Occupation-Based Intervention in Medical-Based Settings

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**Description**
Attitudes, misinformation about documentation and billing, time pressures, and persistence of habits may all play a role in creating barriers to using occupation-based intervention.

**Disciplines**
Occupational Therapy

**Comments**

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Occupation-
O ccupational therapy clinicians in medical-based settings sometimes feel caught between providing occupation-based intervention and meeting the needs of the health care system; that is, to treat the maximum number of clients, obtain reimbursement for services, and provide intervention within limited settings (i.e., clinic or client’s room). This article examines the various barriers to providing occupation-based intervention and presents strategies to overcoming those barriers, using the Occupational Therapy Practice Framework: Domain and Process¹ (Framework) as a guide.

It is clearly the unique focus on occupation that distinguishes our profession from others. Our choice of the type of intervention and the approach we use allows us to make appropriate matches between a client’s needs, wants, expectations, and intervention options. It is therefore a critical part of practice to develop an occupational profile for each of our clients before setting client-centered goals. Equally essential is the need to show how our intervention is different from that of other health professionals, which includes ensuring that we do not appear to be doing the same intervention for different reasons.²

The evidence is clear that engagement in valued occupations may be more helpful in developing independence and motor skills than other forms of intervention.³⁻⁴ So how do we overcome the barriers in medical-based settings to allow implementation of occupation-based interventions?

**TYPES OF INTERVENTIONS**

It is useful to begin by defining *occupation-based activity.* In 2002 the American Occupational Therapy Association (AOTA) replaced *Uniform Terminology III* (UT-III) with the Framework. The Framework aligns our practice language with the *International Classification of Functioning, Disability, and Health* created by the World Health Organization.⁵ The Framework also demonstrates a clear and unique focus on occupations.

Briefly, the Framework delineates types of occupational therapy interventions as:

- **Therapeutic use of self:** A clinician’s planned use of his or her personality, insights, perceptions, and judgments as part of the therapy process.
- **Therapeutic use of occupations or activities**
  - **Occupation-based activity:** Allows clients to engage in valued occupations in their own context (e.g., bathing or showering in their own home with adaptive equipment).
  - **Purposeful activity:** Allows clients to engage in goal-directed behaviors or activities that are therapeutically designed and will lead to participation in occupation(s) (e.g., getting in and out of a clinic bathtub with a variety of grab bars).
  - **Preparatory methods:** Helps prepare clients for purposeful and occupation-based activities (e.g., standing in a frame to improve endurance for showering).

- **Consultation process:** A clinician’s use of knowledge and expertise to collaborate with a client to identify potential solutions, try the solutions, and adapt them to maximize efficiency. The clinician is not directly responsible for the outcome.
- **Education process:** A clinician imparts knowledge and information about occupation and activity that does not result in actual performance of the occupation.

Each type of intervention has its place in practice. Let us examine a clinic visit for a client who has had a stroke and is in an inpatient rehabilitation setting. The client arrives to therapy with his wife, who stays for the session. He has dense right hemiparesis and a humeral head fracture. One of his goals is to resume a hobby of wood carving. The therapist first conducts an assessment of pain (assessment, not intervention). She then uses electrical differential therapy to block pain receptors and does a short series of repetitive shoulder movements (preparatory activities). The client then engages in a therapist-directed carving activity using, for practice, wood the therapist found in the clinic (purposeful activity). Lastly, the client develops the idea for a new carving. His wife brings a new piece of wood and his carving tools from home. The therapist adapts the tools as necessary to allow the client to complete the carving (occupation-based activity).

Both preparatory and purposeful activities are designed to support engagement in occupation. In this example neither preparatory activity nor purposeful activity alone met the client’s goal of participating in an
authentic carving activity. It is not that preparatory or purposeful activities are inappropriate or inappropriately used in any given treatment; it is that if used exclusively, or in isolation, our practice becomes difficult to differentiate from that of other health care providers.

We show our practice to be unique by focusing on occupation in all treatment settings.

**BARRIERS TO USING OCCUPATION-BASED ACTIVITY**

In 1998 Anne Fisher, in her Eleanor Clarke Slagle lecture, encouraged occupational therapists to embrace more occupation-based activities in their practice. However, many reports from students suggest that preparatory and purposeful activity are still the predominant types of intervention used in medical-based settings. To differentiate between purposeful activities and occupation-based intervention, it is helpful to use some examples. In purposeful activities, a client might copy directions, fold towels, or transfer soil into a pot. Purposeful activities have goal-direction and purpose, but they do not necessarily constitute what a client needs, wants, or is expected to do (e.g., the copying is for someone else, the towels are folded for the clinic, and the client is not interested in horticulture). Transitioning from purposeful activities to occupation-based activities need not be arduous. Using the previous examples, having the client’s family provide something that the clients need to copy (e.g., directions to a physician’s office), having the client launder and fold personal clothing, and bringing a small planting container from the client’s home can transform purposeful activities into occupation-based activities. There is substantial evidence that supports the use of occupation in intervention, and numerous personal testimonials by our consumers and clients. Supporting the use of desired occupation helps clients to reclaim their lives.

