1995

How Level I Fieldwork programs are being influenced by the changing health care system

Teri Lin Jetter
San Jose State University

Follow this and additional works at: https://scholarworks.sjsu.edu/etd_theses

Recommended Citation

Jetter, Teri Lin, "How Level I Fieldwork programs are being influenced by the changing health care system" (1995). *Master's Theses*. 1147.
DOI: <https://doi.org/10.31979/etd.4tjk-9cea>
https://scholarworks.sjsu.edu/etd_theses/1147

This Thesis is brought to you for free and open access by the Master's Theses and Graduate Research at SJSU ScholarWorks. It has been accepted for inclusion in Master's Theses by an authorized administrator of SJSU ScholarWorks. For more information, please contact scholarworks@sjsu.edu.

INFORMATION TO USERS

This manuscript has been reproduced from the microfilm master. UMI films the text directly from the original or copy submitted. Thus, some thesis and dissertation copies are in typewriter face, while others may be from any type of computer printer.

The quality of this reproduction is dependent upon the quality of the copy submitted. Broken or indistinct print, colored or poor quality illustrations and photographs, print bleedthrough, substandard margins, and improper alignment can adversely affect reproduction.

In the unlikely event that the author did not send UMI a complete manuscript and there are missing pages, these will be noted. Also, if unauthorized copyright material had to be removed, a note will indicate the deletion.

Oversize materials (e.g., maps, drawings, charts) are reproduced by sectioning the original, beginning at the upper left-hand corner and continuing from left to right in equal sections with small overlaps. Each original is also photographed in one exposure and is included in reduced form at the back of the book.

Photographs included in the original manuscript have been reproduced xerographically in this copy. Higher quality 6" x 9" black and white photographic prints are available for any photographs or illustrations appearing in this copy for an additional charge. Contact UMI directly to order.

UMI

**A Bell & Howell Information Company
300 North Zeeb Road, Ann Arbor, MI 48106-1346 USA
313/761-4700 800/521-0600**

HOW LEVEL I FIELDWORK PROGRAMS
ARE BEING INFLUENCED BY THE
CHANGING HEALTH CARE SYSTEM

A Thesis

Presented to

The Faculty of the Department of Occupational Therapy
San Jose State University

In Partial Fulfillment
of the Requirements for the Degree
Master of Science

by

Teri Lin Jetter

December, 1995

UMI Number: 1377238

**Copyright 1995 by
Jetter, Teri Lin
All rights reserved.**

**UMI Microform 1377238
Copyright 1996, by UMI Company. All rights reserved.**

**This microform edition is protected against unauthorized
copying under Title 17, United States Code.**

UMI

**300 North Zeeb Road
Ann Arbor, MI 48103**

© 1995
Teri Lin Jetter
ALL RIGHTS RESERVED

APPROVED FOR THE DEPARTMENT OF OCCUPATIONAL THERAPY

Karen Diasio Serrett, Ph.D., OTR, FAOTA

Gordon U. Burton, Ph.D., OTR

Amy Killingsworth, M.A., OTR

APPROVED FOR THE UNIVERSITY

Serena H. Stanford

ABSTRACT
HOW LEVEL I FIELDWORK PROGRAMS
ARE BEING INFLUENCED BY THE
CHANGING HEALTH CARE SYSTEM

by Teri Lin Jetter

The purpose of this study was to gain information to help eliminate the shortage of fieldwork sites available to San Jose State University's Occupational Therapy Department. The following were areas examined in relation to student fieldwork programs: (1) attitudes held by occupational therapy managers, (2) perceived influences of managed health care and, (3) which clinical supervisors were willing to initiate student programs in their facilities. Questionnaires were mailed to clinical supervisors of 258 health care facilities in the San Francisco Bay Area that employed Occupational Therapists.

Findings revealed that clinicians continue to feel a strong commitment to their role as clinical educators, although the clinical environment is rapidly changing. Identified clinical changes were re-organization, patient care program changes, and higher productivity expectations. Many clinical supervisors indicated their clinical environment was not suited for clinical education, that they were not adequately prepared for the role of clinical educator, and in general the fieldwork education program was not effective in preparing students. A significant number of clinical supervisors, willing to participate in SJSU's fieldwork program, were identified.

TABLE OF CONTENTS

ABSTRACT	iii
LIST OF TABLES	vi
CHAPTER 1. INTRODUCTION	1
Purpose	1
Statement of the Problem	1
Research Questions	3
Definition	4
Assumptions	5
Limitations	6
Significance of the Study	6
CHAPTER 2. LITERATURE REVIEW	9
Overview	9
Level I Fieldwork	9
Purpose	9
Structure	11
History	12
Costs and Benefits	14
Current Changes Influencing Student Programs	15
Managed Health Care	15
Limited Number of Fieldwork Sites	20
Factors Influencing Student Success	20
Supervision	21
Environment/Treatment Setting	24
Interpersonal and Professional Skill Development	25
Stress	26
Conceptual Framework	27
Summary	29
CHAPTER 3. DESIGN AND METHODOLOGY	31
Purpose	31
Questions	31
Respondents	32
Procedures	33
Data Collection and Analysis	34

CHAPTER 4. DATA AND RESULTS	36
Research Questions	36
Question One	36
Question Two	43
Question Three	43
Question Four	46
Question Five	47
Question Six	48
Question Seven	53
Question Eight	54
CHAPTER 5. DISCUSSION, IMPLICATIONS AND RECOMMENDATIONS	56
Discussion	56
Question One	56
Question Two	57
Question Three	58
Question Four	59
Question Five	59
Question Six	60
Question Seven	63
Question Eight	64
Professional Implications and Recommendations	65
REFERENCES	71
APPENDICES	
A. Questionnaire	75
B. Cover Letter for Participants	80

LIST OF TABLES

TABLE 1:	Type of Organization	37
TABLE 2:	Type of Practice Setting	38
TABLE 3:	Area of Practice	39
TABLE 4:	Focus of Treatment	40
TABLE 5:	Size of Occupational Therapy Department	40
TABLE 6:	Percent of Time Providing Patient Treatment	42
TABLE 7:	Number of Occupational Therapy Staff Employed	42
TABLE 8:	Current Participation in Clinical Education	44
TABLE 9:	Perceived Influence of Managed Health Care	45
TABLE 10:	Type of Agency Influenced by Managed Care Contracts	46
TABLE 11:	Changes in Practice in Past Year	47
TABLE 12:	Changes in Student Fieldwork Programs	49
TABLE 13a:	Values and Attitudes Toward Student Skills - Part 1	49
TABLE 13b:	Values and Attitudes Toward Student Skills - Part 2	51
TABLE 14:	Values and Attitudes Toward Student Fieldwork Programs	52
TABLE 15:	Barriers to Participation in Fieldwork Education	54
TABLE 16:	Benefits to Participation in Fieldwork Education	55

CHAPTER 1

INTRODUCTION

Purpose

The purpose of this study was twofold. The first was to obtain demographic information from health care agencies employing occupational therapists in the San Francisco Bay Area that may be helpful in identifying new fieldwork sites. This information may be used by the Department of Occupational Therapy at San Jose State University (SJSU) to update fieldwork files. The second was to gain a better understanding of how student clinical programs and clinical supervisor's attitudes toward student programs are being influenced by the rapidly changing health care climate.

Specific areas of investigation were: 1) demographic information of work settings, employees and clientele, 2) current involvement and interest in fieldwork programs, 3) perceived influences of managed care changes on the structure of the work place and adjustments to these changes, 4) perceived influences of managed care changes on student clinical programs, 5) clinicians' values and attitudes toward clinical education and student skill development, 6) perceived barriers to participation in student clinical programs, and 7) perceived benefits to participation in student clinical programs.

Statement of the Problem

Recently, there has been a dramatic increase in the number of students interested in studying occupational therapy at SJSU,

creating a high demand for academic and clinical opportunities. Concurrently, widespread health care management changes are greatly affecting the delivery of occupational therapy services in the clinical setting. Fieldwork clinical programs may be influenced in two ways: (1) growing academic demands may not be met as a result of the shortage of fieldwork sites and (2) students may need further preparation to be successful in the work environment due to the rapid changes taking place.

Clinical experience is an essential part of the occupational therapy curriculum as it links the student's technical abilities to their knowledge of theory, transforming them into skillful professionals. The continuity of this process is being threatened by the evolving health care system. Crist (1991) stated, "many current academic programs are not completely successful in transforming incoming students into practitioners, and fieldwork educators are finding this same dilemma as their practice becomes more complex" (p. 3).

Managed care changes may be affecting job satisfaction of those working in clinical settings. Meyers (1995) found that when student supervisors were not satisfied with administrators, there was a direct effect on the clinical education of students. Hearing supervisors talk about dissatisfaction increased students' stress. Continuous communication between subordinates and administrators enhances clinical education by decreasing stress. Meyers (1995) concluded that "clinical education may be enhanced

and stress reduced for all persons involved through improved communication, structure, education and support" (p. 107).

The changes in health care have resulted in the restructuring of clinical departments, increasing pressure for productivity and decreasing time for student supervision. This may be contributing to the degree of stress under which therapists are currently working. Increased work loads and decreased time and support are limiting therapists' interest and ability to participate in clinical education. Additionally, these changes may be creating a need for fieldwork students to be more independent and self directed.

Research Questions

The questions that guided this research were:

1. What are the current demographics relating to the work environment for occupational therapists employed in the San Francisco Bay Area?
2. Are there clinical supervisors interested in participating in fieldwork education who are not currently doing so?
3. Do clinical supervisors perceive that their clinical practice of occupational therapy has been influenced by managed health care changes?
4. What are identified as changes that have occurred in the clinical setting in the past year?
5. What is the perceived impact of clinical practice changes on student fieldwork programs?

6. What are the values and attitudes of clinical supervisors toward student skills and student programs?

7. What do clinical supervisors identify as barriers to the participation in fieldwork education?

8. What do clinical supervisors identify as benefits to the participation in fieldwork education?

Definitions

Academic Fieldwork Coordinator: The faculty member at the academic institution that monitors the fieldwork experiences (AOTA, 1994).

Clinical Supervisors: A clinical therapist who has managerial and supervisory responsibilities for a particular department, in addition to treatment oriented responsibilities. Used interchangeably with clinical manager.

Didactic Assignments: Course work assigned to students that is instructive in nature and used for the purpose of teaching or learning.

Fieldwork Education: The clinical portion of the occupational therapy curriculum. It is used interchangeably with the terms practicum, internship, fieldwork, fieldwork experience, and clinical or fieldwork education program.

Level I Fieldwork: A fieldwork experience required of occupational therapy students as an integral part of didactic courses. It is integrated throughout the academic program; the

amount and nature of the experience is decided by the academic educational program (AOTA, 1994). It is often referred to as a practicum.

Level II Fieldwork: A fieldwork experience for the minimum length of 6 months, which is usually divided into two, three month work experiences. It is designed to promote clinical skills (AOTA, 1993). It is often referred to as an internship.

