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Collaborative care: a programmatic proposal to improve occupational therapy in acute care

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BOSTON UNIVERSITY
SARGENT COLLEGE OF HEALTH AND REHABILITATION SCIENCES

Doctoral Project

**COLLABORATIVE CARE:
A PROGRAMMATIC PROPOSAL TO IMPROVE
OCCUPATIONAL THERAPY IN ACUTE CARE**

by

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Submitted in partial fulfillment of the
requirements for the degree of
Doctor of Occupational Therapy

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DEDICATION

I would like to dedicate this work to my colleagues at St. Joseph's Hospital and Medical Center in Phoenix, Arizona. Thank you for inspiring me on a daily basis to be a better Occupational Therapist.

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Boston University, Sargent College of Health and Rehabilitation Sciences, 2021

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ABSTRACT

The problem is the current challenge of the acute care environment itself, which includes significant intra-professional challenges for occupational therapists. The evidence reviewed revealed that occupational therapists have difficulty maintaining a holistic approach with a lack of standardization in how they deliver care and an ever decreasing length of stay in which to provide said care (Atwal & Caldwell, 2003; Britton et al., 2015; Crennan & MacRae, 2010). Collaborative Care is a program proposing to increase client-centeredness and client collaboration through the consistent use of subjective and objective assessments. These assessments are complementary to one another yet serve to deepen and broaden the occupational therapist's understanding of each client as an individual. They aim to allow the therapist to capture essential, yet holistic, information about each client's occupations for an optimal discharge and functional independence post-discharge. While many acute care settings are incorporating the use of one or more of these strategies, there is no evidence to show that all are being used as a cohesive, programmatic manner for increased standardization and quality of care (Crennan & MacRae, 2010; Griffin & McConnell, 2001).

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LIST OF ABBREVIATIONS

| | |
|---------------|--|
| ACA | Affordable Care Act of 2010 |
| ADL | Activities of daily living |
| AOTA | American Occupational Therapy Association |
| ArizOTA | Arizona Occupational Therapy Association |
| CINAHL | Cumulative Index to Nursing and Allied Health Literature |
| CMS | Centers for Medicare and Medicaid Services |
| EHR..... | Electronic health record |
| FIM | Functional Independence Measure |
| IADL..... | Instrumental activities of daily living |
| IRB..... | Institutional Review Board |
| MBTOTR..... | Modified Blaylock Tool for Occupational Therapy Referral |
| PPS..... | Prospective payment systems |
| SJHMC..... | St. Joseph's Hospital and Medical Center |

GLOSSARY

Acute care-refers to the inpatient hospital environment including emergency medicine, trauma care, pre-hospital emergency, critical care, surgery, and short-term stabilization.

Client-centered approach-emphasis on a patient's or client's right to choose goals and/or interventions based on his or her identified needs for services, i.e., what is most important to the client and/or family.

Holistic care approaches the whole person, acknowledging the interconnection of mind, body, spirit, and environment.

Hospital discharge readiness is defined as physical stability, adequate support, psychological ability, and adequate information and knowledge to support a safe discharge from the hospital (Galvin et al., 2017).

Throughput is a term utilized to reflect a focus of moving patients through the hospital system. (i.e., throughput-focused)

Unplanned readmission to the hospital is defined by CMS as a readmission to the hospital within 30 days for the same condition.

CHAPTER ONE – Introduction

Healthcare is big business, a multi-trillion dollar industry to be exact (Centers for Medicare and Medicaid Services [CMS], 2018). In the United States, it accounts for 20 percent of the gross domestic product. The implementation of the Affordable Care Act (ACA) of 2010 redefined priorities of healthcare with these triple aims: cost effectiveness, quality outcomes, and the consumer experience (Pritchard et al., 2019). Quality care as defined by the ACA is efficient, patient-centered, equitable, effective, and timely (Watterson et al., 2018). As part of the ACA, the Centers for Medicare and Medicaid Services additionally implemented the Hospital Readmission Reduction program to penalize hospitals with excessive readmissions that occur within 30 days for the same medical condition, up to three percent of reimbursement (CMS, 2019).

The system is now largely driven by prospective payment systems (PPS) which are predictive based on diagnoses and/or planned procedures. These PPS estimate hospital length of stays and reimbursement rates, which have resulted in shorter hospital stays from a decision-making standpoint as well as total length (Frakt, 2016). In an effort to cut costs, many systems have also created bundled payment systems, incentivizing hospitals to refer patients to less expensive post-acute care rehabilitation services, such as home health or outpatient (Pritchard et al., 2019). All of the aforementioned changes and challenges in healthcare have markedly impacted the role of the acute care occupational therapist. The challenge and the opportunity for acute care occupational therapists is to efficiently adapt to the changing demands of healthcare while contributing a unique perspective to a patient-centered hospital experience (Griffin & McConnell, 2001).

In the continuum of rehabilitation services, acute care occupational therapists have the shortest amount of time to provide intervention, with typical hospital stays ranging from two to five days. The role of the acute care occupational therapist includes the ability to evaluate current function in contrast to typical or prior function and to determine the interconnection of diagnoses and its effect on performance and participation in a holistic manner (Pritchard et al., 2019). One of the primary roles is discharge planning, which requires complex decision-making and reasoning skills to consider specific client factors, rehabilitation potential, and options for discharge (Hamby, 2011). This role has recently been highlighted in a landmark study by Rogers et al. (2017) as a means of reducing readmissions. The authors found spending on occupational therapy was the only category that was shown to be statistically significant in reducing hospital readmission rates for several chronic diseases.

Along with the shifting focus of health care, the acute care environment, in itself, presents a challenge for occupational therapists. It is fast-paced, medical condition-centric, throughput-focused, and silo practice-oriented, creating intra-professional challenges specific to occupational therapy (Britton et al., 2016). These intra-professional challenges include: difficulty adhering to a holistic approach (Connolly et al., 2009; Terry & Westcott, 2012); decreased client centeredness and respect for client autonomy with discharge decision making (Maitra & Erway, 2006; Moats, 2006); a lack of standardization of the delivery of care impacting consistent practices (Crennan & MacRae, 2010); and an ever decreasing length of stay in which to provide intervention (Atwal & Caldwell, 2003; Britton et al., 2015). The consequences of these challenges are

they lead to an over-emphasis on the medical condition while neglecting the client's psychosocial health.

As a clinician, the acute care hospital environment can be challenging and frustrating, because it remains “a predominantly hierarchical and paternalistic medical model” (Smith-Gabai, 2011). In addition, occupational therapists in this environment seem to demonstrate difficulty maintaining a client-centered and occupation-based approach (Maitra & Erway, 2006). It is however a professional responsibility to remain holistic and client-centered, even with the time pressures and confines of the medical environment. The intended outcome of this doctoral project is to create an evidenced-based, theoretically-grounded, holistically-minded program specifically for acute care occupational therapists. This proposed comprehensive program will ensure a streamlined and standardized process including an early, client-centered, thorough, and discharge focus for occupational therapy in acute care.

CHAPTER TWO – Project Theoretical and Evidence Base

Overview of the Problem

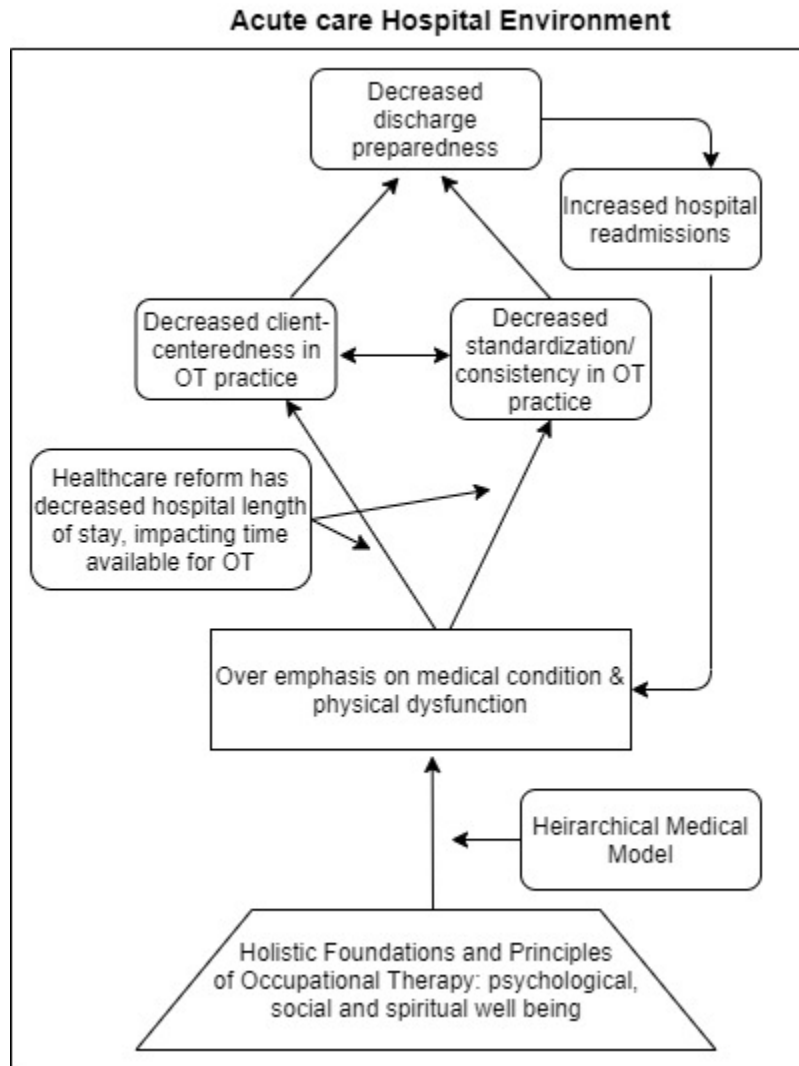
The primary goals of the acute care hospital are to: medically assess and stabilize patients, diagnose and treat medical conditions, expedite discharge when medically stable, and prevent unnecessary readmissions (Kroch et al., 2016; Wadhera et al., 2019). Secondary goals are to improve functional status and safety by preventing physical and cognitive complications, which are key components of occupational therapy interventions (American Occupational Therapy Association [AOTA] Acute Care Fact Sheet, 2017). Further goals are based on healthcare reform which are to: deliver quality care, prevent hospital acquired infections and unplanned readmissions, provide cost effective care, and maximize the consumer experience (Pritchard et al., 2019).

Historically, the foundations of the occupational therapy profession are based in individualized holistic health care. Holistic care approaches the whole person, acknowledging the interconnection of mind, body, spirit, and environment. While the medical model has heavily influenced the field of occupational therapy by elevating its scientific and societal standing, it has also moved the focus farther from the holistic perspective, by potentially neglecting psychological and social aspects of recovery (Lohman & Peyton, 1997; McColl, 1994). This observation is echoed in multiple qualitative surveys from practicing acute care occupational therapists who report the medical model has impacted them by: being known for a “subset” of their skills (Britton et al., 2015), having numerous ethical dilemmas especially around maintaining a holistic and client-centered approach (Atwal & Caldwell, 2003; Britton et al., 2016), which

subsequently limit the scope of their assessment to physical dysfunction again neglecting potential psychosocial deficits (Griffin & McConnell, 2001; Welch & Forster, 2003).

Several studies have demonstrated this narrowed scope of acute care occupational therapy assessments, which rarely move beyond physical dysfunction to include spiritual well-being (Belcham, 2004) or psychosocial well-being (Terry & Westcott, 2012). Terry and Westcott (2012) found that persons with unmet psychological needs often have difficulty maintaining physical function and have reduced social function and quality of life. By limiting their scope, occupational therapists can neglect critical components of their client's lives by lacking investigation into their meaningful life roles at home, work, or leisure. This information should ideally be used to holistically determine discharge needs including: additional equipment or post-acute care recommendations, social support needed for community access, or services unique to the client's needs (Smith-Gabai, 2011). This lack of holistic assessment and client-centeredness is an issue specifically in the acute care environment. Psychosocial factors, especially those linked to readmissions, should be routinely assessed by occupational therapy (Terry & Westcott, 2012). Figure 2.1 provides a visual representation of the problem and the aforementioned professional challenges and stressors.

Figure 2.1. *Visual representation of the problem*



Occupational therapy has tremendous opportunities to highlight its distinct value to hospital organizations. The overarching goal from a hospital standpoint, continues to be the prevention of readmissions while delivering quality care in a cost-effective manner (Pritchard et al., 2019; Roberts et al., 2020). Readmissions are a challenging topic to break down given their complexity and the numerous reasons that can cause them. Rogers et al. (2017) found spending on occupational therapy was the only category

shown to be statistically significant in reducing readmission rates for several chronic diseases when compared to other hospital services. These results were achieved by occupational therapists' specific focus on providing practical solutions to increase safety at home for patients and their caregivers and by assessing cognition and safety awareness for home management tasks and responsibilities (Rogers et al., 2017). DePalma et al. (2013) found that unmet activities of daily living (ADL) needs were found to directly increase the risk of readmission (DePalma et al., 2013). Greysen et al. (2017) found that while patients participated in and understood their discharge plan, they were not routinely asked to identify or anticipate potential difficulties carrying out that plan. This left many patients returning home to encounter unanticipated problems caring for themselves (Greyson et al., 2017).

All of these examples highlight opportunities for occupational therapy services to fill an unmet need. Interestingly though, occupational therapy was found to be an under-utilized or un-utilized service in these studies (DePalma et al., 2013; Greysen et al., 2017; Rogers et al., 2017). Despite occupational therapy proving to be a valuable and necessary service in the acute care setting, the professional potential for the discipline is not being maximized due to its lack of thorough and holistic involvement in discharge preparedness process.

The components of the visual model represent the complexities of the acute care environment and the resulting trickle-down effect on occupational therapy practice. The evidence supports that readmissions are an issue which can be impacted by unmet ADL needs and decreased preparedness, each of which are opportunities for acute care

occupational therapy intervention (DePalma et al., 2013; Greysen et al., 2017; Rogers et al., 2017). Additionally, there is overwhelming qualitative support to highlight the unique challenges acute care occupational therapists face including clinical and ethical challenges, supporting the need for change (Atwal & Caldwell, 2003; Britton et al., 2015; Britton et al., 2016; Connolly et al., 2009; Crennan & MacRae, 2010; Griffin & McConnell, 2001; Maitra & Erway, 2006; Moats, 2006; Roberts et al., 2020; Terry & Westcott, 2012; Welch & Forster, 2003).

