

**The American Occupational Therapy Association
Report to the Executive Board**

DATE: October 3, 2005

FROM: Ad hoc Workgroup on Implementing Occupation based Practice

Cathy Nielson, MPH, OTR/L, FAOTA, Chair
Mary Jane Youngstrom, MS, OTR, FAOTA
Corky Glantz, OT/L, BCG, FAOTA
Mary Lou Henderson, MS, OTR/L
Nancy Richman, OTR/L, FAOTA
Susanne Smith Roley , MS, OTR/L, FAOTA
Gerri Duran, OT/L, AOTA Board Liaison
Maureen Peterson, MS, OT/L, FAOTA, AOTA Staff Liaison

TO: AOTA Board of Directors

SUBJECT: Information for Board Discussion

TOPIC: Implementing Occupation Based Practice

Executive Summary:

The report of the Ad hoc Workgroup on Implementing Occupation Based Practice provides insight into the state of OBP by describing essential features of that practice and delineating some of the barriers to implementation. The report offers a wide range of actions that can be taken by AOTA and in collaboration with organizational partners to facilitate the ongoing development and implementation of occupation based practice. Appendices 1 and 2 include the workgroup's reference list on occupation based practice and the sample interview questions used in gathering information from practitioners about their practice.

Action Items:

1. Overarching: *The profession must be united in understanding and implementing OBP*
2. Education: *Students must be firmly grounded in OBP and have the confidence to enact OBP*
3. Continuing Education: *Practicing clinicians and educators must understand and enact OBP across a variety of practice settings*
4. Communication: *All environments must be inundated with messages about OBP*
5. Practical Guidance and Support: *We must translate OBP into useful examples and tools*
6. Inspiration: *We must create a community of practice that is energized by OBP*

7. Leadership: *We must recognize and develop current and future leaders to sustain OBP*
8. Evidence: *We must establish the efficacy of OBP*

Relation to Strategic Plan: Goal I: D,E; Goal II: A,D,E,F,G; Goal II: A,B,C,D,E,F,G

Fiscal Implications: NA – See comment under Resources Needed

Full Report:

Statement of the Problem

The workgroup was charged to investigate the state of implementation of occupation based practice, including the barriers to implementation, and to make recommendations for the Board's consideration across broad areas of the association such as practice, policy, continuing education and communication. The group conducted a literature review on the topic, interviewed occupational therapists and occupational therapy assistants and engaged in exploratory and integrative discussion.

It is necessary to preface our report with four of our most compelling realizations.

- We consider it unwise to view occupation based practice (OBP) as new or different. OBP is simply good occupational therapy practice – understanding this and articulating it as such can be a powerfully integrating and unifying force within the profession. We found many examples in the literature and in practice of good occupational therapy service provision in which occupation is infused across the assessment, intervention and outcome phases.
- We believe that it is time for the Association to take a clear and definitive position on what constitutes occupation based practice and therefore best practice. It is not adequate to define OBP solely in terms of the outcome of improved occupational performance. Occupation based practice is client centered with occupation specifically integrated throughout the intervention process.
- While we think that a definitive position on OBP should be developed, we do not think that it is advisable to produce a definitive definition of OBP. However, we do see the need to identify the core constructs of occupation based practice. These constructs can then serve as the basis for developing practical applications for use across education and practice settings. Applications might include curriculum models and instructional materials, practical guides for how to use occupation in intervention, how to document this use, how to explain the use of occupation to clients, payers and interdisciplinary colleagues, and examples of how to counter the barriers to OBP.
- Our central “discovery” is the essential role that **linkage** plays in OBP. When preparatory methods and purposeful activity are used in intervention, occupation must be carefully linked to and integrated with these approaches. The isolated use of preparatory or purposeful activity is not OBP. The use of these approaches must be explicitly explained with the relationship to occupation clearly evident and occupation ultimately introduced as primary to the intervention process. Linkage requires that the therapist integrate their technical skill base with their understanding of occupation and consistently use their integrated knowledge to

address all of the complex aspects of occupational performance. Lastly, linkage means making sure that the client understands the purpose of our intervention and why and how participation in occupation is therapy.