Fieldwork Educator: Each individual responsible for student training in the fieldwork placement is considered a fieldwork educator. They may also be known as clinical educators or student educators (AOTA, 1993).

Fieldwork Objectives: Written statements that specify the minimal level of performance the student must meet in order to fulfill fieldwork expectations (AOTA, 1994).

Health Care Facilities: Facilities that offer health care services.

Managed Health Care: A system designed to manage health care cost by imposing a set of techniques used on behalf of purchasers of health care benefits (Smith & Elberth, 1993).

Site Fieldwork Coordinators: The clinical student supervisor in charge of student placement within the facility, contact with academic fieldwork coordinator and overseeing student clinical education.

Assumptions

The researcher had three main assumptions while doing this study: 1) those surveyed understood the terminology used in the

questionnaire, including use of fieldwork and managed health care terms, 2) managed health care effects are being felt by many of the occupational therapy clinics used in this study, and 3) clinical managers surveyed had sufficient fieldwork education experience to contribute to the study, although they may not have currently been participating in clinical education.

Limitations

Due to limited financial resources, a follow-up/reminder to the respondents was not sent. This limitation may have had an effect on the response rate for this survey, limiting the quantity and comprehensiveness of information obtained.

The primary resources used to identify facilities to be included in this study, the SJSU data base and the Occupational Therapy Association of California (OTAC) Directory, did not have current mailing information for many facilities. Fifty-nine mailed surveys were not received due to a change of address or contact person and were returned to the sender, again limiting the amount of information obtained.

No conclusions can be drawn from the results of the demographics and current working conditions portion of the survey because the respondents were not selected using a random sample methodology and there is no baseline for comparison. Therefore these findings can not be generalized to other geographic locations.

Significance of the Study

This study attempted to identify the effects of current trends and changes occurring in the occupational therapy clinical setting on Level I Fieldwork student programs. The resulting information was submitted to the Department of Occupational Therapy at San Jose State University as it may be useful in adapting the fieldwork program.

When reviewing the literature, the ensuing commitment to professional and educational excellence was evident throughout the field of occupational therapy. Professionals in all realms, including educators, clinicians and those representing the professional organizations, have continued to strive to strengthen the structure of the field.

The American Occupational Therapy Association (AOTA) is continuously revising, updating and developing its official documents. This is a necessary process as it is apparent that rapid changes are occurring in the health care environment. Academia and the educational curriculum is the foundation upon which professional development begins. It is the responsibility of occupational therapy professionals to remain committed to the development of education programs. Collaborating with academicians allows clinicians the opportunity to provide valued experience useful in structuring the academic foundation.

Presseller (1983) discussed the importance of fieldwork educators communicating changes in the practice setting to

academic faculty and providing input into curriculum development. She states that students will be placed in a variety of settings as a result of changes in the service delivery model and educators must adjust academic activities accordingly.

Crist (1991) presented two ideas to increase the chance of fieldwork survival: changing teaching methodologies and using non-traditional fieldwork models. It is proposed that the occupational therapy academic structure follow that of other health fields and divide the responsibility of education. This model would structure the academic program teachings toward basic didactic and clinical skill and the educator-practitioner teachings toward how to adapt and apply skills to clinical practice (Crist, 1991).

CHAPTER 2

LITERATURE REVIEW

Overview

This review will first present the purpose, structure, history, and cost and benefits of Level I fieldwork. Next, two current changes that may influence student programs, (1) managed health care and (2) limited number of fieldwork sites, are presented. Thirdly, those factors that may influence student success in fieldwork are discussed. The relevant areas discussed in this section include supervision, environment/treatment setting, interpersonal and professional skill development, and stress. Finally, the Occupational Adaptation Frame of Reference, which guided this research, is presented.

Level I Fieldwork

Purpose

A crucial component to the preparation of an occupational therapist is the fieldwork experience, which enhances the student's beginning skills in observation, interviewing and task analysis (AOTA, 1994) by providing supervision and professional role modeling (AOTA, 1991).

As described by the AOTA Essentials (1991), Level I Fieldwork experiences are "designed to enrich didactic course work through directed observation and participation in selected aspects of the occupational therapy process" (p. 9).

Shalik found in her nationwide survey of Level I fieldwork sites and academic programs that the role of the Level I fieldwork student is most often that of the passive observer or assistant and the student is rarely involved in treatment of the patient, although one-on-one supervision is very high (Shalik, 1990).

Presseller (1983), identified fieldwork as an opportunity to develop interpersonal skills with patients and staff, leading to the development of characteristics needed for productive working relationships.

Swinehart and Meyers (1992) used qualitative research to identify the purpose of Level I Fieldwork as described by students, clinical educators and faculty. All three groups identified in the study agreed that one purpose is to integrate theory and practice, thus bringing together the clinic and the classroom.

Following their case study that looked at students and fieldwork problems, Kramer and Stern (1994) stated that the primary concern of faculty members and fieldwork coordinators was to identify whether the student is able to apply theoretical material in practice and perform competently in the clinical environment. Additionally, they stated, "it is important to attempt to identify potential problem areas during Level I Fieldwork to avoid repeated difficulties during Level II placement" (p. 158).

Another study that attempted to clarify the purpose of Level I Fieldwork, analyzed choices of academic faculty, fieldwork supervisors, and students (Kautzmann, 1987). The respondents

ranked 24 predetermined objectives in order of value. The top five faculty and supervisor choices, and top six student choices were in the pre-classified category of student involvement in occupational therapy treatment. These findings reflect the common value placed on student/patient interaction. The author suggested that academic faculty members need to find ways to integrate treatment planning into Level I Fieldwork design, pointing out the need for cooperative planning between academic and facility supervisors. The author concluded that there is a strong agreement between faculty and fieldwork educators on the purposes of Level I Fieldwork, which primarily related to student/patient interaction (Kautzmann, 1987).

Structure

The academic education program has the responsibility to determine the nature and amount of Level I Fieldwork required as guided by their institutional mission, programmatic philosophical base, curriculum design, and resources (AOTA, 1991). Structure, implementation and objectives of fieldwork experiences may vary among academic institutions, creating a need for academic and clinical supervisors to maintain constant communication. Major variables identified in the delivery of the experience included academic curriculum and fieldwork supervision (Kautzmann, 1987).

The following standards are in effect at this time (1995). The placement site must be run by a certified and/or licensed educator, meet educational program's standards and be approved by appropriate accrediting agencies (AOTA, 1991).

General fieldwork objectives are usually developed by the academic educational program as they correspond to didactic course material. There may be collaboration with the fieldwork site in the development of placement-specific objectives (AOTA, 1991). Shalik's (1990) study revealed that goals and objectives are indeed primarily developed by academic faculty with comments from clinical personnel.

Schedule and time structure may vary between academic institutions. Swinehart and Meyers (1992) found that students preferred a week of five consecutive days, rather than a half day for seven weeks. This provided a more well rounded experience allowing them to focus and concentrate on the experience. Patterns of placement of Level I students closely follow the most common areas of practice including: physical dysfunction, psycho-social dysfunction and pediatrics. The setting of these placements tend to be traditional to the field, including hospitals, schools, residential facilities, and rehabilitation centers (Shalik, 1990).

Kautzmann (1987) suggested that faculty members and fieldwork supervisors look beyond their individual needs and work toward strengthening the structure of the Level I Fieldwork experience. A collaborative effort is needed to establish an effective fieldwork structure.

History

As the health care system has developed and changed over the years, so has the fieldwork model. Fieldwork has remained a

primary element in the standards of education although it has faced challenges and changes in structure, content, scope and duration.

Opacich (1995) described three major waves of the development of the current fieldwork model. The first wave was driven by empathy and altruism with a strong mentorship focus on ideational values rather than technical aspects. The second wave, influenced by World War II, marked the beginning of formal education programs and fieldwork experience that shifted from the mentorship focus to a supervisory model allowing less time for "philosophical rumination" (p. 160). The final wave coincided with the second wave and was identified by further development of education programs and a continued lack of mentorship in fieldwork experience.

The first Standards in 1923 required a three month clinical experience for Level II fieldwork which was extended to nine months in 1935 and again changed in 1973 to six months (Presseller, 1983).

There are two features that result in the prevailing fieldwork model: "1) replacement of intense mentorship with an expedient supervisory system and 2) vacillation between commitments to education and job training" (Opacich, 1995).

The literature provides evidence of high value placed on a strong mentorship/supervisory structure as seen by the continued change in the fieldwork structure. The recent changes in health care delivery pose a threat to this structure. To maintain the professionalism of occupational therapy, there must be a continued

effort to modify our educational preparation to meet the demands of the rapidly changing health care field.

Costs and Benefits

There are many costs and benefits, both monetary and non-monetary to those involved in fieldwork education including the student, student supervisor, administrator and patient. Meyers (1995) completed a naturalistic inquiry study to identify monetary and non-monetary costs and benefits. The author states the the results are not generalizable, yet can be useful in other education sites. Her findings can be applied to this study. The study revealed the following costs to the supervisor: stress, space for students, supplies used by students, loss of revenue, frustration, loss of esteem, and responsibility.

Two commonly identified sources of stress for supervisors were (1) organizational structure over which supervisors felt they had little control, and (2) conflicting constructions of nonmonetary cost drivers among supervisors and their administrators. These also contributed to a stressful student experience. Space needed for students was recognized as one of the higher costs along with lost revenue driven by the need for student supervisors to use time to educate students.

The benefits to supervisors were: learning, relationship formation, staying current in practice, satisfaction, self esteem, excitement and professional commitment (Meyers, 1995).

The benefits identified by this study contributed to supervisors' belief that they were doing a service to the profession. Supervisors stayed current in research and treatment techniques to better educate their students. Supervisors also benefited from student projects and assignments, and students enthusiasm for clinical practice.

In a study conducted by Shalik (1990), 47% of the respondents indicated that they perceived no reduction in clinic productivity resulting from the presence of Level I students, 37% felt productivity was decreased and 11% indicated that the presence of Level I students actually increased their productivity. The results of this study also revealed that 70% of the fieldwork sites received remuneration for training, 25% in the form of free tuition for the supervisor (Shalik, 1990).

Current Changes Influencing Student Programs

Managed Health Care

The past several years have been marked by radical shifts in our health care payment system. It is suggested that these changes will continue to occur, eventually reaching every realm of patient care delivery. Managed health care, an alternative form of health care reimbursement, has occurred in response to the dramatic increase in the cost of health care over the past 15 years. This can be seen by the 120% increase in health care cost in the period between 1980 and 1987. In 1991 our country spent 12.5% of the gross national product on health care. This number is predicted to

reach \$1.6 trillion by the year 2000 (Smith & Elberth, 1993). Smith and Elberth (1993) described managed care as "a set of techniques used by or on behalf of purchasers of health care benefits, to manage health care costs by influencing decision making, through case-by-case assessments of the appropriateness of care" (p. 22). Each managed care plan differs, but all attempt to control the cost of service by controlling the location and duration of treatment and still maintaining the quality of care delivered (Smith & Elberth, 1993). This cost controlling approach may have profound affects on the clinical work environment and the delivery of therapy services.