Theoretical Support

Three theoretical frameworks are utilized to better understand how such complexities faced by occupational therapists within this healthcare environment can be illustrated and challenged: the Patient-Centered Care (PCC) framework, the Biopsychosocial model, and the Intentional Relationship Model (IRM). The frameworks are complementary to a practice shift and are complementary to one another. Patient-centered care is focused on providing care to the whole person: their preferences, beliefs, with inclusion of their families and caregivers (Santana et al., 2018). Healthcare has transitioned to PCC in an effort to promote shared decision making between healthcare professionals and their clients including collaborative goal setting and patient directed care (Durocher et al., 2015). Occupational therapy is a profession anchored by the tenet of providing individualized care including establishing collaborative goals and comprehensive holistic understanding of the client, therefore utilizing PCC will be a useful framework allowing occupational therapists to stay true to their anchoring values.

The Biopsychosocial model offers a holistic and client-centered framework to

bridge the divide to integrate social and psychological factors alongside biological. “Prevailing medical model of care favors a reductive and prescriptive approach to interventions addressing pathology, dysfunction, and disability” (Gentry et al., 2018, para 1). This model expands beyond the predominantly utilized biomechanical approach in acute care by addressing social/contextual and psychological factors, creating an inclusive and holistic client-centered approach. Its use allows for the integration of both top-down and bottom-up approaches to delivery of care which broadens its applicability in acute care (Gentry, 2018). Given that acute care occupational therapists have a challenge being holistic with a narrow assessment, this model provides a framework for a broader psychosocial assessment.

Lastly, the Intentional Relationship Model (IRM) provides a theoretical outline of the therapeutic relationship specific to occupational therapy practice. The objective using this model is to teach and hone skill of therapeutic use of self. Given the short amount of time in acute care, it is essential that occupational therapists are able to quickly assess clients’ interpersonal skills and preferences. This allows a more client-centered approach, which has been shown to improve clinical outcomes. A significant part of this model is building the clinicians’ own awareness of their interpersonal preferences and strengths as well as using self-assessment and self- reflection (Taylor, 2008). The use of the IRM will promote the development of an efficient and meaningful therapeutic relationship that is centered on the clients’ goals for hospital discharge.

Previous Attempts to Address the Problem

A thorough literature search was conducted to understand and analyze current approaches being used to address these issues at both the system/hospital level as well as at the individual occupational therapist level. The review consisted of searches in the CINAHL and PubMed databases with the following search terms: “discharge readiness”, “discharge planning”, “acute care or hospital”, “occupational therapy”, “referral”, “standardization”, “assessment or outcome measure”, “hospital readmission prevention programs”. Articles selected were evidenced-based and were prioritized based on level of research rigor. Additionally, there was a concerted effort to find relevant evidence from or directly applicable to the acute care setting. In general, evidence regarding practice trends in acute care occupational therapy is limited, is qualitative in nature, and is largely from the countries of Australia, Canada, and England. Evidence was additionally examined in order to consider multidisciplinary perspectives from professions including nursing, physical therapy, case management and social work. The majority of the literature reviewed from the field of occupational therapy was qualitative research, which typically represents a smaller sample size and potentially a lower quality of evidence. However, there are themes that provide valuable perspectives for practicing acute care occupational therapists and for this doctoral project. The following discussion highlights the results of the multidisciplinary evidence search, from which conclusions have been drawn that support the development of a specific programmatic approach for acute care occupational therapy.

Healthcare Reform and Its Impact on Hospital Length of Stay

Healthcare has continually been reformed to improve efficiencies including cost containment and the client experience (Pritchard et al., 2019; Roberts et al., 2020). This has additionally resulted in a decreased length of stay in acute care hospitals (Britton et al., 2015; Pritchard et al., 2019). While the reduction in length of stay has shown to decrease hospital acquired infections and overall cost of hospitalizations, it also inherently decreases the time available for occupational therapists to provide their valuable services (Atwal & Caldwell, 2003; Britton et al., 2015; Griffin & McConnell, 2001). At its core, occupational therapy is a discipline that aims to be holistic, comprehensive, client-centered, and collaborative (AOTA, 2020), yet the challenges discussed often prevent it from being so in the acute care setting.

While the medical staff in acute care are focused on addressing immediate care needs, a client's functional performance often goes overlooked, which can affect and potentially delay a safe timely discharge (Tan et al., 2016). In order to address this delay in care, early referral or screening for occupational therapy services is essential (Hobbs et al., 2010; Sutton, 1998; Tan et al., 2016). Early referral has been found to consistently increase appropriate referrals, allowing occupational therapists to initiate services earlier in the hospital stay and ultimately to effect a greater change and optimize discharge planning (Hobbs et al., 2010; Pears, 2016; Sutton, 1998; Tan et al., 2016). "Early identification of patients requiring occupational therapy allows more time to provide effective interventions and implement comprehensive, integrated and client-centered treatment plans" (Tan et al., 2016, p.1611).

There was minimal literature available regarding screening and referral to occupational therapy in acute care. Tan et al. (2016) completed a comprehensive search of the literature and identified ten screening tools, which varied by who administers them, the levels of functional evaluation, and the quality of their psychometric properties. The authors utilized the strengths of the other screening tools in the development of the Modified Blaylock Tool for Occupational Therapy Referral (MBTOTR) (Tan et al., 2016). The strengths include: specific to the acute care setting, sensitive enough to identify risk of functional decline to trigger an appropriate occupational therapy referral, while preventing unnecessary referrals (Tan et al., 2016; Tan et al., 2019). The strength of the MBTOTR was much superior when compared to other screenings tools given its 100% sensitivity, meaning there were no irrelevant referrals to occupational therapy (Tan et al., 2016). While this tool appears psychometrically strong, there is no additional evidence available aside from the pilot study which was completed at a large, suburban acute care hospital in Australia (Tan et al., 2019). Another tool reviewed by Hobbs et al. (2010) presented a case report from Mayo Clinic and Hospital on a novel method to triage therapy evaluations. There were however no psychometric properties discussed and a similar system is already utilized within this author's acute care setting.

While there was not a great deal of available occupational therapy-specific evidence regarding screening and referral in this setting, there is sufficient support for the use of a screening process to identify when a client's problem interferes with his or her ability to engage in occupation (Harrison & Hong, 2002; Pedersen & Kristensen, 2016; Tsai & Peterson, 2019). Early identification of functional deficits or safety concern

through screening can lead to early referral to occupational therapy, maximizing the time available for intervention. There is also a critical component of education, as those using the screening tool should have a working knowledge of the scope of occupational therapy services to aid in making the most appropriate referrals to drive discharge planning. Therefore, this doctoral project will incorporate a crucial screening process for referring clients to occupational therapy services as early as possible in their hospital stay. In addition, the development of a physician champion partnership will be a crucial program aspect in order to ensure a consistent advocate for occupational therapy services as well as an appropriate referral stream.

Decreased Client-Centeredness

In maximizing and streamlining occupational therapy services throughout the acute care process, the next challenge identified was how to determine and ensure best client-centered practices in acute care. The national standards of occupational therapy practice include providing services that are client-centered and occupation-based (AOTA, 2020). The available literature reviewed in this area was primarily qualitative in nature, representing valuable perspectives and trends from practicing occupational therapists with survey and interviews (Atwal & Caldwell, 2003; Maitra & Erway, 2003; Moats, 2006; Moats, 2007). The literature consistently supported client-centered and client-driven occupational therapy practice (Bailliard et al., 2020; Lane, 2000; Moats, 2006; Moats, 2007). This terminology (client-centered and client-driven) highlights that the central focus of occupational therapy is the client, the decision maker is the client, and the power in the client-therapist relationship should be shared (Lane, 2000). It is

essential to recognize power dynamics in the therapeutic relationship and the impact the medical model itself can have on respecting client autonomy (Atwal & Caldwell, 2003; Moats, 2006). In acute care specifically, occupational therapists have found it ethically challenging at times to honor client decision making, often within the context of discharge planning (Atwal & Caldwell, 2003; Moats, 2007). A more balanced approach would include “decision making grounded in partnership, shared power, and interdependence” with goal setting (Moats, 2007, p. 92).

There is a distinct opportunity for occupational therapists to promote client choice and client-centeredness, including collaborative goal setting, occupational engagement, justice, and dignity in the acute care environment (Bailliard et al., 2020; Lane, 2000). Client-centered practices aid in building rapport and assist the therapist in understanding the client’s unique perspective, allowing greater engagement in meaningful occupations (Lane, 2000; Moats, 2007). In acute care, evaluation and treatment, assessment, and patient and caregiver education are all opportunities to provide client-centered care, which additionally have the potential to increase discharge readiness and decrease hospital readmission (Falvey et al., 2016).

Knowing that assessment is often an occupational therapist’s first interaction with the client focused on acquiring an overview of the client’s needs, which is an opportunity to ensure client-centeredness from the beginning of service provision. This is a critical component to include from a programmatic standpoint. The literature on assessment and evaluation methods revealed a mix of quantitative and qualitative studies investigating client-centeredness in acute care occupational therapy practices (Crennan & MacRae,

2010; Falvey et al., 2016; Lane, 2000; Moats, 2007; Neistadt, 1995). Qualitative studies offered information that was more robust and valuable including consistent themes representing the complexities of acute care occupational therapy practice (Atwal & Caldwell, 2003; Maitra & Erway, 2003; Moats, 2006; Moats, 2007). Informal interview was most consistently utilized by acute care occupational therapists to determine client's priorities and goals, which was highly variable given interviewing styles and skills, depending on the therapist (Griffin & McConnell, 2001; Neistadt, 1995). However, "informal interview does not appear to yield specific information about what activities are most important to clients, rather formal procedures for assessing clients' goals are far more likely to yield that information" (Neistadt, 1995, p. 435).

Several client-centered assessments were identified in the literature including: Canadian Occupational Performance Measure (COPM) (Toomey et al. 1995), Goal Attainment Scale (GAS) (Kiresuk & Sherman, 1968), Occupational Self-Assessment (OSA) (Kielhofner et al., 2009), and the Role Checklist (Oakley et al., 1986). There are significant considerations for acute care assessments which include length of assessment, clinical utility, time required to administer, training requirements, ease of interpretation, and cost of materials and assessment. While all the assessments listed would be appropriate for the acute care environment, the COPM and GAS both have the potential to be lengthy and are less realistic options for the confines of the acute care environment. Additionally, they require a client to explore and have an awareness of which specific areas/goals they want to address, which may be too advanced for many acute care patients. Further downsides in acute care to the use of the Role Checklist (Oakley et al.,

1986), the COPM (Toomey et al. 1995) and the GAS (Kiresuk & Sherman, 1968) are the short length of stay, which often impacts setting and attaining higher level goals related to work and leisure. If a standardized tool were to be used, it would have to be easily administered yet sensitive to the timeliness of the environment. Additionally, it should be able to reflect the client's preferences and potential functional challenges to aid in goal setting (Kessler et al., 2019). The OSA may be one consideration as it was found to support client engagement and participation in the goal setting process by determining priorities for change specifically in the acute care setting (Model of Human Occupation [MOHO], 2020; Popova et al., 2019).

Decreased Standardization/Consistency in OT Practice

Additional challenges echoed in the literature include the lack of standardization or consistency in occupational therapy practice within acute care (Crennan & MacRae, 2010; Pedersen & Kristensen, 2016; Tsai & Peterson, 2019; Welch & Forster, 2003). This evidence was largely presented in qualitative research studying the perspectives from acute care occupational therapists, with the majority of studies from Australia, England, and the United States (Atwal & Caldwell, 2003; Britton et al., 2015; Crennan & MacRae, 2010; Griffin & McConnell, 2001). The focus of these studies varied from assessing ethical dilemmas to approaching discharge planning to the differences between experienced and novice clinicians; each of these studies had small sample sizes from large acute care hospitals representing one of the weaknesses of the available literature (Atwal & Caldwell, 2003; Crennan & MacRae, 2010). While many clinicians are drawn to the autonomous practice that acute care environment offers, this can create a challenge

in standardizing occupational therapy (Atwal & Caldwell, 2003; Britton et al., 2015). From a client outcomes perspective, clients and hospital administrators should expect the same outcomes regardless of the occupational therapist providing the service. The challenge as an occupational therapy leader is to honor the independence and autonomy of the occupational therapy practitioner, while ensuring delivery of thorough and quality client-centered care.

The literature highlights variability in acute care occupational therapy evaluation practices from documentation to initial intake interview to selection of a non-standardized or standardized assessment/outcome measure (Griffin & McConnell, 2001; Lane, 2000; Pain et al., 2017; Pedersen & Kristensen, 2016, Tsai & Peterson, 2019). A common method of standardization of practice is the use of outcome measures (Pederson & Kristensen, 2016), which is balanced with the additional caveat of selecting an assessment that directly addresses the needs of the individual client (Crennan & MacRae, 2010; Griffin & McConnell, 2001; Moats, 2006). Medicare recommends the use of a standardized measure to support objective functional findings and to support the development of the occupational therapy plan of care (Centers for Medicare and Medicaid Services, 2019). These assessments can be utilized to develop clinical interventions, evaluate client progress, assess change in function and provide client feedback (Raad et al., 2020; Tsai & Peterson, 2019). Occupational therapists are well educated and well suited to administer these outcome measures during an acute care admission. In fact, it may be necessary to administer more than one assessment to accurately capture the pertinent client information impacting discharge including their

strengths and deficits, safety concerns, and different contexts in which the client functions (Crennan & MacRae, 2010; Tsai & Peterson, 2019).

A primary responsibility of an acute care occupational therapist is discharge planning, including making specific discharge recommendations that are based on functional abilities, available social support, and rehabilitation potential (Hamby, 2011). The literature highlights several functional capacity assessments to support discharge disposition and interdisciplinary decision making (Crennan & MacRae, 2010; Falvey et al., 2016) including: the Activity Measure for Post-Acute Care (AM-PAC) (Jette et al., 2013), Timed Up and Go (TUG) (Podsiadlo & Richardson, 1991), grip strength (Mathowitz et al., 1985), Functional Independence Measure (FIM) (Keith et al., 1987), and general ADL assessment (AOTA, 2020). While each of these assessments adds value to the clinical picture, it is unrealistic given time constraints that all of these assessments would be completed in the acute care environment. Therefore, if an assessment tool were to be used, it would have to grossly assess functional abilities and the implications of those deficits on discharge from the hospital.

