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## Interprofessional Primary Care: The Value of Occupational Therapy

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# Interprofessional Primary Care: The Value of Occupational Therapy

## **Abstract**

The authors explore the training and expertise of occupational therapists and the cost benefit of the strategic use of occupational therapists as members of the interprofessional primary care (PC) team. PC practices can optimize successful and cost-effective patient care delivery, outcomes, and access to care by using interprofessional care teams and allowing physicians to off-load patients whose issues relate to routines and habits and do not require diagnostic or prescriptive intervention. This, and the occupational therapist's ability to obtain reimbursement for his or her services, demonstrates that this professional can be an invaluable addition to the integrated PC team. The authors review the educational background, core competencies, and skill set of this group of professionals. Occupational therapists have a comprehensive education and are well equipped to address patient issues related to general health and chronic illness management, behavioral health, rehabilitation, and habilitation. Their ability to treat health issues that affect quality of life and overall function ensures that they are an asset to the interprofessional team. They can improve patient care and assist practices in their goal to achieve the triple aim. The authors encourage PC practices to include occupational therapists as value-added members of integrated PC teams.

## **Keywords**

interprofessional, cost-effective, occupational therapy, primary care, integrated, behavioral health

## **Erratum**

Corrected mathematical errors in Table 4.

## **Credentials Display**

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Improvement in the health of populations and the patient experience of care requires mindful and strategic approaches related to the cost and quality of health care. The literature supports the cost-effectiveness of the occupational therapist as a member of the interprofessional primary care (PC) team and as a health professional in the treatment of chronic illnesses (Metzler, Hartmann, & Lowenthal, 2012; Rexe, McGibbon Lammi, & von Zweck, 2013). With health care reform moving toward reimbursement for quality care and outcomes rather than fee-for-service, occupational therapists, as part of the interprofessional PC team, are strategically positioned to be part of the solution in addressing the health care system's greatest needs. Through leveraging the roles and responsibilities of occupational therapists on interprofessional PC teams, occupational therapists improve current team functioning and the delivery of PC services (Dahl-Popolizio, Manson, Muir, & Rogers, 2016; Muir, 2012; Tracy et al., 2013).

### **The Role of Occupational Therapy in PC**

An occupational therapist is one potential team member who can contribute significant value to the health care team. Occupational therapists are

skilled in addressing physical dysfunction and behavioral and mental health issues and in working with individuals across the lifespan to maximize function and participation. The role of occupational therapy (OT) in PC is not yet well defined and is dependent on such factors as the business model of the setting, the requirements of the interprofessional team, the patients' needs, and the awareness that the other team members have the skill set that OT contributes to the interprofessional PC team (American Occupational Therapy Association [AOTA], 2013; Donnelly, Brenchley, Crawford, & Letts, 2013). However, because the role of OT is frequently misunderstood, occupational therapists are often overlooked and underused as members of the interprofessional PC team (AOTA, 2013; Dahl-Popolizio, Manson, Muir, & Rogers, 2016; Donnelly et al., 2013; Donnelly, Brenchley, Crawford, & Letts, 2014). Table 1 provides brief, illustrative vignettes demonstrating what occupational therapists can do with complicated patient issues in the PC setting. Table 2 provides examples of common conditions where occupational therapists can be a primary or supplemental provider in PC.

**Table 1**

*Brief, Illustrative Vignettes on Issues Addressed by Occupational Therapists in the PC Setting*

<b>Case Description</b>	<b>Examples of Occupational Therapy Clinical Care</b>
45-year-old male presents with complaints of wrist, hand, and shoulder pain that worsens throughout the day, duration 6 weeks. Pain is significantly limiting his ability to work at the computer, which he does at least 8 hr/day. He is a college professor, with teaching and research responsibilities. He has tried over-the-	<ul style="list-style-type: none"> <li>• Complete a postural assessment, develop a customized home exercise program to improve postural alignment, increase patient's flexibility, and decrease his complaints of pain.</li> <li>• Complete an office work space evaluation, make specific ergonomic recommendations, and educate regarding good body mechanics for sitting and computer use.</li> <li>• Discuss how these principles apply to the home office space as well.</li> </ul>

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counter anti-inflammatory medication, but with no real relief.