In a recent survey conducted by AOTA (1995), the primary reason facilities identified for not participating in managed care plans was the low rate of reimbursement for services. Other reasons were the administrative burden and insufficient volume. When asked to describe their opinion of how managed care effects patients, over 60% of non private practice and 80% of private practice clinicians identified increased limits on care. The second most common agreed on effect was less occupational therapy delivered per patient, and thirdly, inadequate care given to patients. Limits identified under managed care were number of visits, dollars per procedure, days of treatment, dollars per day and practice setting (AOTA, 1995). Therapists are expected to accomplish the same goals in less time, creating a shift to a more outcome-oriented focus, thus increasing clinicians' stress level.

The focus of Smith and Elberth's article (1993) was the effect of managed care on the mental health treatment settings where treatment had become more consumer driven and outcome-oriented by providing a continuum of services. They identified the following effects of the managed care: limited benefits and accessibility of services to consumers; increased demands on therapist for documentation and limited time available for direct treatment; concerns about confidentiality and ethical issues as the therapist is placed between the insurance companies and the patient; and changes and expansion in treatment approaches (Smith & Elberth, 1993).

Jabri (1995) discussed changes resulting from managed care with which the occupational therapist may need to be prepared to cope, including: (1) ethical issues regarding limitations on the amount of time permitted for treatment, (2) increasing management roles such as changing management structures within departments from Occupational Therapy Directors to Rehabilitation Managers, (3) functioning within transdisciplinary teams and role blending, and (4) increasing treatment focus on outcome measures. While many clinicians are experiencing these rapid changes, committing to responsibilities such as student supervision may be difficult. Requests from academic fieldwork coordinators may be met with resistance.

An exploratory study was done by Griffin (1993) to determine what occupational therapists perceive as the factors that result in

successful practice in a short-stay environment in Australian occupational therapy practice. This study was done in response to the cost cutting measures introduced into the health care system as they resulted in a number of changes to the work force and the priorities of services delivered in hospitals. The following changes were outlined in the article: decreased number of OT positions, creating a need to prioritize where services were to be delivered within the hospital; pressure for doctors to discharge patients quickly, placing constraints on the nature of OT services provided; and disparity between what students learn about OT services and the reality of the current environment. Griffin (1993) stated, "Students on placement and new graduates entering the short-stay environment face a major adjustment in altering the practice they have been taught in order to provide appropriate services in this setting" (p. 1089).

Griffin (1993) discussed the reconceptualization of occupational therapist role as the treatment environment has shifted from an "assess-treat-discharge" to an "assess-discharge" structure. She stated that "the therapist frequently adopts coordination and patient advocacy roles to ensure the most desirable discharge" (p. 1088). This included detailed referral to follow-up services, family education and providing written material to reinforce their intervention.

Therapists expressed ambivalence about whether they were doing an adequate job as they continually needed to prioritize and

set limits to patient needs. For instance, two settings of the three used in the study did not see patients who were being discharged to nursing homes and priority was given to those who would likely return home.

Other notable outcomes of the changing health care climate were: limited ability to develop special skills in an area because of the lack of long-term intervention, limited time for professional development activities such as conferences, and being faced with dissatisfied families who have questions about rapid discharge (Griffin, 1993).

In response to the changes in reimbursement, the occupational therapy profession has altered its definition, practice, management, ethics, and professional response, according to Howard (1991). She pointed out that what occupational therapists can do and how they document what they do is determined by what is reimbursable, thus what they are is also determined by what is reimbursable. In addition to defining occupational therapy, reimbursement determines the frequency and nature of treatment. This results in ethical issues for therapists. For example, they may be encouraged to focus efforts on programs that bring in revenue but are less clinically effective. Another ethical concern presented was overworking employees to maintain revenues.

Howard (1991) found that management style in occupational therapy departments are also faced with changes in response to high priority goals such as productivity and efficiency. Changes included

fewer treatment sessions to meet goals, decreasing lengths of stay by focusing treatment on those problems which are keeping the patient in the hospital, use of assistants, aides, volunteers and part-time staff to cut cost, use of computer documentation for faster charting, and doing evening and weekend treatment to speed recovery process (Howard, 1991).

Limited Number of Fieldwork Sites

There is an increasing demand for academic institutions to provide occupational therapy curriculums and fieldwork placements. Crist (1993) estimated an additional 4,350 fieldwork placements will be needed from 1994-1996. This could have a disastrous effect on occupational therapy fieldwork system as it is now structured.

Opacich (1995) identified current terminology, such as "phys-dys" and "psych" as a limiting factor to the future of fieldwork. She states such terminology stifles creativity by placing boundaries and limitation around the practice areas in which occupational therapy can be effective. In contrast to the traditional use of this terminology, current literature points to the need to develop new, non-traditional fieldwork sites to meet demands.

Factors Influencing Student Success

In a study conducted by Meyers (1995), students and student supervisors identified different reasons for student failure. According to supervisors, students were not adequately prepared for clinical work; they had poor technical, problem-solving, and

communication skills and had inadequate self-awareness. Students identified reasons for failure as a result of inadequate supervision, poor communication, inadequate feedback, lack of structure, and personality clashes with supervisors.

Supervision

The student/supervisor relationship and the supervisor's level of experience are strong factors in determining student success. Christie, et al. (1985) suggested that the relationship between the student and the supervisor is the most significant aspect of the fieldwork experience. Hertzberg stated, "Supervisors are the gatekeepers who maintain the quality standards of the profession by providing professional socialization and by acting as role models" (1993, p. 817).

A study to identify fieldwork supervisor's needs discovered that occupational therapy and physical therapy students commonly experience unsatisfactory interpersonal relationships with supervisors and team members (Christie, et al., 1985). Given the importance of the role of a clinical supervisor, it seems necessary to continue to evaluate the procedure used to prepare therapists for these duties.

There are many responsibilities that accompany the clinical supervisory role, including administrative functions and direct daily supervision. As stated by AOTA (1994):

Fieldwork educators who supervise students must remain sensitive to the changing needs of each student while, at the

same time, promoting the student's development of effective therapeutic relationships, evaluation and treatment techniques, and clinical problem-solving skills. In addition, the fieldwork educator must facilitate the assumption of professional responsibility, behavior and attitudes, self-confidence, and personal growth (p. 93).

Professional guidelines do not require supervisory skills training prior to becoming a clinical educator. Requirements are minimal, stating the supervisors of Level I students may be occupational therapy personnel or other professionals who are knowledgeable about occupational therapy and Level I goals and objectives. Supervisors of Level II students must have one year experience in a practice setting.

AOTA has developed a training manual and video for fieldwork educators; Self-paced Instruction for Clinical Education and Supervision (SPICES) (AOTA, 1994) that must be purchased and is not a required prerequisite. Further specification for training required for clinical educators was not found in the literature.

Opacich (1995) identified the lack of preparation of fieldwork supervisors as a continual problem with fieldwork sites. She questioned the practice of expecting clinical therapists, who are not formally prepared, to design and provide clinical education programs.

Yuen (1990) suggested that many supervisory clinicians experience burnout resulting in negative effects on their student's

clinical experience. He proposed more effort needs to go into supervisor's behavior and skill development and speculates burnout is due to inadequate professional preparation. A revised curriculum is suggested.

Swinehart (1992) found that perceived commitment of clinicians to the role of educator has a strong influence on the Level I Fieldwork student's experience. Factors identified which may interfere with supervisor commitment are staff shortages, cancellations of Level I Fieldwork students, requirements the academic program imposes, quality assurance issues, productivity pressures, and location or geography of the site (Swinehart, 1992).

Considering the recent disruption in many clinical settings, created in the wake of managed care changes, supervisors may be in a compromised situation for providing a positive student experience.

In addition to facing changes in the health care system, student supervisors are faced with a changing student population with diverse age, interest and abilities. Kautzmann (1990) completed a study in response to changes in higher education to an older student population and greater disbursement of women into traditionally male-dominated fields of study. The purpose of her study was to identify student supervisors' educational needs by ascertaining their values and attitudes toward adult education as they relate to Knowles' theory and practice of adult education.

When respondents were asked to score on a Likert scale statements derived from Knowles' principle, the highest ranked statement was the acknowledgment of students' need to be oriented to the facility (Kautzmann, 1990). Ranked second was "value of incorporating students' interests, skills, and experience" and third was, "respect for learners' feelings and ideas" (p. 837).

The overall findings of the study were interpreted as a positive indication that attitudes that facilitate learning are present in student supervisors. Supervisors have respect and value for the uniqueness of students, including their ideas, interests, feelings, skills and experience (Kautzmann, 1990).

Environment/Treatment Setting

Meyers (1995) found the most positive student experiences were in environments where supervisors report feeling satisfied with work environment and structure for students was high. Things identified as affecting the student's experience include a thorough site orientation, the provision of a manual and handouts with clear expectations, and sharing experiences with other students (Meyers, 1995). Meyers concluded that structure enhances the student's ability to adapt to a work environment and maximizes their performance.

Students felt stress was reduced by increased structural elements such as eye contact from clinicians, assigned locations in which to work, written schedules, and a single supervisor over multiple supervisors (Meyers, 1994).

Changes in the delivery of treatment effects the students' experience by placing them in a greater variety of settings. The decreased time patients spend in the inpatient setting has decreased the chances that students will see long term effects of their intervention. Presseller (1983) speculated that this will make it more difficult for the student to validate how theory and what was learned in the classroom applied to practice.

Interpersonal and Professional Skill Development

Students often have difficulty with the transition from structured, passive learning to active learning required in the clinical setting. Herzberg's (1993) study to examine clinical supervisors' perceptions of learning characteristics of successful students revealed the following themes: doing, active experimentation, flexibility, adaptability, and teamwork. Sub-skills of the previously mentioned characteristics were ability to structure time, and good communication skills.

Swinehart and Meyers (1992) identified inadequate time management skills and behavior problems as the two major reasons for student failure of fieldwork experiences. They identified a need for the clarification of who is to address student interpersonal skill development. An outcome of their study indicated that faculty expected clinicians to supervise students and manage behavioral problems by giving students feedback.

Sands (1995) presented the student conference model, based on the idea that attitudes and interpersonal behaviors of a student

in the academic setting are good means for an educator to predict fieldwork success or failure. She stated that preparation for fieldwork experience needed to go beyond academics: "Educators have the responsibility to prepare students academically and humanistically for their careers in occupational therapy" (p 150).

Kramer and Stern (1994) used a case study approach to gain insight into problems encountered with students in fieldwork. Difficulty engaging in the supervisory process was a consistent theme found with students having fieldwork problems. Students most needed to develop a sense of personal responsibility for their actions and a willingness to accept feedback.

The literature pointed out the confusion regarding whose role it is to address student interpersonal skill development. Communication must occur between academic, clinical educators, and students themselves to insure student interpersonal skill development needs are met.