Decreased Discharge Preparedness

Decreased time for care leads directly to the challenge of decreased discharge preparedness. In turn, this lack of preparedness for discharge has been found to result in an increased risk of readmissions for acute care patients (Bobay et al., 2010; Grimmer et al., 2016; Harrison et al., 2016). As part of the Affordable Care Act of 2010, the Centers for Medicare and Medicaid Services implemented the Hospital Readmission Reduction program to penalize hospitals with excessive readmissions that occur within 30 days for

the same medical condition up to three percent (CMS, 2019). This program has prompted hospitals to focus heavily on discharge planning and discharge readiness in an effort to prevent unnecessary readmissions, to improve cost effectiveness and patient outcomes (Pritchard et al., 2019; Roberts et al., 2020). Many systems rely on multidisciplinary rounds to initiate discharge planning, to identify any potential barriers to discharge, and to complete discharge readiness assessments (Grimmer et al., 2006; Harrison et al., 2016).

While increased attention has been paid to discharge planning which is typically facilitated by case management and medical staff, this historically does not include client participation (Bobay et al., 2010; Falvey et al., 2016; Grimmer et al., 2006; Wallace et al., 2019). Unfortunately, the client's crucial perspective is often neglected in discharge-decision making in the acute care environment. This creates a professionally dominated dynamic, as opposed to one focused on the promotion of client autonomy and client-centered practices (Lane, 2000; Moats, 2006). The literature highlights a need for discharge planning that includes collaboration with the client reflecting their preferences and participation (Grimmer et al., 2006; Harrison et al., 2016). The studies reviewed utilized a combination of quantitative and qualitative research methods to assess the efficacy of discharge planning and client satisfaction (Bobay et al., 2010; Harrison et al., 2016; Wallace et al., 2019). The search of the evidence revealed several tools that can assist with patient participation by increasing client knowledge and preparedness in the discharge readiness and planning process (Bobay et al., 2010; Wallace et al., 2019). The strength of the evidence includes strong psychometric properties of the discharge

readiness tools (Bobay et al., 2010; Grimmer et al., 2006), evaluation of the tools in a clinical population (Bobay et al., 2010; Grimmer et al., 2006; Harrison et al., 2016; Wallace et al., 2019), and client feedback on their satisfaction from a qualitative perspective (Harrison et al., 2016; Wallace et al., 2019). These tools include the Brief- PREPARED measure (Graumlich et al., 2008) and the Readiness for Hospital Discharge Scale (RHDS) (Weiss & Piacentine, 2006). Both of these tools are self-report, increasing the opportunity for client feedback and participation in the discharge planning process by verbalizing concerns and improving preparedness. Additionally, Bobay et al. (2010) found the RHDS was predictive of readmissions and ED utilization.

The literature highlighted the value of client participation in the discharge planning process, not only to improve client satisfaction, but also to obtain specific concerns or needs directly identified by the client (Bobay et al., 2010; Falvey et al., 2016; Grimmer et al., 2006; Harrison et al., 2016; Wallace et al., 2019). Although these tools are well supported in the literature, they are not currently utilized in the author's acute care system by occupational therapy or the case management team. They are appropriate options to consider for utilization by acute care occupational therapists during the discharge planning process to aid in intervention planning and to empower the client's sense of discharge readiness.

Implications for Program Design

As an occupational therapy leader to a large department of acute care therapists, there is tremendous opportunity to effect real and lasting change in departmental practices and in the delivery of occupational therapy services. The thorough analysis of

the literature strongly supports the proposal of an acute care program that provides a more standardized protocol of care incorporating early referral, collaborative goal setting, and functional capacity and discharge readiness assessments. The proposed program will begin with the implementation of a referral or screening process to identify clients early in their stay, to drive more appropriate referrals to occupational therapy, and to increase the time available for meaningful occupational therapy intervention (Hobbs et al., 2010; Pears, 2016; Sutton, 1998; Tan et al., 2016). The next proposed programmatic change is the implementation of a client-centered assessment to identify client goals, to discuss shared decision making for intervention planning and to facilitate collaborative goal setting (Bailliard et al., 2020; Lane, 2000; Moats, 2006; Moats, 2007; Popova et al., 2019). Additionally, the use of a brief self-care assessment will assist the clinician in painting an accurate functional picture to reflect deficits and to support the clinician's discharge recommendations (Crennan & MacRae, 2010; Jette et al., 2014; Tsai & Peterson, 2019). "The consistent use of functional measures may inform the development of clinical guidelines and protocols, encourage client-centered care, facilitate shared decision making, and promote a more objective evaluation of client outcomes" (Raad et al., 2020, p. 93). The final literature-supported component of the program is the implementation of assessing discharge readiness to provide the client an opportunity to reflect on discharge from the hospital and to identify any potential barriers or concerns (Bobay et al., 2010; Falvey et al., 2016; Grimmer et al., 2006; Wallace et al., 2019). As supported by the literature, these processes will allow the therapist to capture essential, yet holistic information about client's occupations for an optimal discharge and

functional independence post-discharge. While many acute care settings are incorporating the use of one or more of these strategies, there is no evidence to show that all are being used in a cohesive, programmatic manner for increased standardization and quality of care (Crennan & MacRae, 2010; Griffin & McConnell, 2001). While the breadth of the evidence reviewed is difficult to replicate as a single intervention, the compilation highlights the best practices for occupational therapy in acute care and keys to enhancing the process.

CHAPTER THREE – Description of the Proposed Program

Program Introduction

The proposed program is called Collaborative Care to reflect a cooperation and collaboration between acute care occupational therapists and their clients or patients. It focuses on early referral, the use of client-centered, discharge-minded, and evidenced-based assessments and interventions to improve the delivery of and outcomes from acute care occupational therapy. The intent of the program is to increase the quality and efficiency of client-centered occupational therapy services within the acute care environment.

Intended Recipients of Program

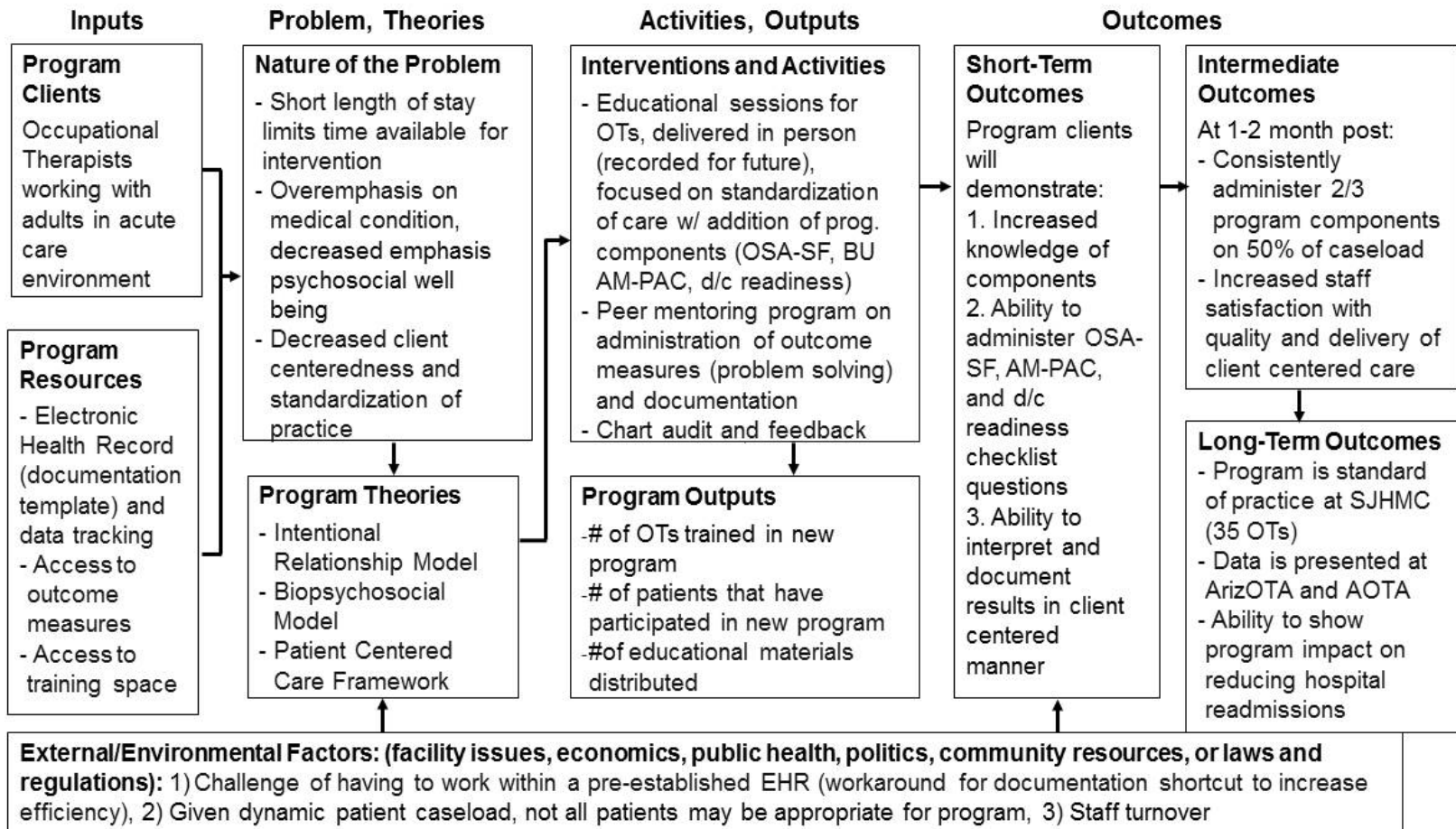
Collaborative Care is designed to address occupational therapy practice within the acute care environment. The intended program participants are occupational therapists practicing in the adult setting at St. Joseph's Hospital and Medical Center (SJHMC), which is located in downtown Phoenix, Arizona. This includes approximately 35 full time, part time, and per-diem occupational therapists, who will be implementing the program. They will receive programmatic education in order to improve and standardize current practice.

Patients within the acute care environment are the beneficiaries of the program. There is an expectation that patients can and will participate in the evaluation process by providing information and identifying goals for acute care and upon discharge. However, it will be necessary for the occupational therapists to determine appropriateness of patient participation. In cases where a patient lacks the ability to actively participate due to

communication and/or cognitive deficits, a family member or caregiver could serve as the patient's representative in the Collaborative Care program. The goal after program implementation will be to collect patient satisfaction information from a survey in order to gain information about patient's experiences with their occupational therapists; the program components will be adapted based on this critical feedback.

Figure 3.1. Program Logic Model

Program title: Collaborative Care



Program Components of Collaborative Care

1. Early, Appropriate, and Consistent Referral to Occupational Therapy Services with a Physician Champion

Early screening has been found to consistently increase appropriate referrals, allowing occupational therapists to initiate services earlier in the hospital stay, creating an opportunity to effect greater change and optimize discharge planning (Hobbs et al., 2010; Pears, 2016; Sutton, 1998; Tan et al., 2016). “Early identification of patients requiring occupational therapy allows more time to provide effective interventions and implement comprehensive, integrated and client-centered treatment plans” (Tan et al., 2016, p. 1611). The available literature suggests that the few screening tools rely on nursing staff for administration (Pears, 2016; Tan et al., 2019). There are several competing nursing initiatives at SJHMC such as infection and fall prevention programs, many of which are directly required for The Joint Commission hospital accreditation programs (Joint Commission, 2020). Due to this, nursing initiatives typically trump other initiatives including those from ancillary services. The decision to recruit a physician champion to screen for occupational therapy services versus using nursing services was an intentional aspect in the development of the Collaborative Care program. To further explain, physicians and occupational therapy both have a vested interest in preventing hospital readmissions and in facilitating safe discharges from the hospital. An additional benefit of utilizing a physician is their working knowledge and experience of the scope of acute care occupational therapy.

Physicians are well versed in asking many of the screening questions such as identifying: cognitive or functional changes, a history of falls or readmissions, or a

concern for health and medication management. These specific concerns were most likely to trigger an appropriate referral to occupational therapy using the MBTOTR. The goal is to ensure a consistent advocate for occupational therapy services as well as to drive an appropriate referral stream. This partnership will initially be trialed with one physician, who will write orders for their specific caseload, as patients are identified to need occupational therapy services. The response time from order to evaluation will be tracked, as well as safety concerns identified, number of treatments and treatment minutes provided prior to discharge, and hospital readmission reasons. These metrics will be used to highlight the value added by occupational therapy and will be used to strengthen this relationship and their advocacy.

With this partnership, the occupational therapy department will show the relationship between early referral to services and the likelihood of follow up for treatment, family and patient education, and discharge readiness. The physician champion has been pre-identified for the Collaborative Care program and is an experienced and well-connected hospitalist. His experience with early referral to occupational therapy will hopefully influence others in his medical group and resident cohort. Specific case examples combined with the quantitative data from the trial of occupational therapy services can be directly shared with his peers, residents, and medical students. The goal is for the physician champion to lead educational initiatives throughout the hospital that promote early referral to occupational therapy services. These initiatives will also be presented to rotating medical students, residents, and contract staff on an annual basis by the champion and the program lead. See Table 3.1

for an educational handout for physicians used to promote an early and appropriate referral.