- Educate patient on modifying his routine to include short standing activity breaks and brief full body stretches to relieve muscle tension.
- Instruct patient on median nerve glides to prevent further development of carpal tunnel syndrome.
- Give handouts with visual cues to assist patient with carryover at home for all of the above information.

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Mom brings in 5-year-old male for a prekindergarten physical with no real concerns, other than he is a little overweight and likes to play on the computer or watch TV. With questioning, mom explains that at daycare, he usually prefers crafts and tabletop games to more active play. At home, he watches TV while mom cooks dinner, which they eat in front of the TV. After dinner, he plays video games or watches TV with his father. He goes to bed around 11 p.m. after a big battle. He is very hard to wake up in the morning, around 6 a.m., to go to daycare.

- Educate parents on age-appropriate routines and expectations, and discuss ways to seamlessly implement them into their daily lives. Provide handouts to improve follow through.
- Establishing healthy routines (meal time, activity choices, and bed time routines) to promote healthy physical activity levels and improve healthy behaviors.
- Provide suggestions on age-appropriate activities to improve hand function and fine motor control in preparation for school activities, such as handwriting.
- Discuss creating healthy habits and routines around physical activity/exercise, social interaction/participation, and screen time for electronic media (e.g., meals without TV).

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Nurse case manager identifies 10 people whose A1C has been high for more than 6 months who have a BMI over 30 and have poor medication compliance. Referred to occupational therapist for group intervention.

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Group education sessions developed in collaboration with nurse and occupational therapist, conducted 1 hr per week for 6 weeks:

- Establishing healthy routines (meal time, activity choices, and bed-time routines).
- Choosing healthy foods and label reading at the grocery store.
- Time saving cooking tips.
- Establishing a routine to increase physical activity and medication compliance.
- Managing stress.
- Thought and behavior modification strategies to improve mood and resulting behaviors.
- Sleep hygiene.
- PHQ-9, a depression assessment, can be administered to determine if depression is a factor in poor control of diabetes.

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70-year-old woman with long history of smoking, chronic obstructive pulmonary disease, and anxiety presents to primary care several times per year for follow-up after repeated ED visits.

- Administration of GAD-7 (anxiety assessment).
- Assist patient to tell the difference between symptoms of anxiety and inadequate air supply/exchange.
- Develop coping strategies to increase self-management of anxiety (guided imagery, cognitive behavioral therapy) and reduce risk of panic attack.
- Pursed lip breathing strategies.
- Appropriate exercise/activity to optimize health.
- Group interventions for support and education.
- Collaborate with medical clinician for behavioral/pharmacological strategies for smoking cessation.

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*Note.* ADLs = activities of daily living; PHQ-9 = Patient Health Questionnaire-9; GAD-7 = General Anxiety Disorder-7. Table is adapted, with permission, from “Enhancing the Value of Integrated Primary Care: The Role of Occupational Therapy,” by S. Dahl-Popolizio, L. Manson, S. Muir, and O. Rogers, 2016, *Families, Systems, & Health*, pp. 274-275. Copyright 2008 by the American Psychological Association.

