Occupational Therapy Practitioners' Perspectives on Occupation-Based Interventions for Clients With Hip Fracture

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OBJECTIVE. Occupational engagement is the foundation of occupational therapy. We identified perspectives of 18 occupational therapy practitioners on integrating occupation-based interventions during postacute care (PAC) rehabilitation for persons with hip fracture to identify occupational therapy's distinct contribution.

METHOD. We conducted six focus groups derived from a purposive national sample of occupational therapy practitioners ($N = 18$). A secondary analysis was conducted to analyze the transcripts for major subthemes around occupation-based interventions.

RESULTS. Three major themes arose from practitioners' perspectives regarding the role of occupation in rehabilitation: (1) conducting an occupational profile, (2) integrating occupation-based intervention in the facility, and (3) identifying goals for occupational engagement after discharge. Challenges and strategies for integrating occupation-based interventions were also identified.

CONCLUSION. Identifying practitioners' perspectives on integrating occupation into rehabilitation may inform strategies to facilitate occupation-based interventions in PAC and define occupational therapy's role in this setting.

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Occupational therapy is rooted in the belief that humans are occupational beings. At the core of this value is a positive relationship between occupation and health (American Occupational Therapy Association [AOTA], 2014). Occupational therapy practitioners focus on occupational engagement to promote health and well-being for people (Mahoney, Roberts, Bryze, & Parker Kent, 2016). However, in postacute care (PAC), the dominant model of care is the *biomedical model*, which is focused on using an objective view of physical factors to implement medical interventions to cure diseases or disorders (Lundström, 2008). In contrast, *occupational engagement* focuses on interventions that take into account meaning and choice for clients to facilitate their recovery and help them rejoin their lives (AOTA, 2014). Consequently, occupational therapy has shifted between a biomedical model approach and an occupation-based approach through the history of the profession (Gillen, 2013).

People who have sustained a hip fracture commonly use PAC rehabilitation before returning to the community (Freburger, Holmes, & Ku, 2012; Nguyen-Oghalai et al., 2008). Patients with hip fracture are at increased risk of subsequent injuries, comorbidities, rehospitalization, mortality, and lowered quality of life (Marks, 2010; Parker & Johansen, 2006). In addition, they often are limited in their activities of daily living and lose functional independence (Ariza-Vega, Jiménez-Moleón, & Kristensen, 2014). With health care reform

and the change from a fee-for-service payment system to a value-based system, these adverse outcomes are now linked to payment structures in an effort to improve patient outcomes. Occupational therapy practitioners must therefore demonstrate their value to the interdisciplinary care team for enhancing care quality and outcomes, specifically using their expertise to promote occupational engagement (Leland, Crum, Phipps, Roberts, & Gage, 2015). The objective of this study was to explore occupational therapy practitioners' perspectives on delivering occupation-based interventions in PAC for clients with hip fracture and thereby illustrate occupational therapy's unique contribution.

Method

Study Design

A secondary analysis of a larger mixed-methods study was conducted to understand occupation-based interventions. This method allows for new or additional research questions that emerged to be further analyzed (Heaton, 2008). The original study used a qualitative approach rooted in grounded theory to conduct focus groups with occupational therapy practitioners, including occupational therapists and occupational therapy assistants, to understand their perspectives on delivering best practices for hip fracture rehabilitation. In addition, quantitative data were captured through electronic medical records to understand clinical documentation and make comparisons between actual documentation and practitioners' perspectives on best practices. The study was approved by the University of Southern California institutional review board.

Participant Sample and Recruitment

Purposive sampling was used to recruit active occupational therapy practitioners in (1) different geographic regions across the United States and (2) a diverse range of PAC settings (e.g., skilled nursing facilities, inpatient rehabilitation, and home health). We wanted to obtain practitioners from a diverse range of PAC facilities because certain key characteristics are known to affect care delivery for individuals with hip fracture (e.g., location, resources, staffing, and patient case mix; Castle & Anderson, 2011; Gozalo, Leland, Christian, Mor, & Teno, 2015; Mor, Zinn, Angelelli, Teno, & Miller, 2004).