Table 3.1. Early Referral Education to Hospital Medical and Resident Staff

| While this guide is a simplification of diagnoses/deficits, the most critical consideration is EARLY REFERRAL in order to maximize time for occupational therapy intervention and recommendations. | |
|---|------------------------------|
| Diagnosis | Consult Occupational Therapy |
| History of falls | X |
| Change in cognition | X |
| Change in ADL function (need DME) | X |
| Change in sensory function | X |
| Failure to thrive at home/readmission | X |
| Multiple medical conditions and/or | X |
| What patients are <i>not</i> appropriate for skilled Acute Care Occupational Therapy? | |
| <ul style="list-style-type: none"> • End of life care (unless family education is required for safe patient care) | |
| <ul style="list-style-type: none"> • Patients who cannot actively participate in skilled therapy (i.e., passive range of motion) • has normal tone, supine slide transfers to a Cadillac chair.). | |
| <ul style="list-style-type: none"> • Patients who are at their functional baseline (when in doubt, order OT) | |
| <ul style="list-style-type: none"> • Patients who are not yet stabilized (i.e., stroke in evolution, spine not yet cleared) | |

2. Thorough Client-Centered Intake Assessment with Collaborative Goal Setting

Of particular relevance in the literature review was the Occupational Self-Assessment (OSA)-Short Form (Popova et al., 2019), which is a self-report measure used to guide client-centered goal setting and intervention planning in occupational therapy (Model of Human Occupation [MOHO], 2020). This three-part assessment has 12 items and specifically addresses perceived competence in completion of activities of daily living (ADL) and instrumental activities of daily living (IADL) (Popova et al., 2019). Moreover, it is sensitive to the timeliness required for acute care taking between seven and 15 minutes to complete. It was found to support client engagement and participation in the goal setting process specifically in the acute care setting (Popova et al., 2019).

“Client provider collaboration on goals can result in shorter hospital stays and better goal attainment” (Neistadt, 1995, p., 428). While it may not be appropriate for every client in acute care, this assessment can quickly facilitate a client-centered practice by determining priorities for change (MOHO, 2020).

The OSA-SF has been purchased and the assessment forms can be readily reproduced and distributed to occupational therapy staff members after training is completed. Training will review the three parts of the assessment: self-assessing performance of skills, ranking importance in their life, and prioritizing four areas targeting for improvement (MOHO, 2020). Clients are able to identify how well they perform the 12 ADLs or IADLs, then further rank how important those same tasks are to them. Finally, they identify and prioritize four areas to address for improvement which the occupational therapist can directly translate into client established goals or use the information for collaborative goal setting process. In order to standardize documentation on results of the OSA-SF and its contribution to collaborative goal setting, a documentation shortcut will be created and utilized by staff. See Table 3.3 for examples of documentation shortcuts to increase therapist efficiency with interpretation and documentation of assessment data.

3. Functional Assessment and Outcomes

The literature review highlighted several functional capacity assessments to support discharge disposition and interdisciplinary decision making (Crennan & MacRae, 2010; Falvey et al., 2016). These assessments need to go beyond patient self-report and have an observational component in order to grossly assess functional abilities and the

implications of those deficits on discharge from the hospital (Nielsen & Waehrens, 2015). One tool which addresses the need to assess the client's functional capabilities while being sensitive to the time constraints in an acute care setting is the Boston University Activity Measure for Post-Acute Care (AM-PAC) daily activity short form (Jette et al., 2013). It assesses the six basic self-care tasks including upper and lower body dressing, self-feeding, grooming, bathing, and toileting. These tasks are measured based on assistance required, on a scale of one for dependence to four for independence, with a total score out of 24. This tool also has a direct prediction of acute care discharge recommendation based on the cumulative score, with recommendations supporting post-acute placement for rehabilitation of less than 18 (Jette et al., 2014). This assessment is widely used in acute care given its ease of completion and predictive ability, as well as its excellent psychometric properties and strong correlation with the gold standard FIM (Keith et al., 1987).

Since this assessment is already widely utilized within the institution, only a brief review of its predictability will be discussed with the occupational therapists. In general, its use currently is to demonstrate a percentage of impairment with self-care function, while the prediction of discharge disposition is less utilized. Education of the additional clinical utility will be provided during training in order to enhance clinical decision making with regards to discharge recommendations. A documentation shortcut will be provided to all occupational therapists to aid in standardization and efficiency, see Table 3.3 for examples. An audit will be completed to ensure its proper usage and feedback will be provided to increase understanding of its use.

4. Discharge Readiness Assessment

Hospital discharge readiness is defined as physical stability, adequate support, psychological ability, and adequate information and knowledge to support a safe discharge from the hospital (Galvin et al., 2017). Assessing discharge readiness is a component of discharge planning, which is one of the primary responsibilities of the acute care occupational therapist. Within short lengths of stay, it is imperative that occupational therapists quickly and efficiently identify barriers and potential solutions to discharge, as identified by the client.

The literature highlights the value of client participation in the discharge planning process, not only to improve client satisfaction, but also to obtain specific concerns or needs directly identified by the client using a variety of tools (Bobay et al., 2010; Falvey et al., 2016; Grimmer et al., 2006; Harrison et al., 2016; Wallace et al., 2019). Although these tools are well supported in the literature, they are not currently utilized within SJHMC by occupational therapy or the case management team. Tools reviewed include the Brief-PREPARED measure (Graumlich et al., 2008), the Readiness for Hospital Discharge Scale (RHDS) (Weiss & Piacentine, 2006), and a discharge readiness checklist (Grimmer et al., 2006). While none of these three self-report tools would be specifically replicated in their entirety given their length and scope; the tools were reviewed and items deemed to be highly relevant to a client's perceived preparedness for discharge were compiled for this program. These items are specifically related to the ability to care for oneself, understanding medications, and identifying concerns about discharging home. The objective of the inclusion of these specific questions will be client

empowerment and readiness through discussion with and participation in occupational therapy.

Method of Education Delivery

A series of educational sessions will be completed to review the intent of Collaborative Care, including the evidence to support the need for change in current practice, the program proposal with specific program components, and the planned steps for implementation. These sessions are specifically designed for acute care occupational therapists. Education will be provided in person, however, based on the number of schedules involved, some participants may need to attend virtually. The sessions will be recorded for future training purposes, for students, and for new hires. There will be didactic portions of the training that provide information on the evidence base and the background of the programmatic changes/standardization as well as hands-on practice with peers. The hands-on portion will include administering outcome measures including receiving peer feedback on interpretation of results and methods for documentation. The program includes both subjective and objective measurement approaches; these are complementary in that they serve to deepen and broaden our understanding of each client as a unique individual. For future training, the hands-on training and peer mentoring components will be incorporated into staff orientation and onboarding as the standard delivery of care. Below is an overview of teaching methods:

- Live educational sessions with occupational therapy staff
 - Virtual attendance if schedules conflict

- Live peer mentoring sessions in small peer groups facilitated by peer program champions
- Chart audits with feedback

The author, who is the acute care occupational therapy program coordinator, along with three peer program champions will administer the educational trainings. The program champions will be responsible for the peer mentoring sessions while the coordinator is responsible for completing chart audits, providing feedback, and collecting data. Peer mentoring sessions will occur within the same week as the didactic portion to increase practice and retention of information. These sessions will use a variety of methods to aid in translating knowledge to action and into routine (Cook et al., 2007; Graham et al., 2006). Cook et al. (2007) found the reported use of outcome measures increased significantly following education. Additionally, the usage increased when assessments were ready to use, which all of the aforementioned assessments are. See table 3.2 below for knowledge translation activity examples.

Table 3.2. Knowledge Translation Activities

| Description | Details/Rationale |
|--------------------|--|
| Learning Profile | <p>This was previously administered by the occupational therapy lead and completed by occupational therapy staff as a means of self-assessment of their individual needs and learning preferences.</p> <ul style="list-style-type: none"> • Training will be tailored to these results including a combination of self-study, small workgroups, and online modules/tests. |
| In person training | <ul style="list-style-type: none"> • Small workgroups will review the OSA-SF, BU AM-PAC daily activity, discharge readiness checklists, and documentation. • Workgroups are to be peer led by peer champions who will serve as mentors. This peer led model is intended to increase comfort with asking questions • Follow up sessions will be led by occupational therapy lead to discuss adoption of program components with results of audit and review utility of documentation shortcuts |
| Electronic modules | <p>Creation of self-directed learning modules focused on:</p> <ul style="list-style-type: none"> • the tenets of occupational therapy practice which are currently inconsistent or lacking in acute care practice • the addition of program components to address the identified gap in care • the intended outcomes of the program |

Collaborative Care training will utilize a number of learning theories to maximize knowledge acquisition and translation into practice. This includes behavioral, cognitive, and experiential learning theories. Mukhalalati & Taylor (2019) identify these three overarching theories to be the most successful and widely used for educating healthcare professionals. Components of all will be incorporated into Collaborative Care training. Positive feedback and reinforcement are elements of behaviorism which will be provided by peer practice and mentoring sessions as well as feedback from chart audits. The initial training sessions utilize a verbal didactic approach to introduce novel concepts to make learning explicit, which is using a cognitive approach. Peer practice and peer mentoring

in real time with clients both represent opportunities to learn by action and experience, representing the use of experiential theories. Finally, adult learning theory will be utilized to approach the adult learner (occupational therapy professional) with respect, honoring their experience and perspective, and to providing training that is relevant and goal oriented. These are all principles of the adult learning theory which was initially introduced by Knowles in 1980 (University of Queensland, 2017).

Following training and peer mentoring, acute care occupational therapists will be charged with delivering the Collaborative Care program as part of providing standardized care. As mentioned, SJHMC's department of acute care occupational therapists consists of 35 staff members from full time to per-diem. The entire staff will be responsible for learning and administering the program. A long-term program goal is to incorporate the assessments (OSA-SF, BU AM-PAC, discharge readiness checklist) into the electronic health record (EHR) system. Embedding these changes into the EHR will be a lofty endeavor as SJHMC is part of a large network of hospitals and changes must be approved by the governing council. This step is very important as documentation is the central tool for communication (Pain et al., 2017). In the implementation phase, occupational therapists will be provided with a master (local) list of a shortcut phrases providing a template for documentation. Each shortcut includes a description of the components, interpretation of scoring, and implications for discharge, see Table 3.3.

Table 3.3. *List of Recommended Documentation Shortcuts*

| Dot Phrase | Content of Documentation Shortcut |
|-------------------|--|
| .osaf | The Occupational Self-Assessment Short Form assesses a clients' competence with completion and ranking of importance of 12 items including basic self-care, caring for one's home, as well as the ability to maintain meaningful life roles. The client identified the following as items of concern ... Additionally, the client identified the following areas which were translated to goals to address within the occupational therapy plan of care. |
| .buampac | The Boston University Activity Measure for Post-Acute Care Daily Activity assesses the six basic self-care tasks (bathing, upper and lower body dressing, grooming, eating, and toileting). Each item is scored from 1 to 4 on the basis of the amount of difficulty a patient has or how much help is needed from another person in completing the task. The higher the score the more the independent a patient is. The patient scored the following: 16/24 reflecting moderate assistance with self-care tasks. Based on this score, the best recommendation for discharge is a post-acute rehabilitation setting, either rehab or SNF. |
| .dcreadiness | Hospital discharge readiness is defined as physical stability, adequate support, psychological ability and adequate information and knowledge (Galvin et al., 2017). Assessing discharge readiness is a component of discharge planning, which is one of the primary responsibilities of the acute care occupational therapist. |

Role of Program Personnel and Stakeholders

The personnel required to implement the program include an occupational therapy leader, which could be a coordinator or lead therapist, as well as a supportive team of occupational therapists willing to participate in the program. The responsibilities of the occupational therapy lead include scheduling education sessions to ensure attendance by all staff, creating educational resources, implementing the program including staff support, mentoring, auditing, and providing feedback. The program lead additionally is the evaluator following program implementation including collecting survey data of therapist and patient satisfaction, organizing and coding data, and determining the need

for programmatic adjustments based on recurrent suggestions.

Staff occupational therapists are the participants in the program. Ideally, they will be open-minded, eager to learn, willing to provide feedback on the program and their overall satisfaction pre and post program. Among those staff therapists, there will be three occupational therapists who will serve as peer mentors and program champions. Peer mentors will volunteer for this additional responsibility and will receive training prior to staff therapists.

The role of management is particularly important to advocate for evolution and change, to acknowledge and support the time required for training and implementation, and to endorse and promote occupational therapy efforts. Management in this case includes direct leaders to occupational therapy and at the highest levels of leadership, the hospital administrators. Involving these stakeholders will be crucial for support and advocacy for occupational therapy.

The long-term goal of this program is generalizability, or the ability to replicate Collaborative Care to other acute care hospitals. It will be able to be implemented by any occupational therapy working in acute care with adults that has the support from their coworkers to evaluate and change practice. This could include occupational therapy leaders (such as coordinators, managers, senior therapists), directors of therapy departments, or staff occupational therapists.

Table 3.4. Collaborative Care Personnel Descriptions

| Role of Personnel/ Prog Stakeholders | Description of Role |
|--|---|
| Occupational Therapy program coordinator/ Collaborative Care program lead | Author of program, provide didactic portion of training to highlight evidence-based practice guidelines, coordinate trainings for staff with alternative schedules, complete chart audits with feedback, and collect data for program implementation. |
| Occupational Therapy program champions | Volunteer position available to three staff therapists who will receive program training first, serve as peer mentors during practice with peers, and assist in collecting data. |
| Occupational Therapy staff | Willing participants of Collaborative Care, eager to learn and implement program in order to impact client centered practice. |
| Therapy Management and Leadership | Advocacy for change and practice evaluation, support for loss of productivity during training times, and implementing program as quality indicator of excellence for occupational therapy. |
| Physician Champion | Advocate for occupational therapy services through early, appropriate, and consistent referral. Provide education to students, residents, and colleagues about outcomes from occupational therapy services. |
| Hospital Administrators | Support ancillary services, specifically occupational therapy and their efforts to provide client centered care and reduce hospital readmissions. |

Desired Outcomes

The implementation of the proposed comprehensive program, Collaborative Care, aims to ensure a streamlined process for occupational therapy in acute care including an early, client centered, thorough, and discharge focus. Program outcomes include:

1. Increased patient satisfaction with occupational therapy services
2. Increased standardization of acute care occupational therapy evaluations (quality assurance)
3. Increased client-centeredness and collaboration with goal setting and discharge process

4. Increased therapist satisfaction with holistic occupational therapy approach
5. Decreased hospital readmissions attributed to comprehensive occupational therapy evaluation and treatment and sound discharge recommendations

Surveys will be issued to therapists before and after participating in Collaborative Care training in an effort to capture both qualitative and quantitative changes in satisfaction with practice. Staff surveys will contain both open ended and closed Likert scale questions. Clients will voluntarily complete surveys with closed questions using the Likert scale, following participation in Collaborative Care.

Potential Barriers and Challenges

There are numerous challenges to overcome with this program including time constraints, individualizing training needs, gaining buy-in from staff, and ensuring consistency. Time constraints include the competing priorities of all the program participants (program lead, program champions, staff therapists, and physician champion). There are significant productivity expectations in a clinical environment which can compete with growth opportunities such as educational and developmental efforts. Some solutions considered to adjust for productivity expectations are creative scheduling of trainings (days without other meetings, straddle two pay periods, etc.).