**Table 2***Examples of What OT Can Contribute to the Team-Based Care with Common Conditions Seen in PC*

<b>Diagnosis</b>	<b>Occupational therapist can address medical/rehabilitative issues</b>	<b>Occupational therapists can address behavioral health issues</b>
<ul style="list-style-type: none"> <li>• Diabetes</li> <li>• Cardiac Diseases</li> <li>• Hypertension</li> <li>• Depression</li> <li>• Anxiety</li> </ul>	<ul style="list-style-type: none"> <li>• Medication adherence strategies</li> <li>• Diet modification strategies</li> <li>• Developing schedules and habits to improve likelihood of adherence</li> <li>• Activity program that is consistent with patient goals and interests</li> <li>• Educate regarding self-management</li> </ul>	<ul style="list-style-type: none"> <li>• Coping strategies</li> <li>• Adjustment to illness</li> <li>• Family education around what to expect and how to help family member succeed with plan</li> <li>• Educate regarding community resources</li> </ul>
<ul style="list-style-type: none"> <li>• Low Back Pain</li> <li>• Shoulder Pain</li> <li>• Tendinitis</li> </ul>	<ul style="list-style-type: none"> <li>• Education regarding postures</li> <li>• Activity modification education</li> <li>• General exercise education</li> </ul>	<ul style="list-style-type: none"> <li>• Coping strategies around loss of function, loss of employment, loss of meaningful recreation, change in family roles</li> <li>• Strategies to manage co-morbid depression and/or anxiety</li> <li>• Chronic pain</li> </ul>

*Note.* Table is adapted, with permission, from “Enhancing the Value of Integrated Primary Care: The Role of Occupational Therapy,” by S. Dahl-Popolizio, L. Manson, S. Muir, and O. Rogers, 2016, *Families, Systems, & Health*, p. 273. Copyright 2008 by the American Psychological Association.

Over the recent decades, most occupational therapists have pursued specialized positions in mental health or rehabilitative settings, despite their broad training. Reimbursement guidelines and the demands and requirements of the practice settings where occupational therapists work were the primary influences of this trend toward specialization. This narrowed focus has resulted in a lack of understanding by the medical community regarding occupational therapists’ broad scope of training and their qualifications for the many clinical services they provide. With the expansion of integrated care, reimbursement opportunities, and the focus on value-based quality care, occupational therapists are increasingly becoming members of the PC workforce and interprofessional care team. The OT assessment focuses on how each patient’s complaints or symptoms affect his or her ability to

complete daily activities, or how his or her daily activities influence one’s health (AOTA, 2010a). Health problems often result from these habitual daily activities. Occupational therapists identify barriers, both internal and external, to optimal function (Metzler et al., 2012), which equates to identification of barriers to optimal health. Occupational therapists’ training and philosophy enables them to provide clinical services to improve self-management of health conditions and independence with activities of daily living, including those activities that affect health and adherence to medical instruction (Dahl-Popolizio et al., 2016).

When a patient requires additional assistance beyond the traditional medical visit for issues such as coping skills to deal with anxiety, exercises to address an acute musculoskeletal

injury, or developmental screening to identify developmental delays, they typically receive a referral to an outside clinic or another provider.

Occupational therapists on the interprofessional PC team immediately address these issues. This results in increased access to care and facilitates cost containment, as the referral to an outside provider may not be necessary and more patient needs can be immediately and collaboratively addressed in house (Dahl-Popolizio et al., 2016).

### **How OT Can Contribute to the Interprofessional PC Team**

Interprofessional teams are typically comprised of multiple health care disciplines applying their unique skill sets and attitudes to supplement the contributions of the other team members (Hall & Weaver, 2001). Occupational therapists, with their broad skill set, contribute to the coordination of care and provide patient care to meet the needs of the patients in their most meaningful context, such as work, home, family, or community. Occupations, as defined by the AOTA, include any activity in which people engage throughout the day (Roberts, Farmer, Lamb, Muir, & Siebert, 2014). These actions and activities are the occupations addressed by an occupational therapist (AOTA, 2010a). The Manitoba Society of Occupational Therapists (2005) discusses the unique role of OT in individual health:

How people perform their occupations is believed to be an important determinant of health and is influenced by personal factors, environments and the occupations that people do. Occupational therapy is the only health profession whose education is

entirely devoted to the study of occupational performance and its impact on people's health and wellness. (p. 3)

This approach of addressing patient motivation in relation to functional activities has been the basis of OT for nearly 100 years and aligns with the World Health Organization's International Classification of Functioning (2014).

