposed to specialist physicians. In the meantime, the marketplace will probably be oversupplied with specialists and undersupplied with primary physicians. What will be the role of the out-of-work psychiatrist? Neurologist? Psychiatrist?

In addition, because of the societal demand for cost containment in the health care arena, demand for services by the health care-related professions will probably increase. Unless the specialist physicians will accept a substantial salary cut, an ever greater number of patients will be referred to the health care-related professional such as the physical therapist, occupational therapist, or speech pathologist when their intervention can satisfactorily substitute for a higher cost service. For example, patients with range of motion or muscle strength problems often could be referred directly to occupational therapy by the primary physician, rather than first being examined by a physiatrist, neurologist, or other medical specialist.

If, as seems likely, there will be increasing need for health care-related services, how can occupational therapists best fit within the managed care model? There is one obvious way in which occupational therapists, clinical psychologists, physical therapists, nurses, and other health care-related professionals can fit within the managed care model—by following the physician’s pattern of service.

Consider the following potential model for the health care-related professions in managed care: a primary health care-related professional who receives the initial medical referral for rehabilitation from the patient’s primary or “gatekeeper” physician, plus a cadre of health care-related specialists. The primary health care-related professional would evaluate the patient’s needs to maximize functioning and recommend to the primary physician the patient’s referral to those health care-related specialists necessary for the patient’s optimum performance.

Who is currently ready to assume this role of primary health care-related professional? Not the nurse who has many critical patient concerns taking precedence over maximizing patient function. Not the speech pathologist or clinical psychologist with their special areas of patient interest. I believe that occupational therapists are the ones directly suited to the role of the primary health care-related professional. Occupational therapists have long been the advocates of maximizing patient function for work, play, and activities of daily living. That is, we have traditionally viewed our patients in terms of their potential return to productive life-styles. Whenever cost is an issue, as it is now under managed care, and in all probability as it will continue to be in the future, the emphasis of health care is on practical results of intervention to offset health care expenses by patients’ return to productive life-styles. Occupational therapists are the health care-related professionals directly concerned with the evaluation of patients’ productivity and attuned to determining what components need to be addressed for their maximum functioning.

As occupational therapists, we do not emphasize just one area such as language assessment, motor activity, or psychological functions. We emphasize the holistic evaluation of our patients. In terms of the Model of Human Occupation (Kielhofner, 1985), we evaluate the performance, the habituation, and the volitional subsystems as they inter-
act with the environment. This holistic view is inherent in the perspectives of all major occupational therapy theories (Miller & Walker, 1993). In the role of primary health care-related professional, we would have no problem determining what is interfering with function in terms of the patients' environment and life goals. If language is a deterrent to maximum productivity, then we could recommend the speech pathologist for specialist evaluation. If motor difficulties are the problem, we can suggest specialist intervention by the physical therapist. If cognitive or emotional states need attention, we would recommend the clinical psychologist as the specialist of choice. If vocational needs are a problem, we would refer the patient to the rehabilitation counselor.

The idea that we are the discipline directly concerned with patient productivity in his or her environment and can provide functional assessments and recommendations for further specialized evaluations essential to maximize patient function is logical in terms of the professional expertise, not only of the occupational therapist, but also of the other major health care-related professions. But what are the implications of such a plan? Are there difficulties outside the realm of logic?

Like the physicians' model, such a plan would mandate education of many more occupational therapists and production of fewer health care-related professionals functioning in specialist roles (e.g., physical therapists, speech pathologists). This mandate would require a remarkable adjustment across the health care-related professions, both in education and service settings. The idea of such a change in structure raises a multitude of questions. For the health care-related professionals in specialist roles, would the threat of diminished numbers be offset by the promise of the greater prestige of the specialist over the generalist? Would doctoral education be nationally funded for these specialists? Would there be demand for specialist residencies? Would there be a temporary oversupply of physical therapists, speech pathologists, and others?

On the other hand, would we as occupational therapists be satisfied by the promise of increased numbers in our discipline? Would specialty interests within the field of occupational therapy be abandoned? Would there be little appreciation for traditional doctoral education for occupational therapists except as teacher preparation for generalist practitioners? Or would the new clinical doctoral programs in occupational therapy be the model for preparing the generalist therapist to refer patients for specialist interventions? Would such doctoral level training price our services out of demand? What are the political implications of such a plan? Would less functionally oriented health care-related professionals, with greater political clout than that of occupational therapists, desire (and obtain) the role of primary health care-related professional? These are just a few of the questions inherent in such a change in structure for the services of the health care-related professions.

Another issue related to the role of occupational therapists in managed care involves prevention and wellness programs. For decades, such creative leaders as Wilma West, Jerry Johnson, and Lorna Jean King, have advocated the role of occupational therapy in prevention. Our place in prevention is not an issue in occupational therapy (Levy, 1993). How our role as occupational therapists in prevention of dysfunction will mesh with that of other health care-related professionals in managed care may be a major issue. If we assume the role of the primary health care-related professional, should our major intervention be preventative? Or should there be a specialist whose primary function is prevention, a person trained in health education? Perhaps our future occupational therapy generalist education should show us how to refer various facets of prevention to the appropriate specialist psychologist, physical therapist, or other professional.

In conclusion, I have elaborated on but one possibility for the role of occupational therapists in managed care. The suggested plan is fraught with difficulties. One alternative cost-cutting option is to combine disciplines, that is, to educate an occupational-physical therapist. This alternative is fraught with even greater difficulties because it is generally unappealing to occupational therapists ("Speak Out," 1994). The issue remains: What is our role in managed care? Is there an attractive alternative?

References