Stress

Meyers (1995) found that student performance worsened with increased stress. Stresses were identified by students as being watched by their supervisor, having trouble with critical thinking time management and communication, lacking skills in treatment techniques, fearing failure, working with very ill patients, and the adjustment to the role of worker. Stress was also caused by negative feedback from supervisors. In one case, negative feedback was identified as the reason for a student's failure. Hearing

supervisors talk about dissatisfaction increased their stress. Continuous communication between subordinates and administrators enhanced clinical education by decreasing stress (Meyers, 1995).

Conceptual Framework

The Occupational Adaptation Frame of Reference was used to guide this research. Occupational adaptation is described by Levine and Brayley (1991) as "the process by which individuals make their behavior, attitudes, or values more suitable to meet external and internal demands" (p. 622). Role function is indicated by the individual's ability to be successful in adapting performance to meet environmental demands in an open system by using feedback from the environment (Levine & Brayley, 1991).

Schkade and Schultz (1992) described occupational adaptation as a process integrating the constructs of "occupation and adaptation into a single interactive construct" (p. 829). "Occupational adaptation is the process through which the person and the occupational environment interact when the person is faced with an occupational challenge calling for an occupational response reflecting an experience of relative mastery" (p. 831). Using meaningful occupations, this frame of reference focuses on the person's internal adaptation process. This framework is applied to the normative process of adaptation when it is disrupted by trauma, illness or transition and considers relevant holistic factors including

the environment, the person and their interaction (Schkade & Schultz, 1992).

The view of the person includes the individual's sensorimotor, cognitive and psychosocial systems, while the environment is discussed in the contexts of work, play and leisure, and self-maintenance. The subsystems identified in the environmental contexts are: physical, social and cultural. Two assumptions are identified: 1) the person desires to behave adaptively and masterfully and 2) the occupational environment demands adaptation and mastery (Schkade & Schultz, 1992).

The occupational adaptation flow process begins with an "occupational challenge and proceeds to a perception of the internal and external expectations for occupational performance" (p. 832). From these perceptions an occupational response is generated, the outcomes are evaluated, and feedback from the response is integrated for further use (Schkade & Schultz, 1992).

Garrett and Schkade (1995) did a study to test the validity of a model of professional development based on occupational adaptation. Results showed three classes of adaptation behaviors used by students: primitive, transitional, and mature. Garrett and Schkade (1994) maintained that when role demands exceed one's adaptive capacity, one is at risk for occupational dysfunction. The students in this study showed an increase of primitive and transitional behaviors when demands were increased or unusual. Professional transition, such as from the classroom to the clinic, is

likely to exceed one's adaptation capacity if one is not adequately prepared or if perceptions of one's role expectations differ from what is encountered (Garrett & Schkade, 1994).

This frame of reference can be applied to the developmental learning process of Level I Fieldwork students as they are in a state of transition from the role of student to that of professional clinician.

Summary

The literature revealed the potential for many interpretations of the purpose and structure of Level I fieldwork, yet demonstrated the continued commitment to maintaining excellence when faced with change.

Recent literature pointed consistently to the dramatic changes taking place in the health care system. The effects of these changes are projected by many and documented by others as already being felt in the clinical setting. There is little information however, describing the direct influences of these changes on student fieldwork programs. Additionally, changes in the student population, such as women moving toward traditionally male-dominated fields of study and a larger older student population, were evident in the literature. These changes also contributed to the fieldwork dilemmas.

Many factors influence student success in fieldwork. Much of the literature pointed to the supervisory process as the most significant of these factors. Also commonly discussed was the

environment or treatment setting, interpersonal and professional skill development of the student, and stress.

A recurrent theme is the need for collaboration between academicians and clinicians to effectively cope with the changes currently taking place. Continuing to provide a positive experience for the fieldwork student is of primary concern, as this is the time the student is able to apply theory to practice and begins to develop skills needed to become a competent therapist.

CHAPTER 3

DESIGN AND METHODOLOGY

Purpose

The purpose of this study was two fold. The first was to obtain demographic information from health care agencies employing occupational therapists in the San Francisco Bay Area that may be helpful in identifying new fieldwork sites. This information may be used by the Department of Occupational Therapy at San Jose State University (SJSU) to update fieldwork files. The second was to gain a better understanding of how student clinical programs and clinical supervisor's attitudes toward student programs are being influenced by the rapidly changing health care climate.

Specific areas of investigation were: 1) demographic information of work settings, employees and clientele, 2) current involvement and interest in fieldwork programs, 3) perceived effects of managed care changes on the structure of the work place and adjustments to these changes, 4) perceived effects of managed care changes on student clinical programs, 5) clinicians' values and attitudes toward clinical education, 6) perceived barriers to participation in student clinical programs, and 7) perceived benefits to participation in student clinical programs.

Research Questions

The questions that guided this research were:

1. What are the current demographics relating to the work environment for occupational therapists employed in the Bay Area?

2. Are there clinical supervisors interested in participating in fieldwork education who are not currently doing so?
3. Do clinical supervisors perceive that their clinical practice of occupational therapy has been influenced by managed health care changes?
4. What are identified as changes that have occurred in the past year?
5. What is the perceived impact of clinical practice changes on student fieldwork programs?
6. What are the values and attitudes of clinical supervisors toward student skills and student programs?
7. What do clinical supervisors identify as barriers to the participation in fieldwork education?
8. What do clinical supervisors identify as benefits to the participation in fieldwork education?

Respondents

The respondents for this research were occupational therapists who were department heads and/or site fieldwork coordinators in the Santa Clara, Golden Gate, and Diablo View Chapters of the Occupational Therapy Association of California (OTAC), and in fieldwork sites who had contracts with the Department of Occupational Therapy at San Jose State University. Approximately 258 clinical sites were identified from a directory of membership and facilities of the Occupational Therapy Association of California (OTAC, 1994) and the data base of clinical sites

provided by Department of Occupational Therapy at San Jose State University.

Procedure

A descriptive research design, using a mailed questionnaire was applied in this study to obtain information about the perceived effects of changes in the management of health care facilities on Level I Fieldwork programs. Data was collected by a mailed self-report questionnaire (Appendix A) designed by the researcher. A pilot study was conducted to elicit feedback from five occupational therapy supervisors on the questionnaire. The questionnaire and cover letter (Appendix B) were hand delivered to the selected respondents representative of the various types of settings to be surveyed, including private practices, skilled nursing facilities, mental health treatment centers, pediatric clinics, and rehabilitation settings. The respondents were asked to complete the questionnaire and participate in a follow-up interview with the researcher to identify areas that needed revision and clarification. The pilot study elicited useful information that was integrated into the final questionnaire.

The survey instrument consisted of 19 questions. The first 6 questions were aimed at eliciting demographic information including funding source, setting, population served, focus of treatment, capacity and census of the facility. Questions 7 was directed toward treatment hours and staffing hours. Questions 8 and 9 inquired about involvement and interest in student fieldwork

and 9 inquired about involvement and interest in student fieldwork programs. Questions 10-13 requested information about managed care impact. Perceptions of student preparation for fieldwork were addressed in question 14. Numbers 15-17 were directed at clinicians' attitudes and values toward clinical education. Numbers 18 and 19 elicited information regarding barriers to establishment of student programs.

Resources used in conducting this study were professional organizations including the American Occupational Therapy Association (AOTA) and the Occupational Therapy Association of California (OTAC) which provided a directory of facilities from which all appropriate respondents were selected, specific literature to complete the literature review, and sample questionnaires from previous surveys to guide in the questionnaire construction. The researcher selected all respondents from the directory that were located within the Santa Clara, Golden Gate, and Diablo View Chapters of the Bay Area.

The Department of Occupational Therapy at San Jose State University provided a data base of facilities that they had currently or previously held fieldwork contracts with to be included in the respondents population for this study. Approximately 125 respondents were obtained from this source.

Data Collection and Analysis

The revised questionnaire, accompanied by a cover letter (Appendix B), explaining the purpose of the questionnaire, was

mailed to the respondents. A stamped, addressed return envelope was enclosed to increase the likelihood of response.

Descriptive statistical analysis was used. Frequencies and central tendencies (mean) were used to describe the questionnaire results. Given the large number of surveys administered (258), descriptive statistical analysis was used to organize the information into manageable categories from which the data could be interpreted.

CHAPTER 4

DATA AND RESULTS

Two hundred fifty-eight questionnaires were mailed to health care facilities with occupational therapy services in the San Francisco Bay Area. Eighty-one (31.4%) questionnaires were returned; 79 were complete and used in the data analysis. Two were incomplete because the agencies did not have relevant information to contribute to the study.

Each research question will be stated then followed by analysis of the data and the results.

Demographic Data

Question 1: What were the demographics relating to the work environment for occupational therapists, employed in the San Francisco Bay Area?

The respondents to the survey identified themselves as follows: clinical education coordinator, practicum coordinator, supervisor, chief occupational therapist, registered occupational therapist (OTR), director of rehabilitation, director of occupational therapy, owner, senior OTR, team leader, director of marketing, vice president of patient care services, activity director, program manager, and program specialist.

Questions 1-7 of the questionnaire focused on demographic data. Respondents were asked to check the type of organization which best described their work setting (see Table 1). There were 79 responses to this question. Private non-profit described 25 (31.6%)

Table 1
Type of Organization
 (n = 79)

Category of Organization	<u>n</u>	Percent
Private, non-profit	25	31.6
Private, for profit	23	29.1
City/County	10	12.6
Public, non-profit	10	12.6
State	5	6.3
Own business	4	5.1
Federal	2	2.5

of the agencies, private for profit described 23 (29.1%) agencies, city or county and public non-profit were each checked by 10 respondents (12.6%), 5 (6.3%) agencies were identified as State affiliated, 4 (5.1%) were identified as their own business, and 2 (2.5%) were identified as federal agencies.

When asked to describe their practice setting by checking all the responses that applied, 39 (49.4%) of the 79 respondents checked more than one response (see Table 2). Skilled nursing facility was checked by 34 respondents (43%), outpatient facility was checked by 32 respondents (40.5%), 30 (37.9%) checked acute care hospital, 25 (31.6%) checked rehabilitation unit or hospital, community agency was checked by 11 respondents (13.9%), and 6 (7.6%) checked private practice/clinic. In the area identified as other there were 21 responses. Subacute rehabilitation was identified by 6 respondents (7.6%), home health service identified

Table 2
Type of Practice Setting
 (n=79)

Setting	<u>n</u>	Percent
Skilled nursing facility	34	43.0
Outpatient facility	32	40.5
Acute care hospital	30	37.9
Rehabilitation unit or hospital	25	31.6
Community agency	11	13.9
Private practice	6	7.6
Other	21	26.6
*More than one response	39	49.4

by 5 respondents (6.3%), 3 (3.8%) wrote in day treatment center, and developmental center, long term rehabilitation, correctional facility, intermediate living center, transitional care unit, post acute rehabilitation, and school based were each identified by 1 respondent (1.3%).

