Section I

Exploring Historical and Economic Relevance of Community Practice

Chapter 1 and Chapter 2 introduce the community practice of occupational therapy and place it in historical and economic contexts. Included are Stories from Practice that describe how therapists transition from working in an institutional practice to a more flexible, but sometimes challenging, community practice working with clients in their natural environments. One challenging experience encountered by some therapists is the transition to working in natural environments where clients' cultures differ from those familiar to the therapist. Suggestions for learning about differing cultures are demonstrated in Stories from Practice.

Whether in a hospital or in a client's home, an occupational therapy practitioner relies on professional philosophies, models, and frameworks to guide practice. Evaluation of environment and person viewed through a cultural lens facilitates intervention that enhances community participation and contributes to successful community practice.

Chapter 1

The Beginning of Community-Based Occupational Therapy

Learning Objectives

- Explain the foundation of occupational therapy as functional, purposeful, and meaningful to clients, and a continuing thread through the twentieth century.
- Describe the ability of occupational therapy to adapt to changes in health care.
- Explain the economic value of occupational therapy.

INTRODUCTION

Occupational therapy has it roots in the community practice of offering health-promoting occupations for persons with mental illness. Prior to the twentieth century, most health care was provided in the community, in patients' homes, and through public health services. Advances in infection control and technology gradually led to an increase in hospital services, and most medical and related health services adopted a scientific method of delivery in hospitals. As hospital based care became standard for medical treatment, healthcare costs began to increase. Over time, escalating costs created new concerns related to quality and accessibility within economic constraints. This chapter will identify some of the challenges that have emerged as health care in the United States has become more costly.

Community practice may provide an opportunity for occupational therapy practitioners to expand services to enhance quality of life, including some services not dependent upon payment by third parties. The centennial vision of the American Occupational Therapy Association suggests that occupational therapy practitioners can serve their communities by offering services of health and well-being (AOTA, 2007). As health care continues to be a significant cost in the economies of most developed countries, any services that decrease the need for hospitalization, including occupational therapy, may contribute to lowering healthcare expenditures (Timmons, 2008).

OCCUPATIONAL THERAPY ADAPTS

Prior to the twentieth century, people with mental illness were cared for in the community, and participated with caregivers and others with mental illness in work to sustain the community, exercise, and leisure activities that appeared to lessen symptoms of their illness. The idea of engaging people with disabling conditions in meaningful and purposeful occupations became a focus of the first occupational therapy practitioners (Quiroga, 1995). At the beginning of the twentieth century, as industrialization and urbanization contributed to unhealthy environments, community members with disabilities took part in activities to occupy their minds, to rehabilitate their bodies, and to give structure and meaning to their lives in the belief that participation in activities of daily living could restore them to better function and improve health (Kielhofner, 2004).

Treatment used in early occupational therapy reflected the needs of society. When farming was the main means of survival for a majority of the population, growing vegetables and fruit and raising animals for food helped sustain communities of people with mental illness. These activities occupied the minds and hands of workers and gave them a sense of satisfaction as they contributed to the survival of themselves and others. As farming became less essential to community survival, occupational therapy practitioners discovered that craft activities popular in the early twentieth century, such as needlework and woodwork, produced work that could be sold to others and enable those with disabilities to contribute to their support (Reed and Sanderson, 1999).

Although many of these occupations, such as farming, woodwork, and needlework are no longer practiced widely in much of the world, there remain communities of persons with disabilities who nonetheless must be able to sustain themselves.

A Story from Practice

On the edge of a village in Ukraine, in old buildings surrounded by farmland, sits a home for boys who are developmentally disabled. The boys range in age from toddlers to young adults and receive care and supervision from a small staff of dedicated workers. A visit to this home finds one in the midst of excited and smiling boys, eager to shake your hand and engage in a friendly conversation or ball game. Times were not always so good for this home. The building has a former life as a sanatorium and was in poor condition when the boys arrived. Over time and with support from local and international humanitarians, this home has acquired used furniture, school desks, and therapy equipment. The boys now take pride in showing visitors their rooms with tidy beds, their school and recreational areas, and their kitchen. To survive in a place where there is not enough money to buy food, clothes, or other necessities, however, these boys and their caretakers must take care of their own needs. Some of the boys farm the land or raise animals for eggs, milk, and meat. Other boys take responsibility for helping keep their home and clothes clean. Some boys learn cooking skills to assist in meal preparation. In this home, there is no occupational therapist, but the value of occupation sustains these boys in their daily living. They learn skills to help themselves and one another, and take great pride in their work.