The occupational therapist on the interprofessional PC team is an additional professional who assists with many issues that complicate health and increase health care costs. For this reason, an occupational therapist is a benefit to the collaborative interprofessional PC team and the patients. With the top of the license principle, using their full skill set, occupational therapists provide whole-person care for populations, groups, and individuals in the PC setting, especially for those with or at risk of developing chronic illnesses (Roberts et al., 2014). This care is continuous, comprehensive, and coordinated over the lifespan and across all elements and levels of the health care system and includes collaboration with other team members, patients, caregivers, and families to make optimal decisions regarding overall health. With an emphasis on quality improvement and management of chronic conditions, costs will be reduced and the health of the population will improve (AOTA, 2013).

### **Occupational Therapist Education and Training**

The American Occupational Therapy Association (AOTA) is the national professional organization of OT and provides accreditation and academic program consistency through the

Accreditation Council for Occupational Therapy Education (ACOTE). The AOTA(2010b) outlines minimum standards that an occupational therapist must have to safely and effectively provide OT services to individuals, groups, and populations. An occupational therapist enters the field after earning either a master's or clinical doctoral degree in OT, passing a national certification examination, and obtaining licensure through the state in which they intend to practice. Core curriculum comprises biological and physical sciences, including anatomy, physiology, neuroscience, kinesiology, and biomechanics. Core content of OT educational programs also includes knowledge and understanding of human behavior and analysis of how disease, disability, trauma, and injury impact an individual's physical and mental health. Occupational therapists learn about the physiological process of diseases as well as the psychological and physical implications to function and quality of life that diseases impose. Through their training, OT practitioners deliver services to promote health and wellness, prevent disease and disability, develop skills not yet obtained, and provide compensatory or remedial strategies to improve an individual's function with his or her everyday living skills (ACOTE, 2011).

Integrating behavioral health into PC is cost-effective, and it is critical to address frequently co-occurring medical and behavioral health issues (National Association of State Mental Health Program Directors, 2012). It is not widely understood that occupational therapists receive training in mental and behavioral health and have a unique skill set focusing on roles, habits, and

routines that can add to the expertise and effectiveness of the interprofessional PC team (AOTA, 2010a). The profession's educational standards related to behavioral health include knowledge of the current *Diagnostic and Statistical Manual of Mental Disorders* (DSM) relating to "psychiatric diagnoses, etiology, symptoms, impairments, clinical course, and prognosis" (AOTA, 2010a, p. S35; ACOTE, 2011). Further, OT educational standards include, but are not limited to, the ability to effectively evaluate and provide appropriate clinical care for patients with common comorbidities of mental illness and chronic medical conditions, such as diabetes, obesity, substance abuse, chronic obstructive pulmonary disease, attention deficit hyperactivity disorder, and autism. Occupational therapists are educated in multiple models of evidence-based group and individual approaches to provide clinical care effectively, including cognitive behavior therapy, psychoeducation, behavioral approaches, motivational stages of change, social and emotional learning, and more (AOTA, 2010a). Furthermore, in the last 5 years, the ACOTE (2011) mandated that all OT educational programs require at least one of the student's clinical rotations to focus on "psychological and social factors that influence engagement in occupation" (p. 34).

After graduation, an occupational therapist may practice as a generalist in a variety of settings or complete additional training and earn a board certification in one of several specialty areas. Depending on the needs of the specific PC setting, these specialist skills can complement the general

OT training and meet the needs of the patient population (see Table 3).

**Table 3**

*Current Recognized Specialty Certification Areas*

**Board Certifications Specialty Areas**

- 
- Hand Therapy (CHT – Certified Hand Therapist)
  - Gerontology (BCG)
  - Mental Health (BCMh)
  - Pediatrics (BCP)
  - Physical Rehabilitation (BCPR)
  - Driving and Community Mobility (SCDCM or SCDCM-A)
  - Environmental Modification (SCEM or SCEM-A)
  - Feeding, Eating, and Swallowing (SCFES or SCFES-A)
  - Low Vision (SCLV or SCLV-A)
  - School Systems (SCSS or SCSS-A)
- 

**What Occupational Therapists Currently Contribute to PC**

As a generalist working in PC, the occupational therapist's clinical care strategies focus on improving overall function and self-management of health (Donnelly et al., 2014). The PC setting has required a renewed focus on the generalist approach to OT practice. In this model of care, occupational therapists provide rapid, targeted evaluations and brief, evidence-based clinical care strategies consistent with the pace of the PC clinic. An occupational therapist in PC practice does not negate the need for referrals to specialized OT services, such as neurological rehabilitation, certified hand therapy, and developmental rehabilitation, when patients need more involved clinical care than can be provided in the PC setting.