Before the 2015 AOTA Annual Conference & Expo, emails were sent to possible participants by means of occupational therapy state and national aging communities, health system rehabilitation departments, and rehabilitation company networks as well as through snowball sampling. Additionally, during the national

conference, fliers were disseminated to advertise the focus groups. To be included in the focus groups, participants had to be licensed occupational therapists or occupational therapy assistants, have at least 1 yr of clinical experience working in a PAC facility with clients with hip fracture, and attend the annual conference.

Data Collection

All focus groups were conducted at the 2015 AOTA Annual Conference & Expo, facilitated by a researcher with training in qualitative methods and supported by one research assistant, who took field notes during the session. Focus groups varied in length, ranging from 30 to 60 min. A semistructured interview guide was used to explore the participants' perspectives on delivering high-quality hip fracture rehabilitation. Probing questions covered topics such as their top priorities when addressing clients with hip fracture. Participants also completed a brief questionnaire that included details on age, sex (male or female), race and ethnicity, clinical discipline (occupational therapist or occupational therapy assistant), length of professional experience, type of PAC facility in which they practiced, and experiences practicing in other types of settings.

Data Analysis

Procedures for analyzing the data were rooted in grounded theory, which allows for themes and subthemes to arise from the data (Corbin & Strauss, 1990; Padgett, 2012). We used this approach to analyze the data through three coding steps: (1) open, (2) axial, and (3) selective. The focus groups were audio recorded and transcribed verbatim. Multiple members of the research team read the transcripts to ensure that the recordings were replicated in the transcripts. Two research team members independently coded each transcript using an open-code approach to develop a codebook. After coding the first focus group, the entire research team convened to discuss the procedure and the codes that were used to inform the initial development of the codebook. The research team met to discuss the process, codes, and themes and subthemes that emerged after every transcript was coded. The codebook was refined throughout the process to ensure consistency. Field notes, team meeting notes, and an audit trail for coding decisions were used throughout the analysis process to ensure consistency and consensus.

Using occupation-based interventions in rehabilitation was one theme that arose from the initial analysis and was further explored in a secondary analysis. Subthemes were analyzed under the major theme of implementing occupation-based interventions in practice. Field notes, team meeting

notes, and an audit trail for coding decisions were used throughout the analysis process to ensure consistency, consensus, and trustworthiness of the data. The qualitative software ATLAS.ti (Version 7.5.6; Scientific Software Development, Berlin, Germany) was used to organize and facilitate data analysis.

Results

Six focus group sessions were held with a total of 18 occupational therapy practitioners from 13 states (Table 1). Their clinical experience included skilled nursing facilities, inpatient rehabilitation facilities, home health agencies, and outpatient rehabilitation facilities.

Three themes emerged from the qualitative data analysis that described participants’ perspectives on the integration of occupation in PAC: (1) conducting an occupational profile, (2) integrating occupation-based intervention in the facility, and (3) identifying goals for occupational engagement after discharge. In the following sections, we present examples of each theme; each example is labeled to indicate in which of the six focus groups the example originated (e.g., Focus Group 1 [FG1]).

Theme 1: Conducting an Occupational Profile

The participants emphasized the importance of initially evaluating the client by conducting an occupational profile to understand “who the person is.” By having a discussion with the client, the participants were able to evaluate the occupations in which the person was engaged before entering the facility and what was meaningful to that person. One participant described asking these questions as asking, “What are the typical things that people do for leisure, especially in engagement and understanding that

this [hip fracture] isn’t preventing that?” (FG3). The client’s response to this question helps the occupational therapy practitioner understand the client’s meaningful activities before the hip fracture to support the client to be able to engage in these occupations again.

Similarly, knowing the habits, roles, and routines of the client before the hip fracture can help facilitate engagement in meaningful activities. One participant described the role that a client used to have as a seamstress and how that can be a tool for practitioners to use to support engagement in rehabilitation:

Oh my gosh, she loves handwork. I would’ve asked the family what is it that she did. Romance novels and handwork. She was a seamstress until she was 84. She worked full-time until she was in her, you know, late 70s. Anyway[,] she loves to do things with yarn. (FG5)

The participant then went on to describe how this information was used to guide her treatment sessions by embedding these meaningful activities during the client’s rehabilitation stay.

Participants also discussed potential barriers that arose when interviewing clients about their prior occupations. Clients with hip fracture are often older adults with multiple comorbidities. Thus, participants frequently discussed the challenges they experienced when trying to complete a client’s occupational profile if he or she had dementia or a cognitive impairment that limited communication.

A strategy that participants used to mediate potential barriers during development of a client’s occupational profile was to involve family members. When evaluating a client’s prior occupations, involving family members in these initial evaluations is important; as one participant mentioned,

When looking at an occupation-based focus as to what is important to that individual [the client], we have begun to use engagement tools, how engaged is that person in the success of their health[,] and we do that with the patient and with the family member. (FG5)

Involving the family can help ameliorate the issues that arise when clients are unable to explain their occupational engagement prior to the hip fracture.

Theme 2: Integrating Occupation-Based Intervention in the Facility

Focus group participants consistently discussed incorporating occupation-based interventions into therapy sessions. Instead of focusing on rote exercises, the participants used meaningful activities to achieve therapy session treatment

Table 1. Characteristics of the Study Participants (N = 18)

Variable	M (SD) or n (%)
Age	50.32 (12.91)
Female	17 (94.44)
Race	
Black	1 (5.56)
White	17 (94.44)
Years of experience	24.95 (13.15)
Full-time employee	13 (72.22)
Current facility ^a	
Skilled nursing facility	10 (55.56)
Inpatient rehabilitation facility	3 (16.67)
Acute care	3 (16.67)
Home health care	1 (5.56)
Other ^b	3 (16.67)

Note. M = mean; SD = standard deviation.
^aParticipants could work at more than one facility. ^bOther refers to other settings not listed.

objectives. One participant described his thoughts on the basic exercises and how they could be improved:

I think there's something to being outside of the gym setting. I think that's kind of the crux [always providing therapy in the gym] to a lot of these other things [achieving client goals], right? At least it's not the [exercise] bands, gym-like rotating [alternating therapy sessions so there is variation in gym-based exercises and occupation-based activities]. I guess [occupational therapists] should go to the client and not have the client go to [the gym] every single time. (FG3)

Similarly, another participant provided an example of modifying the treatment plan by using an alternative method to the usual gym exercises that targeted the same performance skills but was embedded within an occupation-based intervention that was meaningful to the client:

We had been working on adjunctive things [reaching, balance, working within the client's base of support], kind of in the middle of the plan of care . . . like touching my hand or tossing a ball . . . and then we decided that, he loved to cook, so we did cooking. He shows up to therapy the next day with an entire spice rack. . . . So, I put all of the things up in our kitchen where they typically would go and we worked on both breaking down the task, but also carrying the pans and mixing [ingredients], how he should incorporate the assistive device [the standard walker] into the kitchen. (FG3)

Participants identified multiple barriers to providing occupation-based interventions while the client was in the facility. At the organizational level, certain facilities may lack the resources to provide occupation-based interventions. One participant stated, "Sometimes you don't have that mock kitchen, you have a beverage station. . . . There might not be a mock kitchen set up to try all this stuff" (FG4). Facilities with limited access to equipment are often restricted in being able to provide occupation-based interventions.