CHANGES IN HEALTH CARE

Some of the greatest gains in the history of health care resulted from improvements in sanitation and nutrition—societal benefits that grew out of the industrial revolution. The twentieth century was well under way before modern medicine as we know it had a significant impact on the health of individuals (Folland, Goodman & Stano, 2007). Prior to the twentieth century, physicians treated most patients in their homes. Early hospitals were shunned because of their association as last resorts for people with incurable diseases or an inability to pay for care at home (Folland, Goodman & Stano, 2007). At the turn of the century, modern hospitals developed as a result of better infection control, advances in medical treatments, and urbanization, which led to a concentration of people needing and able to pay for medical care in a single location.

Treatment in psychiatric hospitals included the use of meaningful occupations under the direction of specially trained occupational therapy practitioners to help patients achieve an improved state of health (Quiroga, 1995). As soldiers returned from World War I with physical and mental

disabilities, reconstruction aides were trained to restore function through rehabilitation. Although occupational therapy had long been provided in the community, physical rehabilitation resulted in occupational therapists joining other medical care providers in developing scientifically based approaches to treat people with disabilities (Folland, Goodman & Stano, 2007; Wilcock, 1998).

ECONOMICS OF HEALTH CARE

As medical treatment transitioned to hospital care, public pressure increased for more hospitals to serve both cities and rural areas. With the end of World War II, governments allocated funds for more hospital construction in areas considered to be in greatest need based on population. Government financial support of physician education followed as forecasts predicted a serious shortage of physicians. In the 1950s, advances in drugs and surgical techniques increased demand for hospital care (Dranove, 2000).

Prepaid health insurance began at the turn of the twentieth century, was offered by major industries during World War II, and served as a worker incentive as well as a cost-saving measure for the employer. Although health insurance was limited to a few employers, the mid-twentieth century booming economy, scarcity of workers, and wage restriction led to creation of worker compensation packages, including health insurance. Health insurance was a minimal cost to employers, as most people managed health costs through private payment, but healthcare benefits were an employer incentive to recruit and retain workers. In 1960, healthcare expenditures were 5.2 percent of the U.S. gross domestic product, with each individual's health care averaging $149 per year (Dranove, 2000). Through the 1960s, the majority of Americans had employer-sponsored health insurance, and those excluded by age or poverty benefited from the 1965 creation of government-funded Medicare and Medicaid (Dranove, 2000).

During the second half of the twentieth century, medical practices of all types moved into ever expanding hospital buildings. Physicians, nurses, physical and occupational therapists, and other healthcare providers saw the majority of their patients in a hospital environment. New medical professions emerged to provide technical skills needed in hospitals. An economic relationship developed between health care and the national economy. Most workers, provided health insurance by their employers, paid nothing out of pocket for their health care. As a consequence, more medical services were utilized than necessary, a practice that in some cases made people less well. The term "moral hazard" describes a situation when services or products are free or available at a very low cost and people utilize more services than

they need or would choose if they had to pay for them. Consumers' unawareness of the actual cost of health care increased demand and, although it prolonged lives, it came with a large monetary cost to society.

As healthcare costs continued to escalate in response to consumer demand and medical advances, managed care and legislation briefly contained costs in the mid-1990s (Timmons, 2008). In response to these efforts to contain costs, hospitals, pharmaceutical companies, and other healthcare providers employed lobbyists to protect their economic interests. The expense of hiring and employing these lobbyists added further to healthcare costs because any expense to a provider is passed on to the consumer in higher fees (Folland, Goodman & Stano, 2007). Healthcare costs again escalated as advances in medical science led to life-saving procedures that resulted in increasing numbers of individuals who required very expensive care for the rest of their lives. Gradually increasing life expectancy due to better overall health has also resulted in increasing numbers of people with high-cost needs for medicine or special care. All of these factors continue to contribute to escalating healthcare costs (Dranove, 2000).

Various countries have adopted different approaches to pay for health care. In the United States, in the mid-twentieth century, private insurance was chosen to pay for health care because it was not very expensive for the employer, provided the employer with a tax advantage, and was an incentive in hiring and retaining employees. Over time, this method has become very expensive for employers to maintain and contributes to production costs of all goods and services produced in the United States. In recent years employers have shifted more of the actual cost of health care to employees through higher premiums, deductibles, and co-payments. Some employers are unable to absorb the cost of health insurance, so it is not available to all employed residents of the United States. As a result, an estimated 47 million Americans are uninsured and another 25 million people are underinsured (Timmons & Cookson, 2008). Individuals without the means to pay for health care delay treatment and have poorer health as a result, which ultimately adds to the cost burden of health care in the United States. Those who have the means to pay for health care, however, may receive some of the best care in the world (Timmons & Cookson, 2008). As insurance companies and government programs continue to pay for most health care in the United States, they have been able to influence where health care is dispensed, what types of services are provided, and for how long these services can be made available (Folland, Goodman & Stano, 2007). The following story illustrates the influence of the marketplace on supply and demand for occupational therapists as a result of cost structures imposed on health care.

