Reflecting on key influences shaping occupational therapy services in a Saskatoon primary health care setting

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I have been interested to see the focus in recent years on developing occupational therapy services in primary health care settings. My interest is fuelled by my 30 years of experience as an occupational therapist in such a setting, namely the Saskatoon Community Clinic. Over the years I have come to realize how much the environmental context influences development of occupational therapy services. This paper will highlight my experience with some of the key influences, such as: the nature and values of the practice setting, health care trends, changing government priorities, as well as changes within the occupational therapy profession.

Practice setting

The Saskatoon Community Clinic recently celebrated its 50th anniversary. It is a cooperative health care centre that has always provided what is now called primary health care. It was certainly in the forefront of providing such care in Saskatchewan and is very different from many primary health care centres in that:

- The staff, including the physicians, are all salaried employees.
- An interdisciplinary group of staff and services are available including physicians, nurse practitioners, lab and X-ray services, counselling and community mental health nursing, dietetics, nursing, occupational therapy, pharmacy, and physiotherapy services.
- Governance is under the direction of a board of directors elected by the members (i.e., patients).
- A strong social justice philosophy permeates the approach to health care and there is an active history of advocacy by the clinic's members, board and the organization.
- Westside Community Clinic, a second site located in an inner city area, serves low-income and aboriginal populations.

The clinic hired its first occupational therapist as a consultant over 40 years ago after a pilot study demonstrated that occupational therapy services provided cost-effective use of resources within such a community setting. When the position became vacant in 1983, I applied for it because I had always had an interest in working with people in their 'real worlds,' that is, their homes and communities. Little did I realize what unique opportunities the clinic would offer for my learning and growth as a therapist and as an individual.

Prior to starting at the clinic, my previous experience had been in a variety of positions within hospital settings. When I began working in the community-based setting, I continued to rely on physicians to refer patients to me, as was typical within the medical model of service of that time. Despite endeavouring to educate physicians about all the ways that their patients could benefit from occupational therapy services, growth was an uphill battle. However, times changed and there was a move within health care away from the traditional medical model to other approaches. Changes to the provincial Occupational Therapy Act allowed for direct access to service and the clinic was supportive of this change. Saskatoon Health Region restructuring led to stronger partnerships between the clinic occupational therapist and other community-based services, including regional community occupational therapy services, client service coordinators/assessors and home care providers. Referral sources have expanded from clinic physicians and staff to include health region personnel and a growing number of self- or family referrals. The mainstay of the clinic's occupational therapy services over the years has included home-based assessments, ergonomic assessments, recommendations for equipment and environmental modification as well as a group program for seniors. Other services and groups have come and gone over time.

Over the years I learned much from the clinic's strong social justice approach and its particular interest in providing service to people who are marginalized and underserved. These organizational values have given me the flexibility to experiment with different approaches to the delivery of occupational therapy services. Some examples include the following:

- A collective cooking program that brought together women with long-term mental health issues who were socially isolated.
- Participation in inter-agency partnerships seeking to address community health promotion needs, such as the Saskatoon Falls Prevention Consortium. The Consortium's interest was the development of a falls risk strategy for the health region and one of the products was an algorithm to guide identification of those at risk and subsequent decision making.

In addition, my employer has been fully supportive of my advocating for clients in relation to a variety of health and social service agencies. One example would be when conflicts arise between client interests and service provider policies and practices,

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my role has been to advocate with and for clients, for consideration of their perspective. Such advocacy can be difficult to do in situations where avoiding inter-agency or inter-departmental conflict takes precedent to client needs or where one's professional role is defined very narrowly to the exclusion of advocacy work.

Health care trends and impact of government priorities

The emergence of the health promotion philosophy was of great interest to the clinic, but it was not until the Saskatchewan Department of Health embraced the philosophy and provided funding that innovative program implementation could fully take place. The health promotion approach changed my program planning from a focus on diagnostic groups to one based on key population groups. The primary population groups that the clinic's occupational therapist provides service to are: seniors with complex health needs, persons with significant disabling conditions, and aboriginal clients who use the Westside clinic. A key population group where occupational therapy service has remained limited is those facing mental health challenges. One of the more challenging lessons of the health promotion approach was that the best people to provide a service to certain population groups may not necessarily be the professionals, but rather they might be, for example, aboriginal peer leaders. My role within the clinic's health promotion initiatives evolved to become one of participating in program planning and support rather than being a direct provider of the initiatives.

When the Saskatchewan Department of Health switched its priorities and funding focus from a health promotion approach to chronic disease management, the Community Clinic adjusted its focus and program development in keeping with this change. Despite the fact that the majority of occupational therapy clients were living with chronic diseases, I found it difficult to find a place for occupational therapy within the chronic disease management strategies being implemented. This was because the initial focus was primarily on biomedical markers such as blood glucose levels or the percentage of patients on statin medications. However, occupational therapy programs were gradually expanded to include the coordination of an interdisciplinary falls screening process, as well as partnering to provide self-management skills workshops for clients dealing with mental health challenges. The special edition of *Occupational Therapy Now* (Packer, 2011) that focused on self-management strategies has been helpful in guiding my reflection on the potential roles of occupational therapy and the importance of promoting participation in everyday activities as a legitimate and important measure of program outcomes. Unfortunately, the advent of fiscal constraints has hampered further development of this occupational therapy role.

Developments in occupational therapy

Developments in the profession of occupational therapy also influenced my work at the clinic. In an era of seeming specialization of occupational therapy, the publication of the *Occupational Therapy Guidelines for Client Centred Practice* (Canadian Association of Occupational Therapists [CAOT], 1991) confirmed that my practice as a community-based generalist, with a focus on daily occupation, was very much at the core of occupational therapy philosophy. The publication of *Enabling Occupation: An Occupational Therapy Perspective* (CAOT, 1997) helped me to articulate the processes that I had instinctively developed. This led to the development of a charting outline and approach that was more consistent with an occupational therapy frame of reference than with a medical model of charting. During the clinic's recent change to electronic medical records (EMR), it was a challenge to maintain that occupational therapy frame of reference within a record designed primarily around the medical model of record keeping.

Moving forward

I see many opportunities for expansion of the role of occupational therapy within our primary health care setting, given adequate resources. This includes meeting the needs of a growing number of at-risk seniors living in the community; those living with dementia; those seeking an active, independent retirement or those who are forced by financial constraints to continue to work despite increasing impairments. Self-management strategies that facilitate participation in everyday life could be further developed for persons with multiple chronic conditions. Occupational therapy services designed with a recovery-oriented approach could be developed in partnership with those with mental health challenges. Occupational therapy services in our Westside Clinic could be expanded as well. Some population groups with high needs include clients living with HIV and homeless people attempting to transition from the streets into independent housing (R. Marvel, personal communication, August 2, 2012). Recently, occupational therapy services have been expanded at Westside Clinic to the population of clients with HIV. This was initiated when clinic physicians were seeking information about the cognitive status of some of their clients. The ongoing challenge is to find assessment methods that are sensitive to the particular cultural contexts and socioeconomic characteristics of this population.

Primary health care settings offer diverse challenges and opportunities for the development of the role of occupational therapists. The influence of the environmental context is an important consideration in this development. It is a big challenge to maintain key values of both the organization and profession within the ever-shifting world of health care.

One of the most rewarding parts of my work in a primary health care setting has been the chance to work in partnership with the many amazing, resilient, and determined clients I have met over the years. To them I owe the greatest thank you for the honour of sharing this journey with them.

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