To explore the potential barriers to using occupation, four graduate students and I analyzed the practice of and interviewed six clinicians whose roles varied from community-based home-health intervention to acute care in medical model settings. We intentionally selected therapists who, during our interactions, had stated that occupation-based activity was important to treatment. The therapists had between 2 and 15 years of experience, were fieldwork educators, and were practicing in urban areas. All were shadowed for 4 to 6 hours per day, over multiple days, for a total of 16 hours per therapist. They did not know the purpose of the observation until it was over.

We classified the types of interventions they used according to the Framework definitions. To highlight the challenges they faced, we interviewed each for 1 hour using a semistructured approach with the following questions: How do you use occupation-based activity in therapy? What do you perceive the barriers to be to implementing occupation-based activity? Beth was one of the therapists with whom we worked and whose situation is typical for many. She works approximately 40 hours per week in an acute care facility. In this medical-model setting, she spends 80% of her direct client contact hours in preparatory activities. She stated that she does so because her supervisor (who is an occupational therapist) expects her to provide this type of intervention, and the treatment coverage other occupational therapists ask her to provide has preparatory activities listed. She stated, “The clear message I get is that both exercise and range of motion are what I am supposed to be doing with these clients.” She is not asked to provide an occupational profile on the evaluation and intervention plan forms, she has few alternatives for where she treats clients, and she has 30 minutes in which to treat clients. She believes that billing for occupation-based intervention is not straightforward, and that she will have to justify to the treatment team why her intervention was occupation-based. Although many therapists within her setting agree occupation is important, little time is spent determining how to use more occupation in practice. This is a typical scenario for many therapists. What should Beth do in this case? To answer this question, it is helpful to discuss some of the important issues Beth’s case presents (e.g., documentation, practice habits, and the context or environment for therapy).

**PRACTICE ANALYSIS**

Analyzing one’s practice helps to clarify how evaluations, intervention, documentation, and discharge or home programming could be more consistent among therapists and should reflect an emphasis on our unique service: occupation-based intervention. A practice analysis can help you understand how much of your practice involves which type of intervention. Figure 1 presents...
a worksheet that reflects the Framework classification of types of interventions to assist you in this exercise.

Documentation should also reflect our unique focus on occupation, and should include all of the relevant occupations that a client needs or is expected to do upon discharge. The book Applying the Occupational Therapy Practice Framework: The Cardinal Hill Occupational Participa-

CONCLUSIONS

But what are the implications of this occupational therapy practice framework? The Occupational Practice Framework (OPF) provides examples and explanations of occupation-based documentation (see Figure 2). Analyzing how well your forms reflect and support an occupation-based approach is also useful, so a chart is presented in Table 1 on page 14 to assist you. If after completing these exercises you determine there is less occupation in your practice than you would like (for example, 50% or fewer of your interventions), the next step is to determine how to work differently to increase this percentage.

Fortunately, the Centers for Medicare & Medicaid Services (CMS) has opened the door for documentation to focus on functional needs. On December 29, 2006, CMS issued Transmittal 63, which contained important Medicare outpatient therapy policy changes. It requires therapists to include in their documentation of evaluations either the results of a specified performance measure tool or an explanation of certain factors.

If a therapist chooses to not record the results of one of four specific instruments, then the documentation must contain information supporting illness severity or complexity, supporting medical care before the current episode, indicating beneficiary health related to quality of life, indicating beneficiary social support, and indicating objective measurable beneficiary physical functioning. The requirements outlined in Transmittal 63 help occupational therapy practitioners push both for more documentation on functional needs and for stronger outcome measurement tools in rehabilitation.

INCREASING OCCUPATION IN YOUR PRACTICE

General strategies to increase occupation in intervention are to give clients what they need and let them choose priorities for intervention (which is basic to a client-centered approach), identify clients with similar interests and treat them in occupation-based groups, and analyze your intervention frequency and duration to be sure it is occupation based. Questions to ask yourself when implementing these strategies might be:

- Do I have clients who could be treated together? If so, schedule them as a group whenever possible.
- Am I providing clients with what they need and what will benefit them? If not, do I need to change the frequency or duration of treatment? Facilitate client and caregiver participation and focus on the skills the client is most concerned about.
- Do I have an idea of what occupation-based groups are possible in my treatment setting? Work with

Figure 2. Cardinal Hill Healthcare System Occupational Profile (Adult)