Individualizing training needs refers to therapists' learning preferences and their unique schedules. With a large staff, there are a variety of schedules to consider and accommodate for training. The education sessions will be available in virtual format for those who are unable to attend in person with the added incentive of paid attendance. Peer mentoring support and feedback will need to be individualized to meet learning

preferences and will need to be available to support program implementation seven days a week. Additional training will be provided to support the peer program champions' ability to adapt learning approaches from didactic to hands-on to reinforce sessions.

Gaining buy-in from staff within a large, diverse department of occupational therapists will be also be a potential challenge. A pre-program survey comprised of open-ended questions will assist therapists in evaluating their own practices and assumptions. This program is not only asking hard questions about their current practice, but also asking to acknowledge that change is necessary. It will be critical to gain their support and commitment to the program for its success.

Lastly, ensuring consistency in the use of program components and assessments may pose a challenge. This will be addressed through thorough trainings, individual practice and feedback sessions with peer mentors, periodic observations and intermittent refresher opportunities, and use of data collection for departmental wide program feedback. Building components into the EHR will be a long-term goal in order to increase the programs longevity. In the short term, documentation shortcuts will aid in efficiency and data collection.

Conclusion

Collaborative Care is focused on increasing the quality and efficiency of occupational therapy in the acute care environment. This program utilizes an early referral to maximize time for intervention and standardizes the use of client-centered, discharge-minded, and evidenced-based assessments. The intent of the program is to

improve the satisfaction of occupational therapists by reinvigorating their holistic and client-centered practice, and for patients who receive superior client-centered care.

CHAPTER FOUR – Evaluation Plan

Program Scenario

The goal of the Collaborative Care program is to meaningfully improve the current practices of acute care occupational therapists. These changes are for the betterment of patients, the hospital organization, and the occupational therapists who are providing care. Collaborative Care is an educational program designed for clinical acute care occupational therapists intended to aid in standardizing care provided to inpatients. The program will be delivered in a series of educational sessions, available in person and virtually, to accommodate staff schedules. The training sessions review the evidence to support the problem and the four program components including hands-on practice and peer feedback.

The following describes a comprehensive plan in order to evaluate the program as a whole. This will be accomplished by a mixed methods design with quantitative and qualitative research methods. The disseminated findings of this program evaluation research will contribute to elevating service delivery that is intended to enhance patient outcomes and staff satisfaction. The findings will be utilized by clinical occupational therapy staff, therapy leadership, hospital administrators and physician partners, as well as the state occupational therapy association.

Vision for the Program Evaluation Research

Short term findings of the program evaluation research are intended to translate knowledge into clinical skills that optimize acute care occupational therapy. The short term results will be critical to reveal the willingness of staff to reflect on their own

practice, the ability to mobilize therapists into a supportive team, and to demonstrate how occupational therapy can contribute to the hospital organization as a whole. The ultimate goal in the short term is to improve staff and client satisfaction.

The long-term findings will contribute to the understanding of how a holistic profession such as occupational therapy working within the medical model can remain loyal to their holistic tenets. The results could be converted to a continuing education course for other hospital systems interested in elevating traditional acute care occupational therapy practice. This would be one method of generalizing the program to other institutions. The results could also be used to influence occupational therapy students' level of preparedness prior to acute care fieldwork experiences.

While the prospect of “research” continues to be daunting, this program is an excellent example of how to thoughtfully evaluate the evidence to determine knowledge gaps and to make quality changes in practice. The objective is to use the results to make substantive change in current acute care occupational therapy at SJHMC. Below illustrates an example of how study findings might be utilized.

In the landmark study by Rogers et al. (2017), spending on occupational therapy services was found to reduce hospital readmissions as compared to other hospital services. What did occupational therapy do to reduce readmissions? They provided individualized intervention that reduced barriers to discharge and improved functional status by addressing deficits. Additionally, they provided direct education to patients and caregivers to increase discharge readiness. The Collaborative Care program incorporates several crucial components that is intended to impact readmissions including client centered care, collaborative goal setting, early referral, functional assessment, and discharge readiness. The program evaluation research results will be utilized by hospital administrators to highlight the value added by occupational therapy to client centered care, client and staff satisfaction, as well as reducing unnecessary hospital readmissions.

Engagement of Stakeholders

Stakeholders are defined as having a care or concern in something. Collaborative Care has several important groups of people involved and invested in the program. These include participants in the program including both the program lead, program mentors, and the occupational therapists learning the material and implementing the program with acute care patients. Although not directly involved, therapy leadership and hospital administrators also have a vested interest in the outcomes of the program.

List of Key Stakeholders

- Occupational therapy staff
- Program champions/peer mentors
- Acute care therapy manager
- Senior director of therapy services
- Physician champion for program
- Hospital research staff/statistician
- Hospital administrators

The program champions will be identified by their interest and willingness to participate in the novel program. These individuals have already expressed an interest in expanding their holistic practice and are leaders within the department. At soft launch, the program will be introduced to these three to five individuals as a means of trial implementation to ensure feedback and necessary changes are incorporated prior to full implementation. These program champions will serve to increase staff morale with the new changes, to provide one on one peer mentoring, and to administer some of the

educational sessions to staff. They will also assist with data collection.

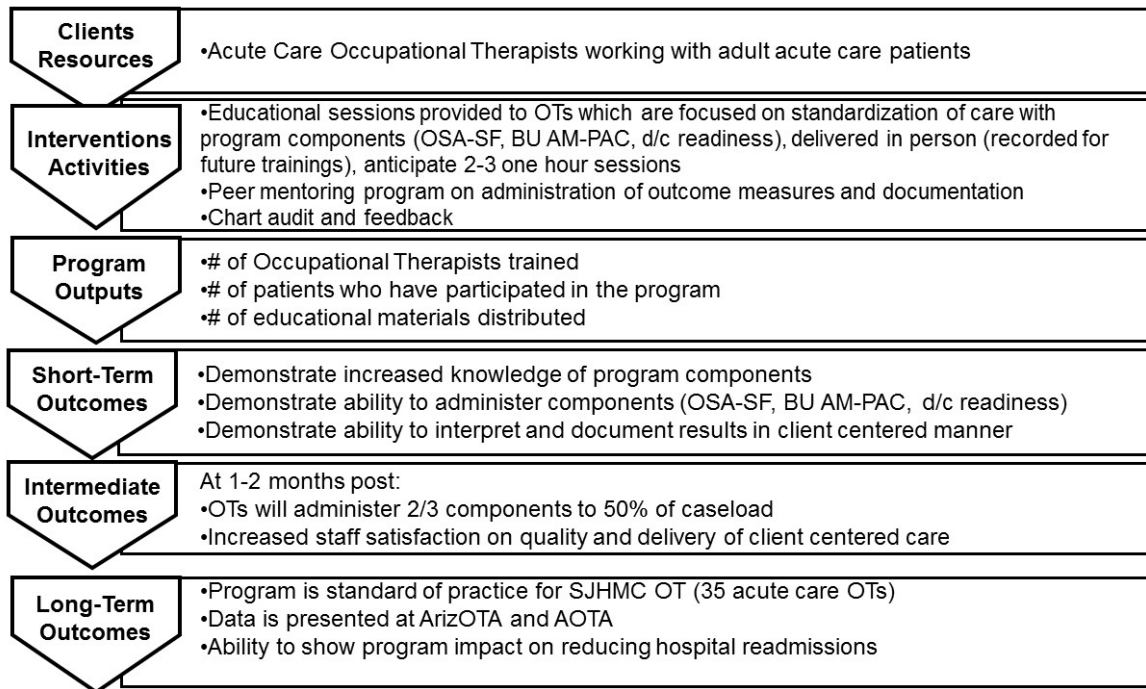
The role of the hospital research staff, who are employees of SJHMC, will be crucial in assisting to draft an institutional review board (IRB) protocol, to submit and guide revisions, and to educate on research policies that will be essential for research methodology. While the research staff is not necessarily vested in the specific outcomes of the occupational therapy research; it is their role to assist clinicians through the research process to ensure compliance and adherence to regulatory requirements. The statistician on staff will play a crucial role with data analysis following data collection.

The physician champion has a critical role to play to drive a steady stream of appropriate occupational therapy referral to maximize the time available for intervention. The physician champion will also be added to the IRB submission as an investigator, however this is not a requirement at SJHMC. Since the physician champion is also the chief of medical staff, his role also includes serving as an educator to other physicians, residents, and medical students on the role of occupational therapy and the introduction of Collaborative Care.

The aforementioned relationships with peer champions, research staff, and the physician champion have already been established in previous chapters of this doctoral manual. Each stakeholder group will be invited to participate in separate meetings, in order to provide appropriate levels of program specificity, to maximize knowledge and engagement while fostering the relationship. For example, the occupational therapists administering the program will need to be provided with much more substantive information about the evidence that was utilized to create the program as compared to

hospital administrators, who will be more interested in how the program impacts throughput, discharge planning, and patient satisfaction. Following these educational program meetings, stakeholders will be issued an anonymous survey for honest feedback and suggestions on the program.

Figure 4.1. Simplified Logic Model for Use with Stakeholders



Preliminary Exploration and Confirmatory Process

Within each stakeholder meeting, program information will be presented including the background of how the problem the program is addressing was identified, including a visual representation, some of the critical research that supports the program components, and finally on how the research is being completed on the program’s effectiveness. This information will be provided in a PowerPoint presentation. Handouts will be available with a bulleted list of the program components, the intended outcomes,

as well as a list of references. Since the stakeholders have different interests in the program, it will be critical to ensure the content matches to spark interest. For example, staff will be more vested in their own satisfaction, their peers' satisfaction, and their perceived efficacy; in contrast, administrators will be more vested in client satisfaction and how occupational therapy is reducing readmissions, which is their bottom line. Anonymous surveys will be administered following the meetings to obtain honest feedback on the program in order to make necessary modifications. Additionally these surveys will be an opportunity for feedback on the program research questions, design, and proposed methodology. The need for additional meetings with stakeholders or the development of subcommittees will depend on the results of said surveys. Evidence based information about the choice of data collection tools will be shared with stakeholders to gain their buy-in on data collection methods and tools.

Program Evaluation Research Questions by Stakeholder Group

Each unique group of Collaborative Care stakeholders will have different interests and objectives to consider for program development and implementation. Knowing this, it will be crucial to pursue the valuable perspective of participants in each group using research questions tailored to their specific needs (see Table 4.1). This targeted approach will allow the Collaborative Care program to more effectively understand and represent each group's varied levels of knowledge about acute care occupational therapy practice and vested interest in the success of an occupational therapy initiative within the complex SJHMC system.

Table 4.1. Program Evaluation Research Questions by Stakeholder Group

| Stakeholders | Types of Program Evaluation Research Questions |
|--|---|
| Acute care OT program coordinator, the researcher | <p>Qualitative:</p> <ul style="list-style-type: none"> • Is the program perceived to be of value and meaningful? • Does the program impact OT's sense of efficacy? • Does the program increase OT's sense of their holistic practice? <p>Quantitative:</p> <ul style="list-style-type: none"> • Will the OTs participating in the program report increased knowledge and skills in administering the components of Collaborative Care? • Does the program impact patient satisfaction with client centered care? • Will the program have an impact on increasing discharge readiness and decreasing hospital readmissions? |
| Acute care OTs, and peer program champions, who are both persons actively involved in program delivery | <p>Qualitative:</p> <ul style="list-style-type: none"> • Was the program content relevant to acute care OT practice? • Were the program education sessions delivered at an optimal pace and intensity for learning? • Were the program sessions combined with peer mentoring/practice sufficient in order to implement the program? • Is there anything that should be changed to improve program content or delivery? • Is the program meaningful? <p>Quantitative:</p> <ul style="list-style-type: none"> • Did participants gain needed knowledge and skills in order to implement the program? • Does the program increase efficiency in acute OT practice as measured by decreased documentation time and increased patient caseload? |
| Manager and director of therapy services, hospital administrators, physician champion, who are all facility administrators | <p>Qualitative:</p> <ul style="list-style-type: none"> • Does the content of the program match organizational goals? • Were program participants sufficiently prepared to apply the learning content in their clinical practice? • Did the patients/families participating report a favorable experience with the care received? • Were any problems or issues reported? <p>Quantitative:</p> <ul style="list-style-type: none"> • Is there an increased cost to implementing IACOTP? • Can the research data be used to demonstrate improved quality of care? • Has the program positively impacted employee reported job-satisfaction? |

Research Design

The research design for evaluating the Collaborative Care program will utilize a mixed method design. Pre and post program surveys will be issued to the occupational therapists in the acute care department. The purpose of the preliminary survey is to stimulate self-reflection on their ability to adhere to holistic tenets of occupational therapy and their current satisfaction with practicing in the acute care environment. The questions will be open ended in order to explore different themes about practice. There will also be a component of the survey that is assessing knowledge.

The post-program survey will utilize a Likert scale with specific questions to gain feedback and overall satisfaction with the actual program training and program itself. Within this post-program survey there will also be open ended questions for reflection on additional training needs and feedback on specific program components including their comfort level with administration. Based on the results from staff surveys, focus groups will be tailored to delve deeper into topics revealed by the surveys. The focus groups will be led primarily by the program champions as opposed to the researcher to have a less emotional and more neutral facilitator. The focus groups will remain intentionally small with three to five occupational therapists in order to promote honesty and safety for sharing.

Following program implementation, surveys will be issued to patients who receive the program, with a combination of Likert scale questions and open-ended questions. Sample questions may include:

- Did the occupational therapist assess how ready you felt for discharge?

- Did they assess how well you were taking care of yourself (functional ability)?
- Did they collaborate with you on what it most important to you to address during your hospital stay (client-centered care and collaborative goal setting)?
- Were you satisfied with your occupational therapy services overall?

Retrospective chart reviews will also be completed to assess both quantitative and qualitative components. Quantitative components include completion and documentation of program components, readmission data, and patient outcomes. Qualitative components include the interpretation of assessment results and establishment of client-centered plan of care embedded within documentation. The initial intent of this program evaluation research study is to show an improvement in staff and client satisfaction with the implementation of a more holistic and client-centered approach.