A Story from Practice

In the early 1990s many occupational therapy practitioners worked in facilities that provided long-term care and rehabilitation to the elderly. Therapy services were compensated by private and government insurance for the elderly at a high rate. Long-term care facilities used the reimbursements for therapy to pay therapy costs, but also to pay for other things in these facilities. As an example of moral hazard, some patients who received therapy did not need the service. Demand for therapists increased as more jobs became available in long-term care facilities. Salaries for therapists rose in response to market demand, and schools of therapy expanded to provide additional therapists to supply the market. As more therapists continued to be hired, costs for care of patients in long-term care facilities became a burden on the insurance providers. As a result, toward the end of the 1990s the government placed severe restrictions on payment for rehabilitation services in these facilities. Many occupational, physical, and speech therapists left long-term care practice as a consequence of the changes in payment structure. Further consequences occurred as the job market for therapists contracted and salaries deflated in response to decreased market demand.

In countries that have chosen to have a national health service, a single government-regulated system of payment for health care provides basic care to all citizens. There are, however, limitations on the care that can be provided, and individuals must often wait to receive non-emergency care. In countries with a national health service, community practice has become an especially important cost-saving measure. Community practice may include vaccination clinics, screening for early detection of disease, and education programs publicizing the health benefits of adequate nutrition and exercise, or of avoiding substances known to cause illness. These community practices have lowered healthcare costs by avoiding or minimizing hospitalizations (Folland, Goodman & Stano, 2007).

OCCUPATIONAL THERAPY ADAPTS TO CHANGE

When most occupational therapy practitioners worked in hospitals or residential care facilities, the practice of occupational therapy developed treatment techniques that advanced the profession by responding to needs of patients and coordinating interventions with other healthcare providers. Most occupational therapy practitioners worked with other therapists in an environment that conveniently kept all necessary therapy supplies close at hand. Practicing medicine in hospitals resulted in increased professional

status and recognition in the community, largely because hospitals had a reputation for providing quality medical care in a safe environment.

Mid-twentieth century practice by occupational therapy practitioners utilized treatment techniques adapted from a medical model, a reductionist approach that viewed the patient as a damaged machine that could be repaired with the proper tools (Kielhofner, 2004). Therapists specialized in treating a variety of disabling conditions with specific treatment techniques. Some therapists found this practice unsatisfying because it relied on repetitive treatments without questioning their value to clients (Wood, 2004). Occupational therapy practitioners began to have difficulty defining their profession except by describing each practitioner's work with a particular population or clinical procedure. A need arose to recapture the origins of occupational therapy and form a new practice paradigm that would define the profession for all of its practitioners (Kielhofner, 2004).

PRACTICE IN THE COMMUNITY

Wilma West declared that integration of people with disabilities back into the community could best be accomplished in the community and not in hospitals. Ann Mosey and Mary Reilly also advocated for learning living skills in the place where they were to be practiced; that is, in the community (Scaffa, 2001). In Canada, occupational therapists acknowledged the importance of taking occupational therapy out of the hospital setting in order to best address the needs of their patients. They believed that the patient's home environment, which included family, cultural values, and community resources, provided a better therapy environment than a hospital, where the focus was on illness and disability (Opzoomer & McCordic, 1973).

While occupational therapy practitioners recognized that a move to community practice would benefit patients, few programs were developed in the community through the 1970s. Occupational therapy practice continued to be associated with the type of medicine primarily provided in hospitals, and occupational therapy education programs prepared students using theories and techniques intended for practice in hospitals or clinic environments. In addition, few mechanisms existed to pay for occupational therapy provided outside the hospital or clinic.