They do, however, address issues that do not require the acute medical expertise of the physician and other non-physician providers (Dahl-Popolizio et al., 2016).

Occupational therapists use evidence-based strategies and assessments to identify and address a wide variety of client needs. Occupational therapists in PC can provide individual and group treatment for behavioral activation, patient engagement, and psychoeducation regarding symptom and disease self-management. In addition, occupational therapists can provide population health management using risk stratification to place patients in appropriate individual and/or group programs for the most efficient use of resources. Population health management strategies focus on preventative care, chronic disease management, and management of behavioral health issues, as well as behaviors affecting health. Occupational therapists evaluate for adaptive equipment when it is necessary to maximize function and safety and minimize pain.

**Business Case for OT in PC**

To fully demonstrate the benefit and sustainability of OT in PC, a business case must be built, as uncertainty about funding an OT position and reimbursement for services have been identified as barriers to inclusion of occupational therapists on the interprofessional PC team (Donnelly et al., 2013; Muir, Henderson-Kalb, Eichler, Serfas, & Jennison, 2014). In addition to explaining the services occupational therapists provide, it is critical to convey that they are not simply an additional expense, but a billable service (Dahl-Popolizio et al., 2016). Occupational therapists are able to use

current procedural terminology (CPT) codes commonly billed in PC. They also provide services reimbursed under the CPT codes of physical medicine and rehabilitation, tests and measurements, therapeutic procedures, orthotic and prosthetic management, evaluation and therapeutic services, muscle and range of motion testing, and special otorhinolaryngologic services (American Medical Association [AMA], 2017; Dahl-Popolizio et al., 2016). It is common knowledge that when patients are unable to access in-house services, they often have difficulty obtaining these services elsewhere due to system and patient barriers to referral completion. As members of the PC interprofessional team, occupational therapists are available to address these patient needs immediately. This facilitates the cost- effectiveness (cost minimization and cost utility) of care teams.

Tables 4 provides an example of OT CPT coding and billing in a typical day and demonstrates the potential revenue generation that offsets the cost of providing OT in PC. Table 5 demonstrates possible billing in a typical day and the potential increased revenue obtained by PC providers when an occupational therapist is treating patients with behavioral or rehabilitative needs, allowing the PC provider to see patients with more immediate medical needs. The AOTA is actively working to increase the number of insurers that accept behavioral health and case management codes for OT services. Limitations on the use, frequency, classification, and reimbursement of CPT codes in PC are controlled by payor (insurer), license, federal, and state regulations and policies. Regulatory guidelines must be thoroughly reviewed for sustainable cost control implementation.

**Table 4***A Typical Day with OT Available in PC*

<b>CPT Code*</b> <b>(visit type)</b>	<b>Number of patients</b>	<b>Minutes spent with patient</b>	<b>Per unit fee</b>	<b>Billed/day/cod e</b>	<b>Hours/day/code</b>
97110 (ex)	2	30	\$32.54/15 min	\$130.16	1 hr
97535 (ADL)	4	30	\$35.04/15 min	\$280.32	2 hr
97530 (act)	5	30	\$35.04/15 min	\$350.40	2.5 hr
97150 (group)	10	60	\$17.52 (untimed)	\$175.20	1 hr
97003 (eval)	1	30	\$85.45 (untimed)	\$85.45	.5 hr
97532 (cog tx)	2	30	\$26.82/15 min	\$107.28	1 hr
<b>Total net reimbursement for a typical 8 hr day</b>					<b>\$1,128.81</b>
<b>Total net reimbursement per year based on this typical day (50 weeks)</b>					<b>\$282,202.50</b>