Client Name: ____________________________  Client #: ____________  DOB: ____________
Initial Date: ____________________________  Discharge Date: ____________________________
Diagnosis: ____________________________________________________________
Precautions: __________________________________________________________
1. Client lives: [ ] with ____________ [ ] alone;
   - in a house [ ] trailer [ ] apt. with ___ steps to enter; [ ] R [ ] L handrail; ___ stories;
   - steps inside home.
2. Client’s discharge environment, resources, and available adaptive equipment:
   ____________________________________________________________
3. Prior to this hospitalization, the client was: [ ] I min [ ] mod in ADLs and
   [ ] I [ ] min [ ] mod in IADLs. Client needed assistance with
   ____________________________________________________________
4. A typical day consists of: wake up time ___ a.m. ___ p.m.; [ ] volunteer [ ] work;
   bedtime _____ a.m. ___ p.m.
   ____________________________________________________________
5. What activities do you participate in for fun and how often?
   ____________________________________________________________
6. How do you learn best? (In rehab you will be learning new things. Do you learn best
   by reading, watching a video?)
   ____________________________________________________________
7. How familiar are you with technology?
   ____________________________________________________________
8. What motivates you to improve?
   ____________________________________________________________
9. How are you coping with your current status?
   ____________________________________________________________

Initial Comments

List 5 occupations you want/need to resume
1. ___________________________________       ____________________________
2. ___________________________________       ____________________________
3. ___________________________________       ____________________________
4. ___________________________________       ____________________________
5. ___________________________________       ____________________________

Discharge Comments

Satisfaction in resuming your roles

Therapist’s Signature _____________________________________  Date __________
Therapist’s Signature _____________________________________  Date __________

Note. R/L = right/left; I = independent; min = minimum; mod = moderate; ADLs = activities of daily living; IADLs = instrumental activities of daily living.
other like-minded therapists and develop some ideas of groups, and then translate these ideas into a group protocol that considers the needs of typical client conditions (e.g., head injury, stroke), group size, and materials need.

Another way to increase occupation-based interventions is to use a variety of occupation-based kits. Using kits allows one to choose a more occupation-based activity for a client with less reliance on preparatory or purposeful activity, when practical and possible. These kits are great to ask volunteers, students, and families to assemble, using materials from garage sales, thrift stores, and donations. After the kits are assembled, they should be placed in easily accessible locations so they are readily available. Table 2 on page 15 includes sample occupations and activities for which intervention kits can be created.

Practitioners experiencing barriers in the environment or context of intervention can try the following strategies:

- Rearrange treatment areas to create a more homelike environment.
- Use the facility to the fullest, including the kitchen, restroom, client's room, lobby, chapel, vending machines, phones, gift shops, and outdoor areas.
- Use the surrounding area to the extent possible.
- Use the client's own community.
- Make outings to hair salons, markets, or places of worship a routine part of rehabilitation.

Additional barriers frequently stated for not incorporating occupation into practice include administration and billing concerns. Figure 3 on page 16 is an example of an occupation-based intervention and the potential current procedural terminology (CPT) codes under which this intervention could be billed. Create opportunities to discuss these codes within your department and ensure that clinicians understand that occupation-based treatment is billable.

**CONCLUSION**

That we need to reassert our occupation-based approach in intervention and demonstrate our unique service in medical-based settings is clear. This is not only the responsibility of clinicians, but also the responsibility of educators and researchers, who must translate evidence into practice and engage in research that clinicians have stated as a priority. It is also administrators’ responsibility to encourage professional development about modifying documentation and billing. It is also practitio-
Table 2: Occupation-Based Kits