In the 1990s occupational therapy practitioners around the world redefined themselves as professionals who prepared people with illness or disability for living life to the fullest in their own communities. Occupational therapists were returning to the foundations of their profession by listening to and addressing the needs of people who needed services. Wood (2004) describes how occupational therapists can care for clients effectively while

also exercising the knowledge and techniques of modern medicine. Occupational therapy practitioners also began to see continued value in providing services perceived as important to the client, rather than prescribing treatment based on prior practice. The Canadian client-centered model for practice became instrumental in helping occupational therapy practitioners view clients as best able to determine their own futures. This led to the concept of partnership between client and practitioner to make the client's future a reality.

This convergence of economic and philosophical principles has led occupational therapy practitioners back into the community. Occupational therapy practitioners began their migration back into community practice in the 1970s by providing services in the public schools, through home healthcare agencies, and through community mental health programs. They recognized that providing their services at the natural point where skills were needed—the person's living and working environments—would make a significant contribution to bettering the lives of people with disabilities.

With this transition from institution to community, occupational therapy practitioners serve traditional roles as well as new roles in community practice. Although most practitioners provide direct care in the community, many also have become consultants to agencies, programs, and individuals. The concept of being part of a community team instead of a medical team shifts the emphasis from illness and disability to wellness and integrating differing abilities into community settings (Baum, 2007).

Occupational therapy practitioners provide needed home health interventions to persons who are undergoing fewer days of hospitalization in an effort to cut healthcare costs. Home based care has proven to be an ideal setting for occupational therapy practitioners to address the client's challenges of life in their natural context. While hospitals have adapted their facilities to accommodate persons with disabilities by providing roll-in showers and raised toilets, clients may return home only to find themselves unable to perform activities of daily living in their own environment. Meal preparation and transfers to and from one's own favorite chair become a rehabilitation challenge with significance to the client in his home. In addition to providing direct intervention, the occupational therapy practitioner becomes an educator to family members. As family members learn more about their loved one's abilities, they can help provide consistency in rehabilitation and assist in solving challenges of living at home with a disability.

Out in the community, the therapist becomes part of a team caring for a client that differs from medical teams and includes family members, friends, teachers, and employers all supporting a client's needs to fulfill valued community roles. The addition of these non-medical team members

may present a challenge to a practitioner who is accustomed to working in a medical environment where there is a common language, service priorities, and payment requirements. While practicing living skills in a natural environment is an advantage, working with non-medical people to address the client's needs may be challenging. It can also be one of the greatest pleasures of working in the community.

Additional opportunities for community practice are constantly being created. Hinojosa (2007) says that many innovative opportunities exist, even in challenging economic times. Baum (2007) identifies opportunities to focus on wellness as people respond to economic necessity by learning to take greater responsibility for their own health. With continued technological advances in health care, an aging population, and rising expectations for health, there will be further demands on healthcare financing. Hospitals have continued to expand, incurring additional debt that must be recovered from patient revenues. Healthcare insurance continues to operate as a for-profit industry in the United States (Folland, Goodman & Stano, 2007). These economic conditions provide an opportunity for occupational therapy practitioners to practice in community settings where they can help promote healthier lifestyles, and perhaps ultimately help to lower healthcare costs (Timmons, 2008).

CHAPTER SUMMARY

This chapter introduces the historical significance of occupational therapy practice in the community. Changes in healthcare economics, as well as medical practices related to cost savings, provide an opportunity for community practice. With preparation for the challenges of community practice, therapists of varying levels of experience can become successful community therapists. In the following chapters, you will learn:

- Where occupational therapists currently work in the community and what they do
- How therapists prepare themselves for community practice
- How they may be paid for their services
- How to develop a community practice.

LEARNING ACTIVITIES

Learning activities are provided to guide your application of the contents of this chapter, which focused on the history of occupational therapy, including healthcare and economic factors that influence occupational therapy practice.

Write answers to these questions in a journal and save them for discussion with others or to document your thought processes as you develop a community practice.

1. Relate the history of occupational therapy as a service adaptive to individual and community needs throughout the twentieth century.
2. Identify current healthcare economic conditions and give examples of why health care in the United States has become so costly. How can community practice help contain these costs?
3. In the Occupational Therapy Centennial Vision, one role of occupational therapy practitioners is to offer services of health and well-being. How would offering these services benefit you, the profession, and your community?
4. Relate cost savings that can be achieved through preventive services—a practice used in single-payer healthcare systems—to occupational therapy services that can be offered in community practice.
5. In this chapter the term "moral hazard," taken from economics, describes disincentives that occur when insurance payments increase use of unnecessary services. Explain how moral hazard relates to your professional code of ethics and how you would guard against this in practice.
6. Explain why the promotion and maintenance of health and wellness through engagement in community, as either a service provider or a volunteer, makes economic sense.

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