*Note.* \*CPT codes (all modifiers) retrieved from the Centers for Medicare & Medicaid Services (2015). Salaries vary greatly and are dictated by setting and region. Current salary range across the nation according to the Bureau of Labor and Statistics (<http://www.bls.gov>) is approximately \$50-\$98,000 per year, with 114,600 jobs in 2014, which is expected to increase by 27% by 2024. As PC is an emerging practice setting, there are no current statistics regarding salaries in this setting.

**Table 5**  
*Potential PCP Reimbursement With and Without OT*

A. Typical Day Without OT			B. Typical Day With OT		
CPT Codes* (visit type)	Number of patients	Total revenue	CPT Codes* (visit type)	Number of patients	Total revenue
99213 (basic) \$72.94	16	\$1,167.04	99213 (basic) \$72.94	4	\$291.76
99214 (moderate) \$108.34	2	\$216.68	99214 (moderate) \$108.34	12	\$1,300.08
99203 (new basic) \$109.05	2	\$218.10	99203 (new basic) \$109.05	2	\$218.10
			99204 (new moderate) \$165.90	1	\$165.90
			99205 (new ill) \$208.45	1	\$208.45
<b>Total Revenue:</b>		\$1,601.82	<b>Total Revenue:</b>		\$2,184.29

Table includes typical PCP schedule of billable visits (A) versus using OT as part of the PC interprofessional team and (B) increasing PCP availability to see new and established high-need patients

Note. \*CPT codes (all modifiers) retrieved from the Centers for Medicare & Medicaid Services (2015). See Table 4 for potential OT billing.

**Conclusion**

Reform is leading us to view health care economics, sustainability, and PC services implementation differently. Medical practices are assuming the risk for their patients’ health and the cost of care. In this changing environment, PC practices must consider all aspects of providing patient care, including the management of whole-patient care, ensuring optimal health outcomes, and injury and illness prevention, while providing all services in the most cost-effective and efficient manner. Quality care and outcomes are critical to

economics and financial practice management. Including occupational therapists on the interprofessional PC team improves quality of care and efficiency in PC settings and specialty practice screening, intervention, and productivity (Dahl-Popolizio et al., 2016; Hart, Elizabeth, & Parsons, 2015; Macdonald, 2006; Metzler et al., 2012; Rexe et al., 2013; Waite, 2014).

To further address the barriers of lack of understanding of the potential contribution of occupational therapists in PC and current reimbursement strategies for sustainability of

occupational therapists in PC outlined in this article, future research is necessary to ascertain the receptiveness of PC physicians to the inclusion of OT in PC. Although OT is not named in its report on the integration of physical and behavioral health care, the American Medical Association (AMA) supports the integration efforts of interdisciplinary teams providing team-based care to address the medical and behavioral needs of patients in PC (McIntyre, 2015). The authors recommend further research into and advocacy with the AMA and other interdisciplinary health care guilds to overcome these barriers to OT in this setting, as the educational background and skill set of occupational therapists offer significant value and complement the skills currently available on the interprofessional PC team.