Respondents were asked to describe their areas of practice by checking all those responses that applied (see Table 3). Fifty-five (69.6%) of the 79 respondents selected more than one response. The selections were as follows: 59 (74.7%) checked physical disabilities, 46 (58.2%) checked gerontology, 28 (35.4%) checked mental health, 19 (24.1%) checked pediatrics, 16 (20.3%) checked developmental, and 4 (5.1%) checked school-based practice.

Respondents were asked to identify the primary treatment

Table 3
Area of Practice
 (n=79)

Area	<u>n</u>	Percent
Physical disabilities	59	74.7
Gerontology	46	58.2
Mental health	28	35.4
Pediatrics	19	24.1
Developmental	16	20.3
School-based	4	5.1
*More than one response	55	69.6

focus used in their facility by ranking psychological, physical or social approaches in order of importance (see Table 4). Following Opacich's method (1995), the number "1" was used to identify the primary focus, "2" the secondary and "3" the least area of focus of treatment. Physical was identified as the primary focus by 61 (77.2%) of 77 respondents, 14 (17.7%) identified psychological as primary and 4 (5.2%) identified social as the primary area of focus. The following are the mean rankings or average scores, on a scale of 1 to 3, of each category: physical 1.39, psychological 2.09, and social 2.39.

Respondents were asked to specify the size of their occupational therapy department by filling in appropriate numbers for those categories applicable to their setting (see Table 5). Forty-five respondents identified the range of the number of beds for in-patient facilities as 6-3000, with a mean of 256.5 beds and standard

Table 4
Focus of Treatment
 (n=77)

Focus	<u>n</u> ranked 1	Percent	Mean Score
Physical	61	77.2	1.39
Psychological	14	17.7	2.09
Social	4	5.2	2.39

Table 5
Size of Occupational Therapy Department

Category	Range	<u>n</u>	Percent
Number of beds	6 - 100	20	44.4
	101 - 400	19	42.2
	401 - 1000	5	11.1
	1001 +	1	2.2
Patients receiving OT services daily	4 - 12	16	26.2
	13 - 25	20	32.8
	26 - 50	18	29.5
	51 - 100	5	8.2
	100 +	2	3.3
Daily case load per OTR	1 - 6	22	38.6
	7 - 12	23	40.4
	13 - 20	7	12.3
	21 +	5	8.8

deviation of 470.6. Most facilities (39 or 86.7%) had 6-400 beds, five had between 401-1000 beds, and only one had more than 1000. Sixty-three respondents identified the range of patients receiving occupational therapy services daily as 4-500 with a mean of 37.8 and standard deviation of 63.9. Most facilities (54 or 88.5%) had 4-50 patients receiving OT services daily, with the highest number of these (20) serving 13-25 patients. The approximate daily case load per occupational therapy practitioner from 58 responses ranged from 1-36 with the mean of 10 and standard deviation of 6.9. Twenty-two (38.6%) stated the daily case load per OTR was 1-6 patients, and 23 (40.4%) said the daily case load was 7-12 patients.

The percentage of time spent during an average workday providing patient treatment was specified by 75 respondents as follows: 8 (10.7%) checked less than 60%, 17 (22.7%) checked 60-70 %, 24 (32%) checked 70-80%, 20 (26.7%) checked 80-90%, and 6 (8%) checked 90-100% (see Table 6).

Respondents were asked to indicate the number of occupational therapy staff employed by their agency (see Table 7). Sixty-three respondents (19.7%) indicated full time OTRs ranged from 1-25, with a mean of 4.1. Six (7.6%) indicated full time COTAs (certified occupational therapy assistant) ranged in number from 1-2, with a mean of 1.2. Full time OT aides were identified by 23 respondents (29.1%) ranging from 1-5, with a mean of 1.7. Part time OTRs were indicated by 49 respondents (62%) ranging from 1-10,

Table 6
Percent of Time Providing Patient Treatment
 (n=75)

Percent of time	<u>n</u>	Percent
< 60	8	10.7
60 - 70	17	22.7
70 - 80	24	32.0
80 - 90	20	26.7
90 - 100	6	8.0

Table 7
Number of Occupational Therapy Staff Employed

Category	<u>n</u>	Range	Mean
Full time			
OTRs	63	1 - 25	4.1
COTAs	6	1 - 2	1.2
Aides	23	1 - 5	1.7
Part time			
OTRs	49	1 - 10	2.5
COTAs	8	1	1.0
Aides	15	1 - 3	1.5
Contract			
OTRs	20	1 - 21	3.4
COTAs	4	1 - 2	1.3
Aides	3	1 - 3	1.7

with a mean of 2.5. Part time COTAs were identified by 8 respondents (10.1%) each listing only one. Fifteen respondents (19%) indicated part time aides ranging from 1-3, with a mean of 1.5. Contract OTRs were indicated by 20 respondents (25.3%) ranging from 1-21, with a mean of 3.4. Contract COTAs were identified by 4 respondents (5.1%) ranging from 1-2, with a mean of 1.3. Contract aides were identified by 3 respondents (3.8%), with a range of 1-3 and a mean of 1.7.

Research Questions

Question 2: Were clinical supervisors interested in participating in fieldwork education who were not currently doing so?

Respondents were asked to indicate their current participation in clinical education (see Table 8). Of 77 responses, 39 (50.6%) were currently supervising SJSU students, 31 Level I (practicum) and 30 Level II (internship). Thirty-eight (49.4%) indicated they were not currently supervising SJSU students, and 23 of this group were supervising students from other universities. When asked if they would consider supervising students if not currently doing so, 21 responded yes, 12 were uncertain and 2 responded no.

Question 3: Did clinical supervisors perceive that their clinical practice of occupational therapy was influenced by managed health care changes?

Forty-nine (64.5%) of the 76 responses were yes; they perceived their departments had been influenced by managed health

Table 8
Current Participation in Clinical Education
 (n=77)

Participation Level	<u>n</u>	Percent
Currently supervising SJSU Students	39	50.6
Level I	31	40.3
Level II	30	38.9
Not supervising SJSU Students	38	49.4
Supervising students from other universities	23	29.9
<hr/>		
(n=35)		
Would consider supervising students if not currently doing so		
Yes	21	60.0
Uncertain	12	34.3
No	2	5.7

Table 9
Perceived Influence of Managed Health Care
 (n=76)

Influence	<u>n</u>	Percent
Changes in OT department		
Yes	49	64.5
No	14	18.4
Anticipating future effects	13	17.1
Changes in fieldwork program		
Yes	24	31.6
No	28	36.8
N/A	24	31.6

care contracts (see Table 9). Fourteen (18.4%) responded no, although 13 of these checked an average of three changes that had occurred in the past year. Thirteen (17.1%) were anticipating future influences. Of those 49 respondents who felt their department had been influenced by managed care contracts, 26 (53.1%) currently had student programs and 23 (46.9%) did not. Twenty-four (31.6%) also felt managed health care influenced changes in fieldwork programs, 28 (36.8%) did not identify influence on fieldwork program, and 24 checked N/A.

The type of agencies that most often perceived influences of managed health care changes are as follows (see Table 10). Of the four respondents who identified themselves as owners of their own business, all 4 (100%) indicated their practice had been influenced by managed health care contracts. Eight (80%) of public non-profit agencies, 18 (78.3%) private for profit agencies, 16 (64%) private

Table 10

Type of Agency Influenced by Managed Care Contracts

Category	<u>n</u>	Percent
Own business	4	100
Public non-profit	8	80
Private for profit	18	78
Private non-profit	16	64
City/county	4	40
State	1	20
Federal	0	0

non-profit agencies, 4 (40%) city/county agencies, 1 (20%) state agency, and 0 federal agencies indicated their occupational therapy department had been influenced by managed care contracts.

Question 4: What were identified as changes that occurred in the past year?

Respondents were asked to check those events their department had experienced in the past year (see Table 11). Of the 79 respondents, 74 (93.7%) checked at least one of the 10 selections and 67 (84.8%) checked two or more responses. The number of selections ranged from 1-9, with a mean of 4.1. Each choice was selected by the following number of respondents: re-organization 46 (62.2%), patient care program changes 44 (59.5%), higher productivity expectations 41 (55.4%), increased non-patient focused staff activities 34 (45.9%), added positions 33 (44.6%),

Table 11
Changes in Practice in Past Year
 (n=79)

Change	<u>n</u>	Percent
Re-organization	46	62.2
Patient care program changes	44	59.5
Higher productivity expectations	41	55.4
Increased non-patient focused staff activities	34	45.9
Added positions	33	44.6
Eliminated positions	24	32.4
Decreased staff development	22	29.7
Increased part time employment	21	28.4
Expanded work hours	17	23.0
Merger	16	21.6
None	5	6.3

eliminated positions 24 (32.4%), decreased staff development 22 (29.7%), increased part time employment 21 (28.4%), expanded work hours 17 (23%), and merger 16 (21.6%). Five respondents did not select any of the choices.

Question 5: What was the perceived impact of clinical practice changes on student fieldwork programs?

Of the 49 respondents who perceived their department had been influenced by managed health care contracts, 19 (38.8%) also perceived their student program had been influenced (see Table 9).

When asked if the indicated changes in their work environment had impacted fieldwork programs, 24 (31.6%) of 76

respondents checked yes. Twenty-eight (36.8%) checked no, yet two of these respondents identified specific changes that had occurred to their student program, and 24 (31.6%) checked N/A. Twenty-six respondents checked between 1-3 ways their student program had been affected with a mean of (1.5) (see Table 12). Nineteen (25.3%) indicated they had experienced restructuring of their student program, 10 (13.3%) had reduced the number of students accepted, 5 respondents (6.7%) indicated there was a greater need to use students productively to replace aides or volunteers, 3 (4%) felt the changes had resulted in a poor student experience, 2 (2.7%) had experienced the elimination of their student program, and 49 (65.3%) checked N/A.

Question 6: What were the values and attitudes of clinical supervisors toward student skills?

Respondents were asked to indicate the value they placed on given student skills when beginning field work by circling the appropriate number (see Table 13a). A scale of 1-5 was presented with "1" equal to extremely important, "3" equal to somewhat important and "5" equal to not at all important. The two highest rated skills were communication skills and common sense, each receiving a mean rating of 1.23. Interpersonal skills mean rating was 1.25, shows initiative mean rating was 1.47, time management was 1.64, theoretical knowledge was 1.97, documentation and clinical time management each received a mean rating of 2.09 and treatment modalities mean rating was 2.43. When these skills were

Table 12
Changes in Student Fieldwork Programs
 (n=76)

Change	<u>n</u>	Percent
Restructuring	19	25.3
Reduced number of students accepted	10	13.3
Greater need to use students productively	5	6.7
Poor student experience	3	4.0
Elimination of student program	2	2.7
N/A	49	65.3

Table 13a
Values and Attitudes Toward Student Programs and Skills
 (n=75)

Skill	Mean score from scale
Communication Skills	1.23
Common sense	1.23
Interpersonal skills	1.25
Shows initiative	1.47
Time management	1.64
Theoretical knowledge	1.97
Documentation	2.09
Clinical skills	2.09
Treatment modalities	2.43

Note: A lower score indicates a higher value on importance. (1 = Extremely Important, 3 = Somewhat Important, and 5 = Not at all Important)

ranked from 1-3, "1" equal to the most valued skill and "3" equal to the least valued skill, communication skills received the most number "1" rankings, 22 or 29.3% (see Table 13b). When analyzing this information each skill was scored by receiving three points for each time it was ranked "1", two points for each time it was ranked "2", and one point each time it was ranked "3". Each skill and its score is listed in order of higher to lower score: communication skills was 102, interpersonal skills was 88, common sense was 81, shows initiative was 80, clinical skills was 24, theoretical knowledge was 23, time management was 18, documentation was 5, and treatment modalities was 3. All skills were ranked at least three times as "1", "2" or "3".