Methods

The research department at SJHMC is robust and well organized, however it is under- utilized by the therapy department to support research. The process to initiate an IRB submission is to complete CITI training, to request an Imedris account, to complete a conflict of interest and submit a current curriculum vitae, and finally to complete and submit an IRB protocol with study specific information. Within the protocol, there are specific sections about the study design, ethics, background, and confidentiality.

Confidentiality in this study will be assured by utilizing RedCap which is software for data collection which is HIPPA compliant. The results of the surveys will be stored initially in the researcher's secure private computer drive prior to translating to RedCap.

The surveys are completed and returned anonymously, which increases the

confidentiality.

Formative/Qualitative Data Collection Methods

The qualitative data will be collected from staff before and after program attendance in the form of a pen/paper survey within the hospital setting. The virtual attendees will have a survey emailed to them, which can be completed and returned electronically or via pen/paper. The open-ended pre-program survey questions are specifically about their reflection and satisfaction on their acute care practice, which is given before program implementation. The open-ended post-program survey questions are specifically regarding the perceived value of the program and its components, their comfort with administration, their satisfaction with the program and suggestions for feedback. The post-program survey is given following program attendance to all sessions. Once themes are analyzed from the surveys, if focus groups are indicated, they will take place in person in small groups of three to five occupational therapists and will be facilitated by the peer program champions. Additional surveys will be given after program implementation to continue to gain additional feedback from staff, program champions, and physician champion.

Methods for Formative/Qualitative Data Management and Analysis

The responses to the open-ended survey questions will be analyzed using descriptive methods in order to compare and contrast the feedback from the occupational therapists. Responses will be transcribed and coded in order to identify recurrent themes, which will be agreed upon by the principal investigator and the qualitative statistician. The staff statistician, who is well versed in qualitative analysis, will be consulted to

analyze preliminary data and to make recommendations for the use of specialized programs for analysis. The use of the statistician will increase the accuracy and trustworthiness of the findings.

Summative/Quantitative Data Collection Methods

The program evaluation process aims the Collaborative Care program and its impact on staff knowledge and satisfaction, patient satisfaction, thorough documentation reflecting client-centered care, and hospital readmissions. Staff knowledge and satisfaction, as well as patient satisfaction are measured by surveys using Likert scales. Documentation is measured by completion of the program components, interpretation of the results, and establishment of client-centered plan of care with collaborative goals. This will be confirmed with documentation review as well as ratings by trained observers in the initial soft launch phase. The data will be collected at SJHMC. For the initial program implementation, data will be collected from 25 patients in which all of the program components were implemented. The recruitment for survey completion will be voluntary with informed consent including an in-person explanation following the occupational therapist's session. Inclusion criteria includes the ability to understand and read English, to cognitively able to follow directions, however family may assist, and to understand the program intent. Following program modifications, an additional 25 patients will be recruited to participate in satisfaction surveys.

Methods for Summative/Quantitative Data Management and Analysis.

Data from chart reviews will be collected and organized using RedCap. Data from surveys will initially be manually entered into Excel and saved in the researcher's

private computer drive. Survey data will be analyzed with the assistance from the statistician to determine if desired changes occurred using numerical ratings from surveys. The majority of the reported results will be descriptive statistics. Since the survey data is ordinal, the nonparametric statistics of significant interest are the range and median, and potential correlation between items. There may be reportable inferential statistics in the form of pre and post ratings from knowledge acquisition and satisfaction.

Disseminating the Findings of Program Evaluation Research

The findings of Collaborative Care program evaluation will be disseminated through a number of methods, depending on the stakeholder audience. For those with preliminary knowledge about the program, such as occupational therapy leadership and hospital administration, findings will be distributed through the dissemination of a two-page executive summary. This summary will highlight program components, outputs, results and recommendations in a succinct, yet impactful, manner. A one paragraph press release will be shared with the state occupational therapy association, ArizOTA, to draw attention to the importance acute care issues and the need for an acute care special interest section. The participants of the program, acute care occupational therapists at SJHMC, will be provided with a more thorough explanation of the results, since they have not only participated in the program outcomes but will have a vested interest in understanding if the program was more effective than standard care. This thorough report will be in the form of a PowerPoint presenting the data following program evaluation during a staff meeting. In all of the aforementioned reports, survey findings will be presented visually in table format to ensure information is presented in an

accessible format (Newcomer & Triplett, 2015). Tables may provide more information depending on audience. Finally, a two-sentence summary could be used to explain the program and its results to participating patients and families, as the program transitions to standard care.

Conclusion

Evaluating Collaborative Care is a necessary step in determining if the program produces the intended outcomes or if modifications are necessary. Adhering to the aforementioned process of thoroughly evaluating the program will increase the rigor of the results. Stakeholders at every level will be provided with the results of the program evaluation to remain informed and invested in the program.

CHAPTER FIVE – Funding Plan

Introduction

The Collaborative Care program is designed to meaningfully improve the current practices of acute care occupational therapists by streamlining and standardizing care. The goal is to implement changes that increase client-centeredness and discharge-mindedness, which is intended to increase patient and staff satisfaction and reduce hospital readmissions. These changes are for the betterment of patients, the hospital organization, and the occupational therapists who are providing care.

The intended program participants are occupational therapists practicing in the adult setting at St. Joseph's Hospital and Medical Center (SJHMC), which is located in downtown Phoenix, Arizona. The participants include 35 full time, part time, and per-diem occupational therapists who will be learning and implementing the program. The program is intended to be a facility run project, with the long-term goal of sharing resources based on outcomes within the larger hospital network of Dignity Health and CommonSpirit Health.

The Collaborative Care program will be delivered in a series of educational sessions, available in person and virtually in order to accommodate staff schedules. The training sessions will review the evidence to support the problem, the programmatic solution including four program components, and opportunities for hands-on practice and peer feedback. The following chapter details the predicted costs associated with program development, implementation, and sustainability over the course of a two-year period.

Local Resources

St. Joseph's Hospital and Medical Center has a wealth of resources embedded within the organization. These local resources include a robust volunteer services department that will be able to assist with program development and implementation. Tasks for volunteers, many of whom are retired, could include word processing to organize materials for teaching sessions, compiling information on different assessments, developing and designing surveys for staff and patients, and preparing PowerPoint packets. Additionally, SJHMC has a well-organized and accessible research department that houses a statistician available for data analysis of survey results to assist in evaluating the efficacy of program. There are also information technology and audiovisual departments, which will be invaluable to accessibility and communication efforts. As an employee of SJHMC, this author has access to basic technology and communication means including telephone, internet, Microsoft Office, and Google Workspace.

Membership in ArizOTA, the state occupational therapy association, could prove a useful resource as well. As a member of this organization, this author has access to resources for dissemination, communication, marketing, and peer networking. Additional local resources include the four occupational therapy academic programs within the metro Phoenix area that have relationships with SJHMC. These academic programs can provide research support (literature review, project scholars, data collection support, etc.), a platform for dissemination of program findings, and an opportunity to imprint the importance of the tenets of Collaborative Care program.

Budget Breakdown

The initial program development costs are largely related to personnel costs for the program developer and lead, this author. The rough estimate for hours invested toward the initial phase of program development is 40 hours per month, increasing to 60 hours during the implementation phase to account for training sessions and staff mentoring. While this program is reasonably within the scope of the author's current role as the acute care program coordinator, the estimation of part-time hours accounts for other responsibilities within this role.

Additional fees that are included in the budget breakdown are for the three occupational therapists who will serve as the program mentors. This time accounts for the unproductive time for staff mentoring, peer practice, and documentation review. The other consultants include audiovisual consultants who will be utilized for filming education sessions and converting them to web-based files. These recordings will be made available for future educational sessions and/or trainings for new employees. Instruction and education time is estimated for the productive occupational therapy staff who program participants, who will be attending program education sessions and implementing the program. These costs are considered mandatory education and are allotted annually, however there is still a cost to the institution for this time. See Table 5.1 for predicted expenses for years 1 and 2 of the program.

The physical costs for program are minimal. The Occupational Self Assessment-Short Form (OSA-SF) is one of the essential program components and costs \$40 for online access and reproducible documents. Additionally, the Boston University Activity

Measure-Post Acute Care Daily Activity requires an annual facility licensing fee of \$195 per year. Other costs include preparing materials for the education sessions.

Table 5.1. Predicted Budget for Collaborative Care Program

| Required Resources | Year 1 | Year 2 | Justification |
|--|---|---|---|
| Personnel (salary & benefits) for program lead | Prog. Dev. Phase \$50/hour x 40 hours/month x 4 months = \$8,000 Prog. Implementation \$50/hour x 60 hours/month x 4 months = \$12,000 Prog. Maintenance/data collection \$50 hour x 30 hours/month x 4 months = \$6,000 Total for lead= \$26,000 | Program Maintenance Phase \$50/hour x 24 hours/month x 12 months = \$14,400 Total for lead= \$14,400 | Based on research of hourly salary for OTs in AZ by Zip Recruiter and U.S. News, the predicted salaries are a general representation for an experienced program lead (10+ years experience) at \$50/hour. |
| Personnel (salary & benefits) for program mentors which include 3 staff occupational therapists, costs are per OT | Hours for staff training \$40/hour x 5 trainings = \$200 Hours for peer practice/mentoring \$40/hour x 20 hours x 3 months = \$2,400 Total for 3 OTs = \$7,400 | Hours for refreshers \$40/hour x 3 trainings = \$120 Hours for documentation review/peer mentoring \$40/hour x 8 hours x 6 months = \$1,920 Total for 3 OTs = \$5,880 | Mentors are staff OTs who volunteer for this additional responsibility with at least 3+ years experience, average wage \$40/hour. |
| Consultants | A/V assistance \$40/hour x 10 hours = \$400 | \$0 | An audiovisual consultant will be required to assist |

| | | | |
|--------------------|--|---|---|
| | | | with assisting in videoing training sessions and converting to files that will remain accessible for years to come for new OTs. There are no anticipated costs for year 2 in the maintenance phase. |
| Instruction | 35 productive staff members averaging \$35/hour, x 5 hours = \$6,125 | 2-3 hours/year. \$35 x 35 staff x 2-3 hours = \$2,450-\$3,675 | The typical productivity expectation is 75% daily for staff OTs. Participation in mandatory education (required modules and program development) is built into the employee's expectation of approx. 40 hour/annually. Year 1 accounts for initial education time (away from clinical care) and year 2 for refresher trainings. |
| Equipment | Microsoft Office \$88.99 | \$0 | If the program were to be purchased, the costs are predicted here. Microsoft Office will be the primary program utilized (Word and PowerPoint for trainings, and Excel for data collection). This is however available as an |

| | | | |
|--|---|---|--|
| | | | employee at SJHMC without additional expense. |
| Supplies | OSA-SF \$40/one time fee for purchase BU AM-PAC facility license fee \$195/year | BU AM-PAC facility license fee \$195/year | The program components include two assessments which have associated fees. |
| OSA-SF https://www.moho.uic.edu/productDetails.aspx?aid=2 BU AM-PAC https://www.pearsonassessments.com/store/usassessments/en/Store/Professional-Assessments/Cognition-%26-Neuro/Activity-Measure-for-Post-Acute-Care/p/P100003000.html#:~:text=Priced%20at%20%24195.00%20per%20year,year%20from%20date%20of%20sale | | | |
| Communication | \$0 | \$0 | As an employee of SJHMC, this author has access to mass communication in the form of daily newsletters, therapy newsletter, social media, marketing department, and mass emails, therefore there are no predicted costs. |
| Materials preparation | Xeroxing and collating presentations for training sessions Costs estimated at 5c/color copy x 50 pages/participant x 35 participants = \$87.50 3 Bound copies for reference = \$50.00 | Color Copies for refresher course, 5c/color copy x 25 pages/participant x 35 participants = \$43.75 Printing costs for dissemination, budget allotment = \$250 | This is considered a local resource as SJHMC has a copy center embedded within it. |
| Travel | In the initial year of the program there are no fees anticipated for travel. | Travel to AOTA conference for program presentation, \$1000, which includes flight, | Following implementation, the plan would be to apply to present the program at AOTA's annual conference. |

| | | | |
|-----------------------------|--|--|--|
| | | hotel, food, gas, and conference fee | |
| Rental of facilities | No fees associated with rental since program will be implemented at SJHMC, rooms available for meetings without cost | No fees associated with rental since program will be implemented at SJHMC, rooms available for meetings without cost | Employees at SJHMC are allowed to schedule and use meeting rooms without any costs |
| Evaluation | No costs anticipated, utilization of data collection-RedCap | No costs, as statistician on staff available for analysis | Considered a local resource, plan includes using research dept |
| Dissemination budget | \$2,002.50 | \$2,002.50 | Refer to dissemination chapter for breakdown of anticipated costs |
| TOTAL | \$42,388.99 | \$27,446.25 | |

Potential Funding Sources

While Collaborative Care is a facility run program, seeking additional financial support from grants or sponsorship would be a small step in demonstrating a commitment to the program. Pursuing these additional sources would highlight an investment in the program by the program developer. The operating budget for SJHMC is multimillion dollars, however every effort to save the organization money, matters. Table 5.2 provides some examples of realistic sources of funding for Collaborative Care. A number of different options are reviewed to demonstrate that funding could be obtained from a variety of different sources from federal to local and from occupational therapy related to more global/general health initiatives.

Table 5.2. Potential Funding Sources

| Agency and Title | Explanation of Criteria and Eligibility |
|---|--|
| AOTF implementation research (IR) grant program (national organization) | Collaborative Care is an occupational therapy specific program. It is directly seeking to improve client outcomes and the client experience in an evidenced based approach. This specific grant is intended to “study the integration of evidenced based health intervention into clinical settings to improve patient outcomes”. https://www.aotf.org/Grants/Implementation-Research-Grant |
| Patient-Centered Outcomes Research Institute (PCORI) grant (federal grant) | PCORI grants seek to answer patient-centered questions about health and health outcomes. Specifically, Collaborative Care is eligible for application of the Broad PCORI Funding as it falls into one of the 5 priority categories, which is improving healthcare systems. Available funds include 1.5 million. https://www.pcori.org/funding-opportunities |
| Corporate Sponsorship from Dignity Health or CommonSpirit Health (corporate donation/sponsorship) | St. Joseph’s Hospital and Medical Center is the largest hospital within the Dignity Health hospital network, and one of the largest in the newly formed CommonSpirit Health (in the merger with Catholic Healthcare Initiatives). One potential avenue for financial support could be a proposal at the corporate level to support this initiative that is intended to improve patient and staff satisfaction and potentially reduce readmissions. Following the results of the landmark study by Rogers et al. (2017), in which OT was found to be only spending category to reduce readmissions. OT has an opportunity to capitalize and act on this finding. Collaborative Care is such a program and is worth the investment for potentially significant and meaningful results. |
| NBCOT Innovation and Impact Awards (national organization award) | While this award does not come with funding, it does provide an opportunity to capitalize on communication and marketing efforts through NBCOT publications and social media, which could reduce potential costs to the institution. https://www.nbcot.org/awards |

| | |
|--|---|
| Administration of Community Living Funding Opportunities (federal grant) | There are a number of funding options listed on this site, however Field Initiated Projects (Research) seems to be the most applicable for the Collaborative Care Program. This may be a grant that is pursued following initial program evaluation, in order to shift the data collection for the program to include persons with disabilities and their transition from hospital to community. Approx. \$200,000 https://acl.gov/grants/copy-field-initiated-projects-program-research |
| Bank of America Grant | SJHMC serves the urban community of Phoenix, which has a wide range of socioeconomic statuses. Additionally Phoenix struggles with a significant problem of homelessness. These are both areas supported by B of A Charitable Foundation. https://about.bankofamerica.com/en-us/global-impact/charitable-foundation-funding.html#fbid=ByuGkffgteX |

Conclusion

Collaborative Care was created and developed for SJHMC, based on observations and frustrations of clinical occupational therapists. It seeks to standardize care delivered in the acute care environment to increase client-centeredness and discharge-mindedness, both of which empower patients to be more active in their healthcare journey. While the intent is for the program costs to be absorbed and supported by the institution, costs were estimated in the above table. An estimated budget and potential funding sources will provide valuable resources to additional institutions who might be interested in implementing Collaborative Care.

CHAPTER SIX – Dissemination Plan

Introduction

The Collaborative Care program is designed to meaningfully improve the current practices of acute care occupational therapists by streamlining and standardizing care. The goal of the program is to implement changes that increase client-centeredness and discharge-mindedness, as well as to increase patient and staff satisfaction and reduce hospital readmissions. The program has several components including early referral and the use of client-centered, discharge-minded, and evidenced-based assessments and interventions to improve the delivery of and outcomes from acute care occupational therapy. The program is achieved through the delivery of several educational sessions for occupational therapist and staff mentoring.

This program was designed for St. Joseph's Hospital and Medical Center (SJHMC) based on the patient population, the grievances and frustrations of the occupational therapy staff, and the large occupational therapy staff seeking change. The program is intended to be a facility run project, with the long-term goal of sharing resources based on outcomes within the larger hospital networks of Dignity Health and CommonSpirit Health. These changes are for the betterment of patients, the hospital organizations, and the occupational therapists who are providing care. The following chapter reviews how critical information about the program will be disseminated to key stakeholders and consumers.

Dissemination Goals

The overarching goal of dissemination is to enhance knowledge of and to promote engagement of potential stakeholders in the Collaborative Care program. Dissemination of program information will begin after program implementation and evaluation, in an effort to ensure the intended program outcomes have been thoroughly demonstrated.

Dissemination will begin one-year post-program creation and six months post-implementation.

Long Term Goal: Following dissemination of program content, the long-term goal would be system-wide adoption (137 hospitals) of Collaborative Care as best practice for acute care occupational therapy reflecting substantive practice change. While the initial goals of Collaborative Care program were to make meaningful change at SJHMC, the larger hospital network of Dignity Health and further CommonSpirit Health certainly can also benefit from the program (timeline approx. 2-3 years).

Short Term Goal 1: Dissemination of program information to the primary audiences will lead to implementation of Collaborative Care into the Dignity Health hospitals in the Arizona service area (SJHMC + 2 other acute care hospitals) (timeline 1 year).

Short Term Goal 2: Dissemination of program information to the primary audiences will lead to implementation of the Collaborative Care program into five acute care occupational therapy departments outside of the Dignity Health or CommonSpirit Health network (timeline 1 year).

Short Term Goal 3: Dissemination of program information to the secondary audience will lead to opportunities to teach program content to entry level OTD students at 3/5 local Occupational Therapy schools (timeline 6-9 months).

Target Audiences

Primary Target Audiences

The primary audiences for the Collaborative Care program include personnel that would have the capability to influence or to actually implement the program into an acute care environment. This includes occupational therapists, hospital administrators, and medical staff. Hospital administrators have a vested interest in how the program impacts hospital throughput, discharge planning, readmissions, and patient satisfaction. While this group of individuals is at the macro level, substantive initiatives and changes often require administrative support prior to hospital or system wide change. One advantage is SJHMC is the largest hospital among the Dignity Health network, meaning our programs often have excellent support at the corporate/system level. The focus on medical staff education as a primary audience includes providing education on how the benefits of early referral through the Collaborative Care program can directly impact their patient's quality of care. Occupational therapists are the participants in the program at SJHMC, however, to get the program into other facilities will require occupational therapists at other facilities and throughout the nation to be informed.

Key Messages for Primary Target Audience

1. The holistic tenets of the profession must be adhered to and reinforced in all settings including acute care. The program components demonstrate these principles and will

- reinforce their application in a clinical setting. Occupational therapists can choose to effect change within their own departments to ensure they are providing the highest quality of care.
2. The use of the Collaborative Care program improves both patient and staff satisfaction. The program ensures a clear client-centered and discharge-readiness focus. The program directly aligns with the priorities established by the Affordable Care Act (ACA) of 2010, which include quality outcomes and the consumer experience (Pritchard et al., 2019).
 3. Collaborative Care reduces unnecessary readmissions by increasing discharge readiness. Centers for Medicare and Medicaid Services additionally implemented the Hospital Readmission Reduction program to penalize hospitals with excessive readmissions that occur within 30 days for the same medical condition (CMS, 2019). Preventing unnecessary and preventable readmissions remains a goal for all hospitals.
 4. Adoption of the Collaborative Care program enhances efforts to improve the quality of client-centered care provided by the organization. Quality care as defined by the ACA is efficient, patient-centered, equitable, effective, and timely (Watterson et al., 2018), which represents the tenets of the Collaborative Care program.

Secondary Target Audience

The secondary audience for the Collaborative Care program are occupational therapy schools/academic programs in the metropolitan Phoenix area. There are five graduate level programs in Phoenix that serve the occupational therapy market within Phoenix and the surrounding areas. SJHMC has an excellent working relationship with

all five schools and contributes to teaching and taking fieldwork and doctoral students. Historically and anecdotally, students receive minimal education on specific approaches provided in the acute care environment and often feel unprepared for this challenging fieldwork setting. This is however an impressionable audience in which a meaningful and career-long impact could be made.

Key Messages for Secondary Target Audience

1. The holistic tenets of the profession must be adhered to and reinforced in all settings including acute care. The program components demonstrate these principles and will reinforce their application in a clinical setting.
2. The constraints of the acute care environment make it challenging to adhere to these tenets. Without specific education on how to adapt to these challenges, many students struggle to succeed in acute care.
3. The standardization proposed by Collaborative Care ensures early referral, client-centeredness, and discharge readiness. Students will feel empowered to implement the evidenced-based components following programmatic education.

Influential Spokespersons

Primary Hospital Administrator and Medical Staff Audiences

1. The first spokesperson for the primary audiences would be the program physician champion, whose role within Collaborative Care is to drive a steady stream of appropriate occupational therapy referral in order to maximize the time available for intervention. The physician champion is the chief of medical staff at SJHMC which is an influential role to hospital administrators as well as physicians and residents

- alike. He is well known at the other two Dignity Health hospitals within the Phoenix area and would be an effective spokesperson to promote Collaborative Care to the Arizona service area. Communication would be delivered in person to residents and physicians and via video messaging to the adjacent facilities.
2. Dr. Andrew Rogers from Johns Hopkins University, who published the landmark article in 2016 highlighting how spending on occupational therapy services was the only spending category to demonstrate statistical significance in reducing hospital readmissions. Dr. Rogers would be able to speak to the goals of the Collaborative Care program to standardize practices in an effort for all acute care facilities to maximize occupational therapy services in an effort to reduce readmission. Activities include participation medical conferences, video messaging, and testimonials.

Primary Occupational Therapy Audience and Secondary Audience

1. Helene Smith-Gabai, author of Occupational Therapy in Acute Care, which is considered the bible for many new acute care occupational therapists. Dr. Smith-Gabai teaches graduate level occupational therapy courses at Brenau University currently. She is well published on the subject of discharge planning in acute care, having studied this topic extensively during her PhD in occupational therapy. Activities include testimonials, video messaging, online teaching/co-teaching, and conference presentations.

Dissemination Activities

Table 6.1 identifies the activities and techniques that will be utilized to disseminate program information to the target audiences. Additionally, tasks are

prioritized based on level of importance and timing. For both audiences, in person contact is the preferred method of dissemination followed by electronic media and finally written information to supplement as references.

Table 6.1. *Dissemination Activities*

| Target Audience | Written Information | Electronic Media | In Person/Live Contact |
|---|---|--|--|
| Primary Audience Hospital administrators and medical staff | <ul style="list-style-type: none"> • Email two-page executive summary to hospital administrators • Email newsletter to medical staff and residents with program highlights, statistics, and testimonials from program champion and patients | <ul style="list-style-type: none"> • Email patient and staff testimonial following Collaborative Care program • Video messaging from influential spokesperson on the program efficacy • These videos will also be utilized to promote the program during OT month, April using the global email employee list | <ul style="list-style-type: none"> • The hospital administrators would be addressed at their monthly meeting by the program lead and the physician champion. • The physician champion would provide programmatic information to residents and medical students at their initial hospital orientation (at each of the Dignity Health facilities in AZ). • The Center for Medical Education hosts the Emergency Medicine & Acute Care Conference annually. This conference whether held virtually or in person would be an excellent venue to promote the Collaborative Care program. The goal would be to have one of the spokesperson conduct a session on the program with support from the program lead. • https://courses.ccme.org/course/ema |
| Primary Audience Acute Care Occupational Therapists | <ul style="list-style-type: none"> • Utilization of state association list serves for bulk mailing to acute care OTs • Mailing would include two | <ul style="list-style-type: none"> • Utilization of AOTA's CommunOT for dissemination to practicing acute care OTs | <ul style="list-style-type: none"> • Presentations at annual conferences of ArizOTA, WROTSS, and AOTA to reach acute care OTs • Utilization of both poster presentations and live seminars for those more interested |

| | | | |
|---|---|---|---|
| | page summary with program information for further information | | |
| Secondary Audience Occupational Therapy Schools in Phoenix | <ul style="list-style-type: none"> Journal articles provided to students to highlight evidenced-base of program Email two page executive summary to OT programs to spark interest | <ul style="list-style-type: none"> Videos of application of program within acute care Video testimonials from influential spokesperson to promote program content and approach Utilization of AOTA's CommunOT for use of list servs and communication to current OT students | <ul style="list-style-type: none"> In person lectures on program content within graduate school education using PowerPoint and videos promoting need for more in-depth teaching of acute care intervention Presentations at annual conferences of ArizOTA and AOTA to reach additional OT academic programs |

Budget

There are minimal dissemination costs anticipated that would not be covered by SJHMC. The benefit of being within a large network of hospitals is the ability to utilize the global access email list to distribute mass information via email. Course registration and travel expenses are reasonable costs that would be reimbursed by the hospital while professional memberships would be reimbursed at half. Both of these are employee benefits. Table 6.2 estimates budget costs for the dissemination process and activities.

Table 6.2. Dissemination Budget

| Target Audience | Activity | Total Cost |
|---|--|-------------------|
| Primary Audience Hospital administrators and medical staff | Use of A/V consultant for video production and formatting (spokesperson videos) \$40/hour x 5 hours = \$200 | \$200 |
| | Registration for spokesperson to attend Emergency Medicine & Acute Care Conference = \$695 | \$695 |
| | Travel allowance to conference = \$600 | \$600 |
| | Internet/email/Microsoft Office access are provided by facility = \$0 | |
| Primary Audience Occupational Therapists | Registration to AOTA = \$451 | \$451 |
| | Registration to WROTSS = \$219 | \$219 |
| | Registration to ArizOTA = \$250 | \$250 |
| | Annual travel allowance for conferences = \$600 | \$600 |
| | Membership to ArizOTA for use of list serv and networking = \$65 | \$65 |
| | Membership to AOTA for use of CommunOT, SIS, and networking = \$225 | \$225 |
| | Bulk mailing costs (printing, paper, postage) = \$500 | \$500 |
| Secondary Audience Occupational Therapy Schools in Phoenix | Use of A/V consultant for video production and formatting (patient and staff testimonies) \$40/hour x 5 hours = \$200 | \$200 |
| | Registration for annual AOTA = \$451 | \$451 |
| | Travel allowance to AOTA = \$600 | \$600 |
| | Internet/email/Microsoft Office access are provided by facility = \$0 | |

| | | |
|--|---|------------------------|
| | Membership to ArizOTA for use of list serv and networking = \$65 | \$65 |
| | Membership to AOTA for use of CommunOT, SIS, and networking = \$225 | \$225 |
| | **There are several fees listed twice under primary OT audience and secondary OTS audience, these fees are not duplicated in the total. | |
| | | Total: \$4, 005 |

Evaluation

The dissemination efforts to the primary audience will be measured largely by the number of hospitals that adopt the Collaborative Care program, and additionally by interest expressed from occupational therapists, administrators, or medical staff following program education in the form of inquiries. Secondary audience efforts will be measured in the number of local schools expressing interest in further information on the program from professor and/or student inquiries. Following education efforts to both audiences, a voluntary survey will be provided for program feedback. Feedback will be utilized to make changes in dissemination efforts, if deemed necessary.

Conclusion

While Collaborative Care was designed to meet the needs of the occupational therapy department at SJHMC, it is an easily replicable program for any acute care facility to adopt. Hospitals whose focus is based on quality client-centered care stand to benefit from this standardized programmatic approach to occupational therapy. The dissemination efforts are aimed at occupational therapists, hospital administrators, and medical staff, as well as occupational therapy students and academic programs.