In addition, the participants frequently described working in facilities that were transitioning from paper to electronic medical records. Thus, a common barrier was the ability to document the delivery of occupation-based interventions in the electronic medical records. For example, a participant stated,

[We have] drop-down boxes for the daily notes [in electronic health records], but they don't help me. They say OK, fine, I did this, but they don't tell me what my patient did and how I changed it and how then they changed, and what the real synthesis is—the real skill part of it [the treatment session]. It is more of a ticker [checklist] to remind me, oh, yeah, I did that, as opposed

to, I now want to document all of it, as opposed to drop-down box. (FG6)

To adapt to this new change in documentation, participants used different documentation strategies, ones that required them to deconstruct the activity and highlight the performance skills that were addressed, not the occupation that drove the activity. For example, a participant described how he documented a cooking activity:

I documented almost everything from the medical model. And it wasn't necessarily what [occupation-based task] we were engaged in, but it was the biophysical response to the activity. So, for example, with balance, how far outside of midline were they, were they able to return [to center], and how much assistance did they need. So instead of [documenting] meaningful engagement in a cooking activity, it [is] documenting how their body responded. (FG3)

Theme 3: Identifying Goals for Occupational Engagement After Discharge

A common theme focused on preparing the client for community discharge. Participants touched on the importance of thinking beyond the rehabilitation stay and developing community-based goals that integrate socialization and returning to meaningful occupations. The focus of these goals was driven by the occupational profile completed at the beginning of the rehabilitation stay.

Participants discussed developing goals with their clients to support occupational engagement after the client is discharged from the facility:

If they're going to discharge [home] immediately [after therapy is over] I have them identify at least one goal for getting out of the house and doing something. Typically [my clients identify] church. Just to make sure they're doing that social participation piece. (FG6)

The participants described promoting occupational engagement after discharge as a vital component of a client's recovery.

One participant described his role as equipping the client with the tools and education needed to engage in meaningful activities after leaving rehabilitation. Although he acknowledged the majority of his clients were retired, he felt it was important to determine whether a client has a goal of returning to work, volunteering, or other valued occupations:

Most of our patients were retired, but on occasion you might get a person who may want to return to work or a volunteer-type job. Whether or not they could still perform those duties, I think that that's a role for OT. (FG2)

Participants said they frequently contacted family members to discuss discharge plans to assist with planning occupational engagement after returning to the community. Given the functional limitations that clients might have after discharge, families are often needed to provide the support to help clients participate in occupations. However, the participants often described lack of family or caregiving support as a common barrier in planning for discharge goals. When a client with hip fracture transitions out of the facility, he or she may still require a degree of assistance, but that assistance may be unstable:

We have a lot of patients [whose] family wants to come stay with them after they go home from rehab, but they don't want to stay very long. They [family members] want to come—"Oh, I'm going to stay with Mom for a week"—and that's great; we just have to remind them that they're there for only the week. (FG6)

Family and caregiver support is important to assist clients with their desired occupations once they have been discharged from the facility; limited social support can be a hindrance to clients engaging in meaningful occupations.

Participants reported that if family members were unavailable, a common strategy they used was providing clients and caregivers with tools and setting up community-based services (e.g., transportation services) to assist clients with engaging in their occupations. As 1 participant remarked,

I think the role of the [occupational therapist] is to provide the patient and the family and the caregiver with as much information, so that they could be armed in terms of that patient's safety and what the patient's strengths are and what their weaknesses are and where they might need some assistance. (FG2)

Occupational therapy practitioners were seen by participants as being able to inform clients on how to engage in desired occupations after discharge by providing information on resources available to support their engagement.

Discussion

This secondary analysis illustrates that the participants valued occupation-based interventions for individuals with hip fracture in PAC. The shift in health care reform from a fee-for-service payment model to value-based care through the Patient Protection and Affordable Care Act of 2010 (ACA; Pub. L. 111-148) highlights the importance of every discipline defining its unique contribution to improve

health care delivery and client outcomes (Fisher & Friesema, 2013). The themes that emerged from this study characterize the value that the occupational therapy profession has in achieving optimal client-centered outcomes in PAC. In addition, this study's findings identify delivering occupation-based intervention as a care process that can guide best practice for occupational therapy practitioners and demonstrate the profession's value to the interdisciplinary care team. By clarifying occupational therapy's contribution through outcome measures that assess, document, and quantify interventions, the profession's value is conveyed to the wider health care system.