Background Information

We were able to identify essential features of occupation based practice that provided us with an understanding of OBP that crossed practice areas and settings. OBP is inherently client centered allowing choice, influence and power to be shared in the intervention process. Occupation is explained to the client and then used in assessment and intervention to clearly address the client's life, goals and roles in both their current and historical contexts. OBP begins with understanding the client's valued occupations, ends with getting them back into those life activities and infuses occupation into the intervention phase through activity selection, analysis and modification. The therapist's activity analysis and environmental/activity modification skills are critical to the linkage process described above and are key factors in using occupation in an integrated approach to intervention. OBP culminates with documentation that illustrates the client's status or progress in his/her ability to actively and meaningfully participate in the activities of his/her life.

The barriers to implementing OBP are related to factors internal to the therapist and profession as well as to issues in our external environments. Internally, two of the most significant barriers relate to the interrelationship of the therapist's value system and habit structure. Many therapists do not have the language or the actions to explain and enact OBP; they rely on existing habits to guide and describe intervention and often act and speak in ways that are inconsistent with the core values of the profession. Externally, there are innumerable setting and system issues that inhibit OBP. These include the expected factors of questions about reimbursement, limited time and resources, productivity expectations, population specifics such as length of stay or acuity and treatment environments that promote reductionism and are impoverished occupationally. Two additional external barriers that should be highlighted are the expectations of the client and the preconceived notions of interdisciplinary colleagues. In both instances, clients and colleagues have perceptions about what constitutes occupational therapy that are based on the medical model and result in questioning if OBP is "really therapy".

We want to be sure to note that these barriers are not insurmountable. We read about and talked with therapists who have either not experienced these barriers or have countered them.

Implications for the Profession

The implementation of occupation based practice is an issue for the profession at large and not only a concern for the Association. OBP is the enactment of our core values in day to day actions and interactions and has the potential to solidify our identity internally

and clarify our contributions to individuals and society. Ensuring that OBP is developed, implemented, and sustained requires collaboration between AOTA and NBCOT, AOTF and ACOTE and partnerships with state occupational therapy associations and state licensing boards. Each entity has access to a segment of the profession and expertise in working with their constituency. Interagency collaboration and partnerships will ensure that the multifaceted and overlapping approaches needed to support OBP are available.

Recommendations

Our recommendations are categorized for convenience but we'd like to stress the need for overlapping, simultaneous, continuous actions to address multiple target audiences. This type of effort will require a long term commitment of all partners. We would also stress the need for practical action that can reinforce values and give the language and behavior to enact those values.

Overarching: *The profession must be united in understanding and implementing OBP*

- Develop a clear and definitive position on what constitutes occupation based practice and therefore best practice
- Identify the core constructs of occupation based practice
- Investigate, describe and provide examples of how therapists integrate their technical skill base with their understanding of occupation and consistently use their integrated knowledge to address all of the complex aspects of occupational performance (linkage).

Education: *Students must be firmly grounded in OBP and have the confidence to enact OBP*

- Develop an AOTA Model Curriculum to exemplify how to teach core constructs of OBP
- Encourage ACOTE to continue to require strong linkages between the knowledge and application of technical skills and the knowledge and use of occupations in intervention.
- Work with educational programs on methods to translate didactic occupation based education to fieldwork education (i.e. CE programs for clinical educators)
 - The newly formed RA ad hoc group dealing with fieldwork may wish to discuss this concept in more depth; they may find some of this group's thinking helpful to their process

Continuing Education: *Practicing clinicians and educators must understand and enact OBP across a variety of practice settings*

- Continue AOTA's emphasis on occupation based continuing education programs and conference presentations
- Develop a Model CE Model/template that would establish parameters for occupation based CE
- Work with agencies that require and/or provide CE (NBCOT, state licensing boards, state associations) to adopt the parameters for occupation based CE

- Develop an OBP CE program similar to past CE programs that diffused change throughout the profession - TOTEMS, PIVOT, SCOPE, & the Occupational Therapy Practice Framework on line course
- Work with the NBCOT to infuse OBP into recertification requirements

Communication: *All environments must be inundated with messages about OBP*

- Continue AOTA's emphasis on OBP in all internal and external communications
- Engage State Association Presidents and AOTA Reps in educating their constituents about OBP (similar to their engagement in the visioning process)
- Develop newsletters articles, PowerPoint and video presentations on OBP that can be distributed to state associations, other organizations and publications