Respondents were asked to circle the response that best described their level of agreement with a series of statements made about fieldwork (see Table 14). A scale of 0-5 was used with "1" equal to strongly agree, "3" equal to neutral, "5" equal to strongly disagree, and "0" was used for I don't know .

The statement, "clinical education is a joint responsibility of clinicians and academicians" received the highest rate of agreement. Scores ranged from 0-5 with the mean of 1.36.

The statement, "fieldwork supervision is the professional responsibility of clinical practitioners" received the next highest rate of agreement with a mean response of 1.49. "Student program guidelines and requirements are clear and easily implemented" was third with a mean of 1.78. " Supervision of fieldwork students helps

Table 13b

Values and Attitudes Toward Student Programs and Skills
(n=75)

Skill	Total score from ranking
Communication Skills	102
Interpersonal skills	88
Common sense	81
Shows initiative	80
Time management	18
Theoretical knowledge	23
Clinical skills	24
Documentation	5
Treatment modalities	3

Note: A higher number for the total score indicates the skill was ranked higher in importance.

Table 14
Values and Attitudes Toward Student Fieldwork Programs
 (n=71)

Statement	Score From Scale
-Clinical education is the joint responsibility of clinicians and academicians.	1.36
-Fieldwork supervision is the professional responsibility of clinical practitioners.	1.49
-Student program guidelines and requirements are clear and easily implemented.	1.78
-Supervision of fieldwork students helps clinicians stay current on professional issues.	1.79
-Fieldwork students are an asset to the clinical setting.	1.81
-I am adequately prepared for the role of clinical educator.	1.82
-Our facility currently provides a good environment for clinical education.	1.96
-The current fieldwork system is effective in preparing students for practice.	2.11

Note: A higher number for the total score indicates the skill was ranked higher in importance.

clinicians stay current on professional issues" followed with a mean of 1.79. "Fieldwork students are an asset to the clinical setting" received a mean score of 1.81. "I am adequately prepared for the role of clinical educator" received a mean score of 1.82. "Our facility currently provides a good environment for clinical education" was the second least agreed with statement receiving a mean of 1.96. The statement least agreed with was "The current

fieldwork system is effective in preparing students for practice" which received a mean of 2.11.

Question 7: What did clinical supervisors identify as the barriers to the participation in fieldwork education?

A list of nine potential barriers to fieldwork programs was provided for respondents to check as many as were applicable to their setting (see Table 15). Of the 71 respondents, who completed this question, 64 (90.1%) selected two or more barriers, with one respondent selecting all nine of the barriers listed. Sixty (84.5%) respondents selected time as a barrier to having a student program, 51 (71.8%) checked staffing, 32 (45.1%) checked resources, 29 (40.1%) selected patient census and staff commitment, 18 (25.4%) checked administrative support, 16 (22.5%) checked work space, 13 (18.3%) checked interest, and 12 (16.9%) checked past experience.

A space was provided for respondents to add barriers that were not previously listed. Nine respondents added other barriers including scheduling (3), lack of compensation (2), need for productivity (1), patient needs for highly skilled therapists (1), ineligibility of newly graduated OTRs (1), and dissatisfaction with past communication with SJSU (1).

Respondents were asked to rank the most prevalent barrier with a "1", the next most prevalent with a "2" and the third with a "3" (see Table 15). A scoring system was developed to analyze the ranking of these identified barriers. Each time a barrier was ranked

Table 15
Barriers to Participation in Fieldwork Education
 (n=71)

Barrier	<u>n</u>	Percent	Score
Time	60	84.5	144
Staffing	51	71.8	72
Resources	32	45.1	27
Patient census	29	40.1	37
Staff commitment	29	40.1	30
Administrative support	18	25.4	21
Work space	16	22.5	10
Interest	13	18.3	9
Past experience	12	16.9	5
Other	9	12.7	

Note: a higher score indicates a higher prevalence of the barrier.

with a "1", it was assigned three points, a "2" ranking earned two points and a "3" ranking earned one point. The points earned for each barrier were totaled, then the barriers were listed in order from highest to lowest scores. The highest scores are representative of those barriers viewed by the respondents as most prevalent. The list and scores follow: time (144), staffing (72), patient census (37), staff commitment (30), resources (27), administrative support (21), work space (10), interest (9), other (9), and past experience with students (5).

Question 8: What did clinical supervisors identify as the benefits to the participation in fieldwork education?

Table 16
Benefits to Participation in Fieldwork Education
 (n=72)

Benefit	<u>n</u>	Percent
Opportunity to strengthen professionalism	66	83.5
Maintain influence in education programs	48	60.8
Recruitment of new therapists	41	51.9
Increased productivity and treatment	32	40.5
None	7	8.9

Respondents were asked to identify what they perceived as benefits to having a student program by placing a check by as many of the provided statements with which they agreed with (see Table 16). Seventy-two respondents (91.1%) completed this question by checking at least one statement and seven respondents (8.9%) did not check any of the statements. Fourteen respondents (19.4%) checked all four statements, 22 (30.6%) checked three and 29 (40.3%) checked two statements.

The benefit provided by student programs most frequently was, "opportunity to strengthen professionalism", which was checked by 66 respondents (91.7%). The second most frequently checked benefit, "maintain input and influence in education programs", was checked by 48 respondents (66.7%). "Recruitment of new therapists" was identified as a benefit by 41 (56.9%) respondents. Thirty-two respondents (44.4%) checked "increased productivity and patient treatment" as a benefit to having a student fieldwork program.

CHAPTER 5

DISCUSSION, IMPLICATIONS AND RECOMMENDATIONS

Discussion

The discussion of the results of this study will be presented in answer to the research questions as they relate to the literature review and the Occupational Adaptation Frame of Reference.

Question 1: What were the demographics relating to the work environment for occupational therapists, employed in the San Francisco Bay Area.

The results of this study reflect the trend toward an increasing continuum of care addressed by a single facility as noted by Smith and Elberth (1993). A large number of respondents chose more than one selection describing their type of practice setting and area of practice, 49.4% and 69.6%, respectively. The multiple practice settings commonly identified were a combination of skilled nursing facilities, outpatient facilities, acute care and rehabilitation settings. Common combined areas of practice included physical disabilities, gerontology, and mental health.

The high response rate of physical focus (77.2%), as the primary approach to treatment, demonstrates the movement away from a psychosocially focused work atmosphere. This may result in decreased opportunities for students to gain exposure to a "holistic" treatment setting that incorporates physical, psychological and social elements of treatment, early on in their education.

The demographic findings are relevant to two areas of the Occupational Therapy program at SJSU: (1) the placement of fieldwork students, and (2) the selection of new fieldwork facilities. The daily case load per OTR, the percent of the work day providing patient treatment, the size of the facility, and the variation in patient care are important structural considerations when attempting to place students in an effective learning environment, which are similar to Meyers' findings (1995). It is important that the student receive a positive and realistic experience during their first exposure to the field of OT. This would not include placement in a facility that provides limited patient interaction. The information provided by the respondents regarding these areas should be carefully considered on a one-to-one basis prior to placing a student in a facility.

Question 2: Were clinical supervisors interested in participating in fieldwork education who were not doing so?

Sixty percent of those not supervising SJSU students indicated that they would consider doing so. This can be interpreted as a positive indication that supervisors remain highly committed to their potential role in student education. This positive response revealed that there are potential fieldwork resources in the Bay Area that had not previously been identified by SJSU, and with an effort on the part of the university, many new options may become available.

Approximately 30% of those surveyed were supervising students from other universities, while not supervising SJSU students. This is significant in that it reflects the willingness of OT supervisors to participate in fieldwork education and possibly points to limited communication between SJSU's Occupational Therapy Department and many of those practicing locally in the field. Yet the literature (AOTA, 1991; Kautzmann, 1987; Shalik, 1990) suggested that continued communication between academicians and clinicians is vital to the continued strength and growth of the profession of occupational therapy.

Question 3: Did clinical supervisors perceive that their clinical practice of occupational therapy was influenced by managed health care changes?

The overall response to this question indicated change was felt by 98.7% of the facilities. Regardless of whether the motivating factor was managed health care or other influences, the clinical work place is currently undergoing a great deal of change.

Of the respondents that indicated they did not perceive influences of managed health care, 92.9% checked an average of three changes that had occurred in the past year in their facility. Although clinical supervisors indicated a significant amount of change, they did not directly link these changes to managed health care influences. The reason for and nature of these changes were not indicated by the respondents. The researcher hypothesized a stronger link between clinical changes and managed health care

influences. There are two possible explanations for the discrepancy in these findings: 1) the indicated changes were a result of influences and trends unrelated to managed health care, or 2) clinical supervisors have limited experience with managed health care, thus are unable to link changes with its occurrence.

Question 4: What were identified as changes that occurred in the past year?

It would appear that those most profoundly influenced by the changes that have occurred in the clinical setting in the past year are patients, who are directly touched by each of the four most commonly selected changes. An average of four changes were selected by the respondents. The four most often selected were re-organization (62.2%), patient care program changes (59.5%), higher productivity expectations (55.4%), and increased non-patient focused staff activities (45.9%).

The results of these changes to the patient might include shorter length of stay, less hours of and more limits on OT services, decreased inclusion of social and psychological issues in treatment sessions, and increased likelihood of receiving treatment from aides and COTAs. These changes may ultimately add up to inadequate care given to patients (AOTA, 1995). The responses to this question are consistent with those of other studies (AOTA, 1995; Griffin, 1993; Howard, 1991; Smith & Elberth, 1993), used to determine current and to predict future influences of managed health care.

Question 5: What was the perceived impact of clinical practice changes on student fieldwork programs?

Responses to this question revealed a willingness of clinical supervisors and administrators to adapt their student programs rather than simply eliminating them. The study also revealed that the changes identified as significantly influencing clinical practice appeared to have had less of an impact on those clinics' student programs.

Approximately 38% of the respondents felt the changes in their work environment impacted their student program. This seems to be a relatively small number when considering 98.7% of all respondents indicated their department had undergone some change in the past year. Only two respondents indicated that they eliminated their student program as a consequence of change and only three felt the student's experience was compromised. Most common changes included restructuring their student program (25.3%) and reducing the number of students accepted (13.3%).