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## References

- Accreditation Council for Occupational Therapy Education. (2011). *Standards and interpretive guide*. Retrieved from <http://www.aota.org/-/media/Corporate/Files/EducationCareers/Accredit/Standards/2011-Standards-and-Interpretive-Guide.pdf>
- American Medical Association. (2017). About the integrated physician practice section (IPPS). Retrieved from [www.ama-assn.org/about-integrated-physician-practice-section](http://www.ama-assn.org/about-integrated-physician-practice-section)
- American Occupational Therapy Association. (2010a). Specialized knowledge and skills in mental health promotion, prevention, and intervention in occupational therapy practice. *American Journal of Occupational Therapy*, 64(Suppl. 6), S30-S43. <http://dx.doi.org/10.5014/ajot.2010.64S30-64S43>
- American Occupational Therapy Association. (2010b). Standards of practice. *American Journal of Occupational Therapy*, 64(Suppl. 6), S106-S111.
- American Occupational Therapy Association. (2013). *Review of new models of primary care delivery*. Washington, DC: Author.
- Centers for Medicare & Medicaid Services. (2015). *Physician fee schedule search*. Retrieved from <https://www.cms.gov/apps/physician-fee-schedule/license-agreement.aspx>
- Dahl-Popolizio, S., Manson, L., Muir, S., & Rogers, O. (2016). Enhancing the value of integrated primary care: The role of occupational therapy. *Families, Systems, & Health*, 34(3), 270-280. <http://dx.doi.org/10.1037/fsh0000208>
- Donnelly, C., Brenchley, C., Crawford, C., & Letts, L. (2013). The integration of occupational therapy into primary care: A multiple case study design. *BMC Family Practice*, 14(60), <http://dx.doi.org/10.1186/1471-2296-14-60>
- Donnelly, C., Brenchley, C., Crawford, C., & Letts, L. (2014). The emerging role of occupational therapy in primary care. *Canadian Journal of Occupational Therapy*, 81(1), 51-61. <http://dx.doi.org/10.1177/0008417414520683>
- Hall, P., & Weaver, L. (2001). Interdisciplinary education and teamwork: A long and winding road. *Medical Education*, 35(9), 867-875. <http://dx.doi.org/10.1046/j.1365-2923.2001.00919.x>
- Hart, E. C., & Parsons, H. (2015). Occupational therapy: Cost-effective solutions for a changing health system. *The American Occupational Therapy Association*. Retrieved from: <http://www.aota.org/-/media/Corporate/Files/Advocacy/Federal/Fact-Sheets/Cost-Effective-Solutions-for-a-Changing-Health-System.pdf>

- Macdonald, D. (2006). Occupational therapists: An environmental scan of the economic literature. *Canadian Association of Occupational Therapists*. Retrieved from <http://www.caot.ca/pdfs/Environmental%20Scan.pdf>
- Manitoba Society of Occupational Therapists. (2005). *Occupational therapists and primary health care*. Retrieved from [http://www.msot.mb.ca/wp-content/uploads/2014/05/PositionPaper\\_PrimaryHealthCare.pdf](http://www.msot.mb.ca/wp-content/uploads/2014/05/PositionPaper_PrimaryHealthCare.pdf)
- McIntyre, J. (2015). *Report of the council on medical service* (CMS Report 6-A-15). Retrieved from The American Medical Association website: <https://www.ama-assn.org/sites/default/files/media-browser/public/about-ama/councils/Council%20Reports/council-on-medical-service/a15-cms-report6.pdf>
- Metzler, C. A., Hartmann, K. D., & Lowenthal, L. A. (2012). Defining primary care: Envisioning the roles of occupational therapy [Editorial]. *American Journal of Occupational Therapy*, 66, 266-270. <http://dx.doi.org/10.5014/ajot.2010.663001>
- National Association of State Mental Health Program Directors. (2012). *Fact sheet on accelerating integrating of primary care, behavioral health and prevention: The SBHA role*. Alexandria, VA: Author.
- Rexe, K., McGibbon Lammi, B., & von Zweck, C. (2013). Occupational therapy: Cost-effective solutions for changing health system needs. *Healthcare Quarterly*, 16(1), 69-75.
- Roberts, P., Farmer, M. E., Lamb, A. J., Muir, S., & Siebert, C. (2014). The role of occupational therapy in primary care. *American Journal of Occupational Therapy*, 68(Suppl. 3), S25-S33. <http://dx.doi.org/10.5014/ajot.2014.686S06>
- Waite, A. (2014). Prime models. Showcasing occupational therapy's role on primary care teams. *OT Practice*, 19(7), 8-10. <http://dx.doi.org/10.7138/otp.2014.197f1>
- World Health Organization. (2014). *International classification of functioning, disability and health*. Retrieved from <http://www.who.int/classifications/icf/en/>