Practical Guidance and Support: *We must translate OBP into useful examples and tools*

- Identify and promote Models of Clinical Excellence in OBP
- Write and distribute explicit examples of OBP across practice settings
- Write and distribute examples of how therapists are countering the barriers to OBP
- Develop and offer a CE program on documenting OBP based on the 2003 Guidelines for Documentation of Occupational Therapy
- Develop examples and guidelines of how to integrate preparatory methods and purposeful activity with occupation, how to link our technical skills base with occupation, how to use occupation in intervention
- Ask the COP to further address OBP and to explicitly develop the linkage between occupation and other intervention approaches in their review of the OTPF
- Develop strategies to ensure that OBP is reimbursed
- Lobby for changes in the delivery systems in which we provide services (particularly the medical health care system) to allow OTs to see client's in their natural environments (home, work, school, community) where daily life occupations actually occur i.e. reimbursement for follow up care in home, community after d/c (not necessarily in home health). These might be along the line of day care types of programs or community re-integration or even prevention programs (like the well-elderly study).

Inspiration: *We must create a community of practice that is energized by OBP*

- Develop and distribute positive client stories about the impact of OBP but also use client stories about their negative experiences with non OBP
- Celebrate and highlight OBP at annual conference and throughout the year
- Emphasize the creative and energizing nature of OBP for therapists
- Promote OBP as a complex and sophisticated practice that taps into multiple modes of clinical reasoning and self reflection

Leadership: *We must recognize and develop current and future leaders to sustain OBP*

- Identify, support and promote leaders in clinical departments that are OBP
- Invest in leadership development for the Association

Evidence: *We must establish the efficacy of OBP*

- Fund and disseminate the results of disciplinary and interdisciplinary research that supports the effectiveness of OBP

Resources Needed

Given the exploratory nature of the group's work, we did not see it as within our scope to assign resource requirements to our recommendations.

Ad Hoc Workgroup on Occupation Based Practice

INTERVIEW SAMPLE QUESTIONS

- 1) How do you use occupation in your practice?
- 2) What does that look like?
- 3) What barriers do you encounter?
- 4) How can AOTA; State Associations, Schools help you address the barriers?
- 5) What skill do you have that allows you to successfully integrate occupation into your practice?
- 6) How do you define occupation based practice?
- 7) What is not occupation based practice?
- 8) Why wouldn't you be occupation based 100% of the time?
- 9) Describe a recent session when you felt you were doing really good OT (best practice).

Appendix 2

Ad Hoc Workgroup on Occupation Based Practice Reference List

- Amini, D. (2004 Feb 9). Renaissance occupational therapy and occupation-based hand therapy. *OT Practice*, 9, 11-15.
- Baker, NA, Jacobs, K, & Tickle-Degnen, L. (2003). A methodology for developing evidence about meaning in occupation: exploring the meaning of work. *OTJR: Occupation, Participation and Health*, 23, 57-66.
- Baum, C. (2000 Jan 3). Occupation-Based Practice: Reinventing ourselves for the new millennium. *OT Practice*, 5, 12-15.
- Bhavnani, G. (2000 Dec). Toward occupation-based practice in hand rehabilitation. *Physical Disabilities Special Interest Section Quarterly*, 23, 1-2.
- Blijlevens, H, & Murphy, J. (2003). Washing away SOAP notes: refreshing clinical documentation. *New Zealand Journal of Occupational Therapy*, 50, 3-8.
- Bonzani, PJ. (2003 Dec). Cumulative trauma disorders: an occupation-based perspective. *Physical Disabilities Special Interest Section Quarterly*, 26, 1-3.
- Chan, J, & Spencer, J. (2004). Adaptation to hand injury: an evolving experience. *The American Journal of Occupational Therapy*, 58, 128-139.
- Chisholm, D, Dolhi, C, & Schreiber, J. (2000 Jan 3). Creating occupation-based opportunities in a medical model clinical practice setting. *OT Practice*, 5, CE-1 - CE-8.
- Chisholm, D, Dolhi, C, & Schreiber, J. (2004). Occupational therapy intervention resource manual: a guide for occupation-based practice. Clifton Park, NY: Thomson/Delmar Learning.
- Cohen, S. (2005 May 23). Breast cancer: the OT role in facilitating recovery. *OT Practice*, 10, 16-20.
- Cox, S. (2002). The poorly understood occupation: exercise. *New Zealand Journal of Occupational Therapy*, 49, 32-36.
- Deane, KHO, Ellis-Hill, C, Dekker, K, Davies, P, & Clarke, CE. (2003). A Delphi survey of best practice occupational therapy for Parkinson's disease in the United Kingdom. *The British Journal of Occupational Therapy*, 66, 247-254.
- DeGrace, BW. (2003). Occupation-based and family-centered care: a challenge for current practice. *The American Journal of Occupational Therapy*, 57, 347-50.

Deshaies, LD, Bauer, ER, Berro, & M. (2001 Jul 2). Occupation-Based Treatment in Physical Disabilities Rehabilitation. *OT Practice*, 6, 13-17.

Lisa D.Deshaies, Ellen R. Bauer, and Michele Berro describe their creative approach to ensuring individualized treatment for patients.

Fischer, MS, Kratz, A, Jimenez, B, Watson, C, Spence, C, Sanford, T, Goertz, H, & Scolaro, M. (2001 Feb 5). Aquatic Therapy: An occupational perspective. *OT Practice*, 6, 14-16.

Fisher, AG. (2003 Dec). Why is it so hard to practice as an occupational therapist? *Australian Occupational Therapy Journal*, 50, 193-194.

Fisher, T. (2003 May 19). New era, new challenges: fostering occupational performance and participation in the 21st century. *OT Practice*, 8, 21-25.

Fortune, T. (2000). Occupational therapists: Is our therapy truly occupational or are we merely filling gaps? *The British Journal of Occupational Therapy*, 63, 225-230.

Golledge, J. (2004). Therapeutic occupation following stroke: A case study in (M.Molineax, Ed.). *Occupation for occupational therapists*, 169-182. Blackwell Publishing, Malden MA.

Hammel, J. (2000). Assistive technology and environmental intervention (AT-EI) impact on the activity and life roles of aging adults with developmental disabilities: findings and implications for practice. *Physical & Occupational Therapy in Geriatrics*, 18(1), 37-58.

Hocking, C. (2001). The Issue is: Implementing occupation-based assessment. *The American Journal of Occupational Therapy*, 55, 463-469.

Kannenber, K, & Greene, S. (2003 Jun 2). Infusing occupation into practice: valuing and supporting the psychosocial foundation of occupation. *OT Practice*, 8, CE-1 - CE-8.

Kaur, D, Seager, M, & Orrell, M. (1996). Occupation or therapy? The attitudes of mental health professionals. *The British Journal of Occupational Therapy*, 59, 319-322.

Legault, E, & Rebeiro, KL. (2001). Case Report: Occupation as a means to mental health: A single-case study. *The American Journal of Occupational Therapy*, 55, 90-96.

Lysaght, R & Wright, J. (2005). Professional strategies in work-related practice: an exploration of occupational and physical therapy roles and approaches. *The American Journal of Occupational Therapy*, 59, 209-217.

McEneaney, J, McKenna, K, & Summerville, P. (2002). Australian occupational therapists working in adult physical dysfunction settings: What treatment media do they use? *Australian Occupational Therapy Journal*, 49, 115-127.

Nelson, DL, & Mathiowetz, V. (2004). Randomized controlled trials to investigate occupational therapy research questions. *The American Journal of Occupational Therapy*, 58, 24-34.

Neufeld, PS. (2004 Aug 9). Enabling participation through community and population approaches. *OT Practice*, 9, CE-1 - CE-8.

Pierce, D. (2001). Occupation by design: dimensions, therapeutic power, and creative process. *The American Journal of Occupational Therapy*, 55, 249-259.

Schell, BA. (2003 Oct 6). Clinical reasoning and occupation-based practice: changing habits. *OT Practice*, 8, CE1-CE8.

Walker, MF, Drummond, AER, Gatt, J, & Sackley, CM. (2000). Occupational therapy for stroke patients: A survey of current practice. *The British Journal of Occupational Therapy*, 63, 367-372.