Question 6: What were the values and attitudes of clinical supervisors toward student skills and student programs?

When evaluating the importance of skills for students beginning Level I Fieldwork, respondents valued the five professional and personal skills consistently higher than the three clinical skills listed. The three most commonly selected skills were communication skills, common sense, and interpersonal skills, all of which reflect personal and professional growth through experience.

It is apparent that clinical supervisors anticipate and prefer that personal skill development is addressed in the academic setting, prior to clinical placement.

The literature review revealed similar findings. Herzberg (1993) presented learning characteristics that clinical supervisors linked to successful clinical students: flexibility, adaptability, teamwork, structuring time, and communication. Poor development in these personal and professional skill areas were identified as the major reasons for student failure (Kramer & Stern, 1994; Swinehart & Meyers, 1992; Sands, 1995). Academic preparation is a crucial time for the development of professional and personal skills, laying the essential foundation for development of specific treatment or clinical skills to be used during clinical experiences.

Values regarding student programs reflect a strong agreement between clinical supervisors that student clinical education is the responsibility of clinicians and academicians jointly. The respondents mostly agreed with the statement that program guidelines and requirements are clear and easily implemented. This was contrary to the suggestions made in the literature review (Kautzmann, 1987) that there needs to be increased continuity and communication to establish an effective fieldwork structure. These results may indicate that the degree and style of communication currently being used are effective in maintaining the fieldwork structure.

Clinical supervisors generally agreed with the value students bring to the clinical setting, including contributing to current professional knowledge and being general assets to the clinical setting.

In general, the respondents least agreed with feeling adequately prepared for the role of clinical educator, that their facility provided a good clinical education environment, and that the fieldwork system in general was effective in preparing students for practice.

The results of this study are in agreement with the literature which suggested that the formal preparation of clinical educators is inadequate at this time. Currently there are no required supervisory training procedures other than one year experience (AOTA, 1994). The lack of professional preparedness of clinical educators may lead to stress, burn-out, and poor student experience (Opacich, 1995; Yuen, 1990). The statement, "I am adequately prepared for the role of clinical educator" was the third most disagreed-with statement, indicating clinical supervisors may not feel the current system is effective given the rapid changes and challenges they are facing in their daily work setting.

The statement which received the most "strongly disagree" responses was, "Our facility currently provides a good environment for clinical education." This response would seem appropriate given the large degree of clinical changes felt by the respondents of this study. The best learning environments for students included those

with structure and where clinical supervisors felt satisfied and in control of their environment (Meyers, 1995).

The general statement, "The current fieldwork system is effective in preparing students for practice", received the most number of disagreement responses, making this the least agreed with statement. Nearly half the respondents disagreed with, felt neutral, or circled "did not know" about this statement, indicating a high level of uncertainty regarding the effectiveness of student preparation through the current fieldwork structure.

Question 7: What did clinical supervisors identify as the barriers to the participation in fieldwork education?

Findings suggest that clinicians are interested in and feel generally positive about their role in clinical education. Lack of interest was not identified as a significant barrier, nor was poor past experiences.

Those barriers to participation in fieldwork education which were ranked the highest appear to be direct results of the changing clinical environment. Common costs of participation in student fieldwork outlined in the literature were stress, frustration, loss of esteem, space for students, supplies, loss of revenue, and increased responsibility (Meyers, 1995). Limited time, staffing, resources and administrative support were also discussed in the literature (AOTA, 1995; Griffin, 1993; Jabri, 1995; Smith & Elberth, 1993) as commonly identified results of health care changes. These costs are

magnified by managed health care, and come at a higher price to the fieldwork educator.

Question 8: What did clinical supervisors identify as the benefits to the participation in fieldwork education?

The responses to this question revealed a strong intrinsic motivation and commitment to professional development on the part of clinicians. A large number of respondents (90.3%) identified at least one benefit associated with having a student fieldwork program, while approximately 20% checked all four benefits provided on the questionnaire. The most often selected benefits -- (1) provide opportunity to strengthen professionalism, and (2) maintain influence in education programs -- are direct benefits to the clinical supervisor. These findings support Meyers' (1995) research in which she identified learning, relationship formation, satisfaction, self esteem, excitement, staying current in practice, and professional commitment, as motivators for participating in student clinical education programs.

Over half the respondents (51.9%) felt participation in student programs was beneficial when it came time for recruitment of new therapists. Supervisors often consider the time and cost associated with recruiting and training new therapists and highly value the opportunity to simplify this process by hiring recent students who are familiar with their setting and have proven to be qualified for the position.

The least identified benefit to participation in a student fieldwork program was "increased productivity and treatment" associated with student training. Cost analysis studies (Shalik, 1987, 1990) have revealed that Level II fieldwork programs are actually cost effective and Level I programs are often perceived as not affecting clinic productivity, although 41 percent of therapists still identified this as a benefit.

Implications and Recommendations

The findings of this study have relevant implications in the following areas: placement of Level I fieldwork students, acquisition of new fieldwork sites in the Bay Area, continued development of the academic curriculum at SJSU, and preparation of clinicians for the role of fieldwork educator.

Because of the many variables and uniqueness of each facility, it is important for the academic institution placing fieldwork students to know and understand the current situation of each site to maximize the student's opportunity for a positive learning experience. The demographics of local San Francisco Bay Area occupational therapy practitioners, present important considerations for academic institutions when placing fieldwork students. Given the influences of managed health care and related trends, the structure of an occupational therapist's work day is changing dramatically in relation to the number of patients treated, amount of time spent with direct patient treatment, type of treatment used, continuum of care provided, focus of treatment,

variety of patient diagnoses seen, co-treatment with other disciplines, use of Certified Occupational Therapy Assistants (COTA) and aides, and amount of time and energy spent developing other roles and professional relationships. Because these variables strongly influence the student's clinical experience and success rate by dictating the degree of structure in the environment, it is vital they are considered prior to student placement.

Those clinical fieldwork sites which are best able to maintain continuity and structure in their student program will likely provide the best learning environment for the student. The clinical educators' satisfaction with and sense of control over their work environment is an important factor in student success and should also be a strong consideration.

In general this study revealed that there are possibly many options for an increased number of fieldwork sites in the San Francisco Bay Area available to the SJSU OT program. Many clinicians seem willing to contribute their energy to fieldwork education who have not previously done so.

This study revealed that clinical supervisors continue to have an overall positive attitude toward fieldwork programs and feel strong intrinsic commitment to remain involved in the clinical education process. They are, however, experiencing a great deal of pressure resulting from health care changes, making it difficult to provide the needed energy to student programs. Most barriers identified were related to changes occurring in the health care

setting such as limits on time and resources. This is important for the academic institution to recognize. By simplifying the process through reducing the time required for administrative and organizational procedures, academicians may find an increased willingness of clinical educators to participate in fieldwork programs.

This study suggests that the primary motivators for and barriers to participation in clinical programs are intrinsic factors that directly affect the clinical educator. Factors such as professional and personal growth, satisfaction and maintaining influence in the education process are primary motivators. The barriers most often identified were also related to the clinicians feelings of professional effectiveness. Further recognition of the personal investment of the clinical educator through remuneration and other expressions of appreciation, may further encourage clinicians to participate in student programs. A common source of remuneration identified in the literature was continuing education privileges. This may be a feasible approach for SJSU to consider.

Respondents placed a high value on the development of interpersonal and professional skills of students prior to entering Level I Fieldwork. Academic institutions may need to incorporate into the curriculum further opportunity to develop such skills. More attention needs to be given to these areas and possibly less to specific clinical skills, which can be addressed during Level I and Level II fieldwork experiences. The role as clinical educator,

providing specific clinical skills, would be most effectively served if their energy was not directed toward dealing with behavioral issues, but remained focused on teaching specific clinical skills.

A common concern identified in this research is the lack of consistency in the education continuum between classroom and clinic. For instance, students are being introduced to a theoretical knowledge base that promotes holism by integrating all realms of the patient, while the "real" clinical approach is primarily focused on only the physical aspects of the patient. Reimbursement is dictating what and how OTRs practice, creating an ethical dilemma for many.

Students need to be provided with a strong value base and tools to deal with the discrepancy between what they believe and what is the current reality. Establishing high standards and values as a new therapist at this time seems difficult given the negative influences and restrictions presented in the practice environment. The academic setting is an ideal place to instill such values and to develop coping skills and methods for maintaining this structural base when challenged by the system. It seems important to the development of the student and the strength of the field of occupational therapy to deal with these issues immediately in the academic setting.

There is some evidence of concern regarding the effectiveness of the current fieldwork structure in preparing students for their role as clinicians. Many clinical supervisors indicated they did not

feel their clinical environment was suited for clinical education, that they were not adequately prepared for the role of clinical educator and in general the process was not totally effective in preparing students. Currently, there is no required preparation for the role of clinical educator. AOTA has developed tools to assist with the process of becoming a clinical educator; Self-paced Instruction for Clinical Education and Supervision (SPICES) and "Say Yes to Fieldwork" (AOTA, 1995) are available but there is no incentive for therapists to use them. Given the inconsistent and often poorly structured treatment setting of late, there may be a need to develop more standardized training procedures for clinical educators to insure a consistent and productive process of clinical education.

The following is a list of recommended areas for future research in the area of fieldwork development:

1. To repeat this study changing the focus to Level II fieldwork.
2. To investigate clinical educators' perceptions of how well prepared students are for fieldwork.
3. To further explore student interpersonal and professional skill developmental process and how this is best approached.
4. To investigate how student professional and interpersonal skills are developed in the classroom setting.
5. To compare clinical educators and academicians perceptions and values regarding student fieldwork programs.
6. To identify how clinicians prepare for the role of clinical educator and what are their preferences.

7. To explore clinical students' perceptions of preparedness of clinical educators and their supervisory needs.

This study provided evidence that recent disruption in the health care system has lead to change and uncertainty for many clinicians, challenging values and ethics traditional to the philosophy of OT. Keeping with its history, AOTA and its members continue to be committed to strengthening the field through modifications of education and practice standards.

Fieldwork experience continues to be the primary bridge connecting theory and practice in the field of occupational therapy. The progression and development of classroom and clinical experiences is dependent on improved communication between clinicians and academicians. It is essential that timely consideration is given to this issue to ensure students are adequately prepared to cope with the tumultuous health care environment.

REFERENCES

- American Occupational Therapy Association. (1991). Essentials and guidelines for an accredited educational program for the occupational therapist. Rockville, MD: Author.
- American Occupational Therapy Association. (1993). Reference manual of the official documents of the American Occupational Therapy Association, Inc. Rockville, MD: Author.
- American Occupational Therapy Association. (1994). Guide to fieldwork education. Rockville, MD: Author.
- American Occupational Therapy Association. (1995). [The impact of managed care on occupational therapy practice]. Unpublished raw data.
- Crist, P. (1991, January). Fieldwork education: Possible solutions to current dilemmas. Education Special Interest Section Newsletter, 1 (1), 3, 6.
- Crist, P. (1993, March). Non-traditional and group fieldwork models: Their time has come. Education Special Interest Section Newsletter, 3 (3), 3-4.
- Christie, B. A., Joyce, P. C., & Moeller, P. L. (1985). Fieldwork experience. Part 1: Impact on practice preference. American Journal of Occupational Therapy, 39 (8), 675-681.
- Garrett, S. A. and Schkade, J. K. (1995). Occupational adaptation model of professional development as applied to Level II Fieldwork. American Journal of Occupational Therapy, 49 (2), 119-126.