<table>
<thead>
<tr>
<th>Kit</th>
<th>Sample Contents and Activities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gardening</td>
<td>Gardening gloves, trowel, potting soil, seeds, watering can, and directions. Have volunteer or family provide a container for discharge setting. During home visits, work in the client’s garden. Plant seeds, pull weeds, water and feed plants.</td>
</tr>
<tr>
<td>Letter writing or handwriting exercises</td>
<td>A variety of writing paper and envelopes, regular and adaptive pens, stamps, magnifying glass, address-book organizing strategies, and a list of memory strategies. Compose letters, send cards to friends and family, keep a journal, and help to pay bills.</td>
</tr>
<tr>
<td>Pet care</td>
<td>Brushes, powders, combs, leashes, nail clippers, litter box, bird cage, and food bowls. Bring client’s pet to a designated area outside. Practice feeding, washing, walking, petting, and playing with the pet. If the client’s pet is not able to visit, the client can simply practice using the items.</td>
</tr>
<tr>
<td>Fishing</td>
<td>Adaptive fishing poles for different types of fishing (casting and fly fishing), client’s fishing supplies, hooks, weights, and flies. Practice casting, reeling, and baiting a hook. Go outside and practice if possible.</td>
</tr>
<tr>
<td>Golfing</td>
<td>Regular and adapted golf clubs, balls, a putting green and cup with ball scoop, tees, and flag. Practice gripping, swinging, and putting outside; provide resources for visiting a driving range.</td>
</tr>
<tr>
<td>Scrapbooking</td>
<td>Regular and adaptive scissors, scissors for decorative edging; glue; hot glue gun and sticks; stickers; buttons; a variety of bulk paper in different fibers, colors, and textures. Ask family to bring in photographs. Make memory pages for family and friends.</td>
</tr>
<tr>
<td>Car care</td>
<td>Rags, bucket, canister vacuum, tire gauge, simple tools for basic car care (e.g., changing oil, adding fluids, cleaning the car, making simple repairs), resource list to get information about specific cars online. Practice checking fluids and tires, and cleaning and waxing a car.</td>
</tr>
<tr>
<td>Polishing shoes</td>
<td>Polish in a variety of colors, rags, shoe brush. Practice the sequence of polishing shoes.</td>
</tr>
<tr>
<td>Sewing</td>
<td>Fabric, needles, pins, Velcro, thread, sewing machine, needle threader. Practice sewing buttons onto own clothing, modifying a personal item, using the sewing machine to make a simple item of clothing.</td>
</tr>
<tr>
<td>Manicures</td>
<td>A bowl, nail files, nail brush, cuticle softener, nail polish remover, clear polish, colored polish, lotion, scrub/exfoliation cream. Practice giving self and a family member a manicure.</td>
</tr>
<tr>
<td>Using a computer</td>
<td>Writing software with word prediction, game software, adapted keyboards. Practice searching the Internet, composing letters, sending e-mail, using interactive programs (i-chat), and playing games.</td>
</tr>
<tr>
<td>Wrapping gifts</td>
<td>Wrapping paper, tissue, note cards, ribbon, scissors, tape. Practice wrapping and tying gifts.</td>
</tr>
<tr>
<td>Assembling small items (e.g., clock, flashlight)</td>
<td>Toolkit, client’s toolbox. Practice assembly and disassembly.</td>
</tr>
</tbody>
</table>

The value of clearly representing occupation-based interventions in documentation.

- Serve on facility committees and task forces to ensure that occupational therapy is represented.
- Provide copies of electronically available occupation-based evaluation forms and discuss a process by which they could be incorporated into medical records and billing procedures.19
- Develop customer satisfaction surveys (written or interview) to routinely collect data specifically about occupational therapy services. Provide these data to administrators.
- Emphasize the need to maintain a current, dynamic practice and to be in line with current definitions of practice.

It is not enough to talk about how preparatory or purposeful tasks are really about occupations; we need to be able to see our clients participating in valued occupations.

Beth used our guidelines to put a number of things into place. First, she talked openly and directly with her supervisor about concerns regarding her perception of a lack of occupation. Her supervisor supported Beth making changes to her interventions, but was hesitant to change the department’s documentation practices. Beth felt more at ease with using occupation-based interventions. She developed two kits with the help of a volunteer, and another two with the help of a Level II fieldwork student. She also asked two receptive colleagues to eat lunch once a week to discuss cases and how they might introduce more occupation into their practice. She is working with me to develop a more systematic way to track the interventions and outcomes she uses with her clients who have had strokes to help make clinical decisions. Beth believes that she is making more appropriate treatment decisions, has inspired changes in others’ practice routines, and believes that her treatment reflects current practice, rather than feeling stuck with a facility that resists changes and is not reflective of current practice.

REFERENCES
Figure 3. Sample Occupation-Based Intervention and Possible Billing Codes

Scrapbooking

A client with a diagnosis of stroke and depression is seen for 50 minutes. She transfers from her wheelchair to a chair that fits comfortably under a table. She uses pictures her daughter has supplied and makes scrapbook pages for inserting into a special book to join. She transfers from her wheelchair to a chair that fits comfortably under a table. She uses pictures her daughter has supplied and makes scrapbook pages for inserting into a special book. She transfers from her wheelchair to a chair that fits comfortably under a table. She uses pictures her daughter has supplied and makes scrapbook pages for inserting into a special book.

Possible Billing Codes

- 97535: Self-care home management training (activities of daily living and compensatory techniques, meal preparation, safety procedures, and instruction in use of adaptive equipment)
- 97112: Therapeutic activities (direct 1:1, use of dynamic activities to improve functional performance)
- 97532: Cognitive skills (to improve attention, memory, problem solving)
- 97537: Community or work reintegration training (shopping, transportation, money management, avocational activities, work analysis)
- 97530: Therapeutic Activities (direct 1:1, use of dynamic activities to improve functional performance)²⁴

Identify one occupation-based intervention you can envision with a current client, along with possible billing codes for that intervention.

Note: One would never bill all of these together. Consult the current CPT manual²⁴ for the exact listing of all potential codes and terminology.