Patient-centered care is a high priority in health care reform that has been shown to improve outcomes and health care experience through engaging patients and families in health care decision making (Hibbard & Greene, 2013). Similarly, conducting an occupational profile reflects patient-centered care through the collaboration with clients and families to understand the clients' meaningful occupations (Maitra & Erway, 2006). Thus, practitioners need to be equipped with tools to engage clients and families in discussions and elicit occupation-based goals they have for their rehabilitation.

By understanding a client's occupational profile, occupational therapy practitioners can engage clients and families in discussions to develop treatment plans that are meaningful to the client and are occupation based. Engaging a client in treatment plans allows for a client-centered care approach in sharing health care decisions, which has been shown to improve health services use, health care costs, and health outcomes (Wolff, Roter, Given, & Gitlin, 2009). Thus, occupational therapy practitioners are well equipped to take a holistic approach in evaluating individuals with hip fracture to engage them in occupation-based interventions.

Occupational engagement is a vital component of the *Occupational Therapy Practice Framework: Domain and Process* (3rd ed.; AOTA, 2014), and occupational therapy practitioners have the knowledge to incorporate a client's new performance skills into his or her previous, altered, or new habits, roles, and routines (AOTA, 2014). Occupation-based interventions should be embedded throughout the rehabilitation process. However, barriers to providing occupation-based interventions have been identified at the facility level with misaligned representation in electronic medical records, which has been found in the literature (Boonstra & Broekhuis, 2010). To promote occupation-based interventions during the rehabilitation stay, changes need to be made in documentation, specifically electronic medical records, to allow

occupational therapy practitioners to be able to document occupation-based interventions.

Incorporating occupation-based interventions during the rehabilitation stay can prepare clients for their discharge back into the community. Having a successful transition back into the community is a national health care priority in preventing readmissions (Leland, Gozalo, et al., 2015; Naylor, Aiken, Kurtzman, Olds, & Hirschman, 2011). By developing occupation-based goals in preparation for discharge, clients will be equipped with knowledge and resources that will allow them to remain in the community and participate in meaningful occupations. Health care reform is focused on improving the quality of PAC services and client outcomes; thus, it is important for occupational therapy practitioners in PAC to establish their value by improving client outcomes through occupational engagement, as required by the Improving Medicare Post-Acute Care Transformation Act of 2014 (Pub. L. 113-185) and the ACA.

Limitations and Future Research

This secondary analysis of a larger mixed-methods study focused on occupational therapy practitioners' perspectives and did not include perspectives of other disciplines or those of the clients and caregivers. Also, the focus groups were conducted at the 2015 AOTA Annual Conference & Expo, which provided time constraints on focus groups. Moreover, because participants were conference attendees, they might have had more insight into and knowledge of occupation-based interventions than clinicians who were not conference attendees. Thus, future research should evaluate perspectives of occupation-based interventions in PAC from clients, caregivers, and other members of the interdisciplinary team. Future research should also further examine occupation-based interventions for PAC clients with hip fracture.

Implications for Occupational Therapy Practice

Because occupational therapy practitioners are trained in delivering care with a holistic approach, they are well situated to collaborate with clients, caregivers, and other stakeholders to develop appropriate occupation-based interventions. The findings of this qualitative study have the following implications for occupational therapy practice:

- Creating an occupational profile as part of an initial evaluation can inform meaningful occupation-based

interventions during the rehabilitation stay and post-discharge goal setting.

- Collaborating with clients and family members can help identify desired occupations to implement in treatment plans and after returning to the community.
- Engaging occupational therapy practitioners in the development of their electronic medical record platform will ensure the documentation of their value in occupation-based interventions.

Conclusion

This study illustrates the perspectives of a sample of occupational therapy practitioners in postacute rehabilitation care on the delivery of occupation-based care. Occupational therapy practitioners identified the importance of engaging and integrating occupations into rehabilitation treatment and fostering engagement in meaningful occupations after discharge for individuals with hip fracture. With health care reform focusing on patient-centered care and the need for occupational therapy practitioners to define their unique contribution, the integration of occupation into health care can become a vital distinction of occupational therapy's role in PAC rehabilitation. ▲

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