Griffin, S. D. (1993). Short bed stays: Their effect on occupational therapy services in teaching hospitals. Archive of Physical and Medical Rehabilitation, 74 (10), 1087-1090.

Herzberg, G. L. (1993). The successful fieldwork student: Supervisor perceptions. American Journal of Occupational Therapy, 48 (9), 817-823.

Howard, B. S. (1991). How high do we jump? The effect of reimbursement on occupational therapy. American Journal of Occupational Therapy, 45 (10), 875-881).

J. Jabri (personal communication, April 18, 1995).

Kautzmann, L. N. (1987). Perceptions of the purpose of Level I Fieldwork. American Journal of Occupational Therapy, 47 (9), 595-600.

Kautzmann, L. N. (1990). Clinical teaching: Fieldwork supervisors' attitudes and values. American Journal of Occupational Therapy, 44 (9), 835-838.

Kramer, P. & Stern, K. (1994). Case Report: Approaches to improving student performance on fieldwork. American Journal of Occupational Therapy, 49 (2), 156-159.

Levine, R. E. and Brayley, C. R. (1991). Occupation as a therapeutic medium: A contextual approach to performance intervention. In C. Christiansen and C. Baum (Eds.), Occupational therapy: Overcoming human performance deficits (pp. 695-631). Thorofare, NJ: SLACK Incorporated.

Meyers, S. K. (1994). Exploring the costs and benefits drivers of clinical education. American Journal of Occupational Therapy, (49) 2, 107-111.

Occupational Therapy Association of California (1994). 1994-1995 Membership and facilities directory of the Occupational Therapy Association of California. California: Author.

Opacich, K. J. (1995). Is an educational philosophy missing from the fieldwork solution? American Journal of Occupational Therapy, 49 (2), 160-164.

Presseller, S. (1983). Fieldwork education: The proving ground of the profession. American Journal of Occupational Therapy, 37 (3), 163-165.

Sands, M. (1995). Brief of New: Readyng occupational therapy assistant students for Level II Fieldwork: Beyond academics to personal behaviors and attitudes. American Journal of Occupational Therapy, 49 (2), 150-152.

Schkade J. K. and Schultz S. (1992). Occupational adaptation: Toward a holistic approach for contemporary practice, Part 1. American Journal of Occupational Therapy, 46 (9), 829-837.

Shalik, L. D. (1987). Cost benefits analysis of level I fieldwork in occupational therapy. American Journal of Occupational Therapy, 41 (6), 638-645.

Shalik, L. D. (1990). The level I fieldwork process. American Journal of Occupational Therapy, 44 (8), 700-707.

Smith, B. C. and Elberth, W. (1993, April 8). Managed care: The key to reimbursement in mental health. OT Week, pp. 22-23.

Swinehart, S. & Meyers, S. K. (1992). Level I Fieldwork: Creating a positive experience. American Journal of Occupational Therapy, 47 (1), 68-73.

Yuen, K. H. (1990). Fieldwork students under stress. American Journal of Occupational Therapy, 44 (1), 80-81.

Appendix A Questionnaire

**A Questionnaire to Determine the Implications of Health Care
Changes On Clinicians and Fieldwork Programs**

We thank you for taking the time to complete this questionnaire. Please answer each question to the best of your ability and return the questionnaire before July 24, 1995.

Your Name (optional) _____
 Your Title (optional) _____
 Facility Name _____
 Address _____

 Phone Number _____ Fax Number _____

Background Information

Please describe the setting of your facility.

1. Type of organization (check one):
 _____ Federal _____ State _____ City/County _____ Public nonprofit
 _____ Private for profit _____ Private, non-profit _____ Own business
2. Practice setting (check as many as apply):
 _____ Acute Care Hospital _____ Outpatient Facility _____ Skilled Nursing Facility
 _____ Rehabilitation unit or hospital _____ Private practice/clinic
 _____ Community agency _____ Other _____
3. Areas of practice (check as many as apply):
 _____ Physical disabilities _____ Mental health _____ Developmental
 _____ Gerontology _____ Pediatrics _____ School-based
4. Primary treatment focus: (rank order; 1-3):
 _____ Psychological _____ Physical _____ Social
5. Size of your occupational therapy department: (answer where applicable)
 _____ Number of beds (inpatient/residential)
 _____ Number of clients who receive occupational therapy daily
 _____ Approximate daily case load per occupational therapy practitioner
6. What percent of an average workday is spent providing patient treatment?
 _____ less than 60% _____ 60-70% _____ 70-80% _____ 80-90% _____ 90-100%
7. Please indicate the number of occupational therapy staff employed in each category:

	<u>Full Time</u>	<u>Part Time</u>	<u>Contract</u>
OTRs _____	_____	_____	_____
COTAs _____	_____	_____	_____
Aides _____	_____	_____	_____

8. Is your department currently supervising San Jose State University fieldwork students?
(check as many as apply)

_____ Yes; _____ Level I (practicum) _____ Level II (internship)
_____ No; _____ We are supervising students from other universities

9. Do you perceive that your department has been affected by managed care contracts?

_____ Yes _____ No _____ No, but anticipating future affects

10. In the past year, has your department experienced any of the following? (check Yes if it applies to you and No if it does not)

Yes	No	
_____	_____	merger
_____	_____	re-organization
_____	_____	added positions (# of therapists_____, #of assistants_____, # of aides_____)
_____	_____	eliminated positions(#of therapists_____, #of assistants_____, #of aides_____)
_____	_____	increased part time employment
_____	_____	patient care program changes (# new_____, # eliminated_____)
_____	_____	higher productivity expectations (increased unit standards)
_____	_____	increased non-patient focused staff activities
_____	_____	expanded work hours
_____	_____	decreased staff development
_____	_____	other (please explain)_____
_____	_____	_____
_____	_____	_____

11. Have the changes indicated above had an impact on your student program?

_____ Yes _____ No _____ N/A

12. How has your student program been affected? (check as many as apply)

_____ Reduction in number of students accepted
 _____ Elimination of program
 _____ Restructuring of program
 _____ Poor student experience
 _____ Greater need to use students productively to replace aides or volunteers
 _____ N/A

13. The following is a list of student skills that may or may not be present upon beginning a field work experience. Please indicate the value you place on the importance of each skill by circling the most appropriate number.

Rank	Extremely Important		Somewhat Important		Not at all Important
____ Communication skills	1	2	3	4	5
____ Interpersonal skills	1	2	3	4	5
____ Shows initiative	1	2	3	4	5
____ Time management	1	2	3	4	5
____ Documentation	1	2	3	4	5
____ Theoretical knowledge	1	2	3	4	5
____ Clinical skills	1	2	3	4	5
____ Treatment modalities	1	2	3	4	5
____ Common sense	1	2	3	4	5

14. Please rank the 3 most valued student skills in the left column above.

15. Circle the number that best corresponds to your values as they apply to the following statements.

	Strongly agree		Neutral		Strongly disagree	I don't know
Fieldwork supervision is the professional responsibility of clinical practitioners.	1	2	3	4	5	0
Fieldwork students are an asset to the clinical setting.	1	2	3	4	5	0
Supervision of fieldwork students helps clinicians stay current on professional issues.	1	2	3	4	5	0
The current fieldwork system is effective in preparing students for practice.	1	2	3	4	5	0
I am adequately prepared for the role of clinical educator.	1	2	3	4	5	0
Our facility currently provides a good environment for clinical education.	1	2	3	4	5	0
Student program guidelines and requirements are clear and easily implemented.	1	2	3	4	5	0
Clinical education is a joint responsibility of clinicians and academicians.	1	2	3	4	5	0

16. Which of the following do you perceive as barriers to implementing a student program. (check Yes if it is a barrier for you and No if not)

Yes	No		Rank
_____	_____	Time	_____
_____	_____	Resources	_____
_____	_____	Patient census	_____
_____	_____	Work space	_____
_____	_____	Staffing	_____
_____	_____	Staff commitment	_____
_____	_____	Interest	_____
_____	_____	Past experiences with students	_____
_____	_____	Administrative support	_____
_____	_____	Other (please explain) _____	_____

17. Please rank the 3 most prevalent barriers in the right hand column above.

18. What are the benefits associated with having a student program at your facility? (check as many as apply)

- _____ Opportunity to strengthen professionalism
- _____ Increased productivity and patient treatment
- _____ Recruitment of new therapists
- _____ Maintain input and influence in education programs

19. If you are not currently supervising students, would you consider doing so?

_____ Yes _____ No _____ Uncertain

Comments: _____

***Again, we thank you for your time in completing this questionnaire!**

Appendix B
Cover Letter

College of Applied Sciences and Arts • Department of Occupational Therapy
One Washington Square • San José, California 95192-0059
Main Office: 408/924-3070 • Fieldwork Office: 408/924-3078 • FAX: 408/924-3088

July 3, 1995

Dear Occupational Therapy Supervisor:

You are invited to participate in this study, investigating the relationship between health care management changes, clinicians and student fieldwork programs. Participants for this study were selected from a list of facilities in the Santa Clara, Golden Gate and Diablo View Chapters, provided by the Occupational Therapy Association of California and other directories. This study will be submitted as a Master's thesis to the Occupational Therapy Department at San Jose State University.

The questionnaire should be completed by the person primarily responsible for the fieldwork program at your facility or the head of the occupational therapy or rehabilitation department if your facility does not currently have a student fieldwork program. The information obtained in this study will be used by the Occupational Therapy Department to update its files on clinical centers employing OTRs in the San Francisco Bay Area and to further strengthen the fieldwork program at San Jose State University. The information may be presented at professional conferences or in professional literature. There are no risks or benefits to those participating in this study.

Participation in this study will require approximately 20 minutes and is voluntary. By returning the completed questionnaire you are consenting to participation in the study. You are not required to provide your name or title. Information provided will remain confidential within the Department of Occupational Therapy and accessible only to faculty.

We hope that you will participate in this study by contributing your experiences and valuable knowledge. If you have any questions regarding the study, please call Teri Jetter at (408) 249-3953 or Dr. Karen Diasio Serrett Ph.D., OTR, FAOTA at (408) 730-1229, Prof. Amy Killingsworth, M.A., OTR, Interim Chair, Occupational Therapy Department, at (408) 924-3072 or Serena Stanford, Ph.D., Associate Vice President for Graduate Studies and Research, at (408) 924-2480.

Please return the survey by July 24, 1995 in the enclosed stamped, addressed envelope. Thank you for your time and participation.

Sincerely,

Teri Lin Jetter, OTS