Collaborative Care aligns with the ACA's priorities to increase quality care and reduce unnecessary readmissions.

CHAPTER SEVEN – Conclusion

The problem identified by this doctoral project is the challenge of the acute care environment itself, which includes significant intra-professional challenges for occupational therapists. The evidence reviewed revealed that occupational therapists have difficulty maintaining a holistic approach with a lack of standardization in how they deliver care and an ever-decreasing length of stay in which to provide said care (Atwal & Caldwell, 2003; Britton et al., 2015; Crennan & MacRae, 2010). Yet, lofty expectations of improved health related outcomes remain the measurement of care, including quality care, decreased re-hospitalizations, and cost effectiveness.

“On one hand, occupational therapists are taught to embrace a fundamental, humanistically based philosophy of practice that emphasizes the importance of the individual. On the other hand, they are expected to practice in an economically defined health care environment, where issues of reimbursement for services are highly valued and are among the key factors to be considered when making evaluation and treatment decisions” (Burke & Cassidy, 1991, p. 173).

Collaborative Care is a program designed to address the aforementioned issues by utilizing evidence and theoretical support. The program is supported by several theories including the Patient-Centered Care framework, the Biopsychosocial frame of reference, and the Intentional Relationship Model. After considerable review of the evidence, there are indeed factors that can influence and potentially reduce the intra-professional challenges faced by occupational therapists. Collaborative Care seeks to increase client-centeredness and client collaboration through the consistent use of subjective and

objective assessments. These assessments are complementary to one another yet serve to deepen and broaden the occupational therapist's understanding of each client as an individual. They aim to allow the therapist to capture essential, yet holistic, information about each client's occupations for an optimal discharge and functional independence post-discharge. While many acute care settings are incorporating the use of one or more of these strategies, there is no evidence to show that all are being used as a cohesive, programmatic manner for increased standardization and quality of care (Crennan & MacRae, 2010; Griffin & McConnell, 2001).

At its core, Collaborative Care is focused on client-centered care, which is a basic tenet of occupational therapy practice. However, it was found by Atwal and Caldwell (2003) that acute care occupational therapists have the greatest difficulty being client-centered as compared to occupational therapists practicing in other settings. Utilizing standardized approaches will ensure occupational therapists are able to obtain the most functionally impactful client-centered information. This information includes their life roles, routines, and habits in their home environment, and immediately helps focus intervention on hospital discharge that is individualized. "If occupational therapists are to help patients be discharged in a timely manner, finding out what activities they need or want to do is critical because patients are more likely to be motivated to perform activities they perceive as valuable" (Robinson & Shotwell, 2011, p. 7).

A comprehensive training program will be incrementally implemented to increase utilization of the Collaborative Care program components with didactic education sessions, peer practice and mentoring, and audits and feedback. Staff will have ongoing

opportunities for mentoring sessions and refresher education to increase their comfort with these novel practices. Education methods are designed to enhance adult learning, professional reflection, learning preferences and knowledge translation.

Collaborative Care aims to improve acute care occupational therapy practice by standardizing holistic and client-centered delivery of care as well as increasing patient participation, satisfaction, and discharge readiness. This program aims to provide occupational therapists the tools they need to perform their roles in a valuable and holistic way. This project and resulting program were inspired by the occupational therapists at SJHMC and this is where the program is intended to be first implemented. The program, however, is easily adaptable to other acute care occupational therapy departments and the funding and dissemination plans were developed with this generalization and expansion in mind.

The acute care environment remains a challenging environment for occupational therapists. There are however numerous opportunities for the profession to highlight its distinct perspective of holism, client-centeredness, focus on health management and self-care/function, and finally discharge mindedness. All of these factors specific to Collaborative Care allow occupational therapists to assist acute care patients safely and efficiently transition through the hospital environment.

APPENDIX A –Executive Summary

CollabOraTive Care: A Programmatic Proposal to Improve Occupational Therapy in Acute Care

Introduction

Healthcare has continually been reformed to improve efficiencies including cost containment and the client experience (Pritchard et al., 2019; Roberts et al., 2020), both of which have resulted in decreased lengths of stay in acute care hospitals. While the reduction in length of stay has shown to decrease hospital acquired infections and overall cost of hospitalizations, it has inherently decreased the time available for occupational therapists to provide their valuable services (Atwal & Caldwell, 2003; Britton et al., 2015). The role of the acute care occupational therapist includes the ability to evaluate current function in contrast to typical or prior function and to determine the interconnection of diagnoses and its effect on performance and participation in a holistic manner (Pritchard et al., 2019).

One of the primary roles is discharge planning, which requires complex decision-making and reasoning skills to consider specific client factors, rehabilitation potential, and options for discharge. This critical role has recently been highlighted in the landmark study by Rogers et al. (2017) as a means of reducing costly and unnecessary readmissions. The authors found spending on occupational therapy was the only category that was shown to be statistically significant in reducing hospital readmission rates for several chronic diseases. While these results have highlighted the value of acute care occupational therapy, current practices continue to be variable. At its core, occupational therapy is a discipline that aims to be holistic, comprehensive, client-

centered, and collaborative (AOTA, 2020), yet there are challenges unique to the acute care environment that can prevent occupational therapy services from being implemented in a way that is meaningful to the client.

Problem

The acute care environment, in itself, presents a challenge for occupational therapists. It is fast-paced, medical condition-centric, throughput-focused, and silo practice-oriented, creating intra-professional challenges specific to occupational therapy (Britton et al., 2016). These intra-professional challenges include: difficulty adhering to a holistic approach (Terry & Westcott, 2012); decreased client-centeredness, decreased respect for client autonomy with discharge-decision making (Maitra & Erway, 2006); a lack of standardization for the delivery of care impacting consistent practices (Crennan & MacRae, 2010); and an ever decreasing length of stay in which to provide intervention (Atwal & Caldwell, 2003; Britton et al., 2015). The consequences of these challenges lead to an over-emphasis on the medical condition while neglecting the client's psychosocial health.

Historically, the foundations of the occupational therapy profession are based in providing individualized holistic health care. Holistic care approaches the whole person, acknowledging the interconnection of mind, body, spirit, and environment. While the medical model has heavily influenced the field of occupational therapy by elevating its scientific and societal standing, it has also moved the focus farther from the holistic perspective, by potentially neglecting psychological and social aspects of recovery. This observation is echoed in multiple qualitative studies from practicing acute care

occupational therapists who report the medical model has impacted them by: being known for a “subset” of their skills (Britton et al., 2015), having numerous ethical dilemmas especially around maintaining a holistic and client-centered approach (Atwal & Caldwell, 2003; Britton et al., 2016). This approach subsequently limits the scope of occupational therapy assessments to physical dysfunction again neglecting potential psychosocial.

Several studies have demonstrated this narrowed scope of acute care occupational therapy assessments, which rarely move beyond physical dysfunction to include spiritual well-being or psychosocial well-being (Terry & Westcott, 2012). Terry and Westcott (2012) found that persons with unmet psychological needs often have difficulty maintaining physical function and have reduced social function and quality of life. By limiting their scope, occupational therapists can neglect critical components of their client’s lives by lacking investigation into their meaningful life roles at home, work, or leisure. This information should ideally be used to holistically determine discharge needs including: additional equipment or post-acute care recommendations, social support needed for community access, or services unique to the client’s needs (Smith-Gabai, 2011). This lack of holistic assessment and client-centeredness is an issue specifically in the acute care environment.

Programmatic Proposal Overview

The thorough analysis of the evidence-based literature strongly supports the proposal of an acute care program that provides a more standardized protocol of care incorporating early referral, collaborative goal setting, and functional capacity and

discharge readiness assessments. The proposed program will begin with the implementation of a referral or screening process to identify clients early in their stay, to drive more appropriate referrals to occupational therapy, and to increase the time available for meaningful occupational therapy intervention (Tan et al., 2016). The next proposed programmatic change is the implementation of a client-centered assessment to identify client goals, to discuss shared decision making for intervention planning and to facilitate collaborative goal setting (Popova et al., 2019). The use of a brief self-care assessment will assist the clinician in painting an accurate functional picture to reflect deficits and to support the clinician's discharge recommendations (Crennan & MacRae, 2010). The final literature-supported component of the program is the implementation of assessing discharge readiness to provide the client an opportunity to reflect on discharge from the hospital and to identify any potential barriers or concerns (Grimmer et al., 2006). As supported by the evidence-based literature, these processes aim to allow the occupational therapist to capture essential, yet holistic information about client's occupations for an optimal discharge and functional independence post-discharge. While many acute care settings are incorporating the use of one or more of these strategies, there is no evidence to show that all are being used as a cohesive, programmatic manner for increased standardization and quality of care (Crennan & MacRae, 2010). The proposed program is called *Collaborative Care* to reflect a cooperation and collaboration between acute care occupational therapists and their clients or patients.

Theoretical Frames of Reference

Three theoretical frameworks are utilized to better understand how such complexities faced by occupational therapists within this healthcare environment can be illustrated and challenged: the Patient-Centered Care (PCC) framework, the Biopsychosocial model, and the Intentional Relationship Model (IRM). These frameworks are both complementary to a practice shift and to one another. Patient-centered care is focused on providing care to the whole person: their preferences, beliefs, with inclusion of their families and caregivers (Santana et al., 2018). Healthcare has transitioned to PCC in an effort to promote shared decision making between healthcare professionals and their clients including collaborative goal setting and patient directed care. The Biopsychosocial model offers a holistic and client-centered framework to bridge the divide to integrate social and psychological factors alongside biological. This model expands beyond the predominantly utilized biomechanical approach in acute care by addressing social/contextual and psychological factors, creating an inclusive and holistic client-centered approach (Gentry et al., 2018). Given that acute care occupational therapists have a challenge being holistic with a narrow assessment, this model provides a framework for a broader psychosocial assessment.

Lastly, the Intentional Relationship Model (IRM) provides a theoretical outline of the therapeutic relationship specific to occupational therapy practice. The objective using this model is to teach and hone skill of therapeutic use of self (Taylor, 2008). Given the short amount of time in acute care, it is essential that occupational therapists are able to quickly assess clients' interpersonal skills and preferences. The use of the IRM will

promote the development of an efficient and meaningful therapeutic relationship that is centered on the clients' goals for hospital discharge.

Key Findings/Recommendations

1. Adoption of the *Collaborative Care* program aims to enhance efforts to improve the quality of client-centered care provided by the organization. Quality care as defined by the Affordable Care Act is efficient, patient-centered, equitable, effective, and timely, which represents the core of the Collaborative Care program.
2. The holistic tenets of the profession must be adhered to and reinforced in all settings including acute care. The program components demonstrate these principles and aim to reinforce their application in a clinical setting. Occupational therapists can choose to effect change within their own departments to ensure they are providing the highest quality of care.

General Conclusions

The *Collaborative Care* program is designed to meaningfully improve the current practices of acute care occupational therapists by streamlining and standardizing care, and by increasing efficiency and quality of care. The goal is to implement changes that increase client-centeredness and discharge-mindedness, increasing the client experience including their involvement and overall satisfaction as well as reducing unnecessary hospital readmissions. These changes aim to enhance occupational therapy service provision in the acute care setting by: helping clients feel more valued, understood and prepared for discharge; streamlining processes and increasing important client outcomes for the hospital organization; and re-establishing processes for occupational therapists to

feel connected to their discipline's foundational tenets and meaningful approaches to care by more intentionally focusing on each client's unique needs.

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APPENDIX B – Fact Sheet



**CollabOraTive Care: A Programmatic Proposal
to Improve Occupational Therapy in Acute Care**
Abbey Glenn MS, OTR/L, CBIS

What is the PROBLEM?

Acute care hospitals present professional challenges for occupational therapy (OT) including its fast pace, overemphasis on the medical condition while diminishing social or psychological concerns ², throughput-focus (expediting rapid discharge) ², and silo practice orientation.

Trickledown Effect on current acute care OT practice as evidenced by the literature:

- Shift away from holistic approach ²
- Decreased client-centeredness and respect for client autonomy ^{1,4}
- Difficulty maintaining occupation-base ²
- Lack of standardization in care
- Shrinking length of stay in which to provide intervention ⁶

What is the SOLUTION?

CollabOraTive Care is a comprehensive program designed specifically for acute care occupational therapists. **Creating a streamlined and standardized approach to OT services in acute care.**

Program Support:

- Evidence-based,
- Theoretically-grounded,
- Holistically-minded,
- Peer support and mentoring
- Combination of didactic and hands-on training

Program Components:

1. Early referral to OT with physician champion
2. Client-centered assessment to foster collaborative goal setting ⁵
3. Functional capacity assessment to support discharge recommendations
4. Incorporation of discharge readiness concepts

Theoretical Support:

- Patient Centered Care (PCC) Framework is focused on providing care to the whole person with shared decision making ⁸.
- Biopsychosocial model bridges the divide between biological factors along with social and psychological ³.
- The Intentional Relationship Model informs therapists how to hone their skill of therapeutic use of self ⁹.

Intended Program Outcomes (assessed through program evaluation):

- Increased patient participation in discharge planning and self care
- Improved patient experience
- Increased OT staff satisfaction through increased collaboration and holistic approach
- Decreased unplanned hospital readmissions

Examples of Potential Scope and Opportunities for Acute OT utilizing CollabOraTive Care

- | | | |
|--------------------------------|------------------------|---|
| + Bathing | + Play | + |
| + Dressing | + Leisure | |
| + Eating | + Safety Procedures | |
| + Care of Others | + Sleep | |
| + Driving & Community Mobility | + Financial Management | |
| + Home Management | + Meal Preparation | |
| | + Social Participation | |



Photo retrieved from <https://otpotential.com/what-is-ot>

Acute care occupational therapy has been shown to increase functional independence, reduce unplanned readmissions, and decrease spending for hospital organizations ⁷.

Provision of OT services:
CollabOraTive Care is intended to change and enhance delivery of OT services by increasing client-centeredness and collaboration between practitioner and client. This change will truly focus on what is most meaningful to the client prior to discharge from the hospital.

Impact on Future Occupational Therapy Practice: While the *CollabOraTive Care* program was designed specifically for the acute care occupational therapy department at St. Joseph's Hospital in Phoenix, Arizona; it is an easily replicable program for other acute care facilities interested and committed to improving the quality and efficiency of occupational therapy services.

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CURRICULUM VITAE

