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Factors that influence occupational therapy decisions in acute care

Nora Hirose
San Jose State University

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**FACTORS THAT INFLUENCE OCCUPATIONAL THERAPY
DECISIONS IN ACUTE CARE**

**A Thesis
Presented to
The Faculty in the Department of Occupational Therapy
San Jose State University**

**in Partial Fulfillment
of the Requirements for the Degree
Master of Science**

**By
Nora Hirose
May, 1996**

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APPROVED FOR THE DEPARTMENT OF OCCUPATIONAL THERAPY

Lela A. Elorems

Lela A. Elorems, Ph.D., OTR, FAOTA

Gigi Smith OTR

Gigi Smith, OTR

Dhun Y. Sharma, MS OTR

Dhun Sharma, M.S., OTR

M. Lou Lewandowski

APPROVED FOR THE UNIVERSITY

ABSTRACT

FACTORS THAT INFLUENCE OCCUPATIONAL THERAPY DECISIONS IN ACUTE CARE

by Nora S. Hirose

The purpose of this pilot study was to explore the methods used by occupational therapists to decide the patients who will receive services and to identify the factors that influence how occupational therapists determine treatment goals in the acute care setting. Ten occupational therapists currently working in the San Francisco Bay Area in acute care hospital settings were interviewed. The occupational therapists identified factors such as the number of evaluations given per day, reimbursement practices, date and place of discharge, the progress and safety of the patient and the beneficial nature of services to the patient as influences on the delivery of occupational therapy. The influences that occupational therapists identified as underlying their decisions regarding treatment goals were initial assessment, standard protocols, discharge plans, reimbursement, culture, intuition, a patient's cognitive and psychological status, socioeconomic status, the wishes of the patient, theory, and the philosophy of the facility.

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CHAPTER 1

INTRODUCTION

Purpose

The purpose of this pilot study was: a) to explore the methods used by occupational therapists to decide the patients who will receive services, and b) to identify the factors that influence how occupational therapists prioritize treatment goals in the acute care setting.

Statement of the Problem

Since the Diagnostic Related Group (DRG) Based Prospective Payment System was installed in 1983, the length of acute hospital stays has decreased, and there has been an increased effort to limit health care costs. As a result, there has been an increased requirement for ancillary services such as occupational therapy to be held accountable for the efficacy and cost effectiveness of their services (Dellarosa, Chan, Toglia & Finkelstein, 1991; Potts & McCann, 1992).

It is believed that the DRG-based payment system has had an impact on provision of care in the acute care hospital setting. As a result of decreased length of hospital stays, occupational therapists often have less time to establish rapport with patients (Rausch & Melvin, 1986), patients are often seen by occupational therapists earlier in their hospitalization in order to provide therapy before discharge (Dellarosa, et al., 1991), and therapists may be required to meet treatment goals in fewer sessions (Scott, 1984).

The use of DRGs has raised the concern that quality of health care may be effected as a result of premature hospital discharge and a reduction in the services provided by hospital personnel (Hightower-Vandamm, 1985; Matus, 1987). As a result of shortened hospital stays, systems may have been developed to implement triage for patients to determine who will receive occupational therapy as well as to determine treatment priorities (Dellarosa, et al, 1991; Potts & McCann, 1992; Rausch & Melvin, 1986).

The demand for occupational therapy has also been affected in the acute care setting by the rapid turnover of patients, large number of referrals and the shortage of occupational therapists (Burke & Cassidy, 1991; Cassidy, 1988; Howard, 1991). In the health care system, occupational therapy is a limited resource and there is a need for a system to prioritize patients and thus distribute occupational therapy services. According to Cassidy (1988), decisions regarding who will receive therapy should be based on the occupational therapists' assessment of who will most greatly benefit from therapy. As a result, occupational therapists need to be able to determine and defend their decisions as to whom will receive occupational therapy services as well as to articulate and justify their treatment goals.

Given the changes in the health care system, there is a need to investigate the factors that influence the clinical reasoning process of occupational therapists as they determine who will receive occupational therapy services and as they prioritize treatment goals in the acute care hospital setting.

Objectives

The objectives for this study were: (a) to examine the way in which occupational therapists determine who will receive occupational therapy services, (b) to gain some insight into factors that influence the treatment planning and clinical reasoning of occupational therapists and (c) to explore whether consistency exists among occupational therapists when determining who will receive therapy and when determining treatment goals in the acute care hospital setting.

Research Questions

The research questions to be answered in this study were:

1. What are the influences that occupational therapists identify as underlying their decisions regarding the delivery of occupational therapy services?
 2. What are the influences that occupational therapists identify as underlying their decisions regarding treatment goals?
 3. Is there consistency among the decisions made by occupational therapists in the acute care hospital setting when determining who will receive therapy?
 4. Is there consistency among the decisions made by occupational therapists in the acute care hospital setting when determining treatment goals?
-

Definitions

The following are definitions of terms used in this research:

Acute Care Hospital Setting - institute in which treatment is provided for a serious illness, for an accident, or after surgery.

Clinical reasoning - The process one uses to transform occupational therapy's body of knowledge into clinical decisions and actions (Paulazzo, 1992).

Consistencies - Factors that are reported by more than 60% of those interviewed to be influential when determining treatment goals and prioritizing patients.

Decisions by occupational therapists - the act of deciding based on the therapists' judgement.

Delivery of Services - The act of providing occupational therapy services.

Influences - Factors that play a role in and effect decision making.

Occupational therapist - one who uses specific activities or methods to develop improve, and/or restore the performance of necessary function, compensate for dysfunction and/or minimize debilitation (Trombly, 1989).

Occupational therapy services - Interaction between the occupational therapist and the patient any time from admission to discharge.

Treatment goals - The desired outcome of the treatment plan.

Treatment planning - The act of designing a detailed proposal for a therapeutic program.

Treatment sessions - The period of time in which the occupational therapist interacts with the patient.

Assumptions

The following assumptions were held by the researcher:

1. The occupational therapist subjects answered interview questions honestly.
2. The occupational therapists were able to accurately articulate their thoughts.
3. The interview process is an effective tool to study the clinical decision making process.
4. Occupational therapists with two years of experience have a more established clinical reasoning process than those with less experience.

Limitations

Limitations associated with this study are:

1. The sample size is small, therefore, generalizations to the larger population cannot be made. These must be considered preliminary.
2. The area in which the interviews were conducted was limited to a small geographic region.
3. Answers to interview questions and thus the results of the study are limited by the interpretation of the researcher.
4. Participation was voluntary which may have some influence on results and findings.

Significance of Study

The influence of society has greatly affected occupational therapy practice. Due to the current health care system, patients in the acute care hospital system are often sicker and are seen for a decreased length of time. The current reimbursement system has affected occupational therapy in definition, practice, management and ethics (Howard, 1991). As a result, occupational therapists are more often required to articulate and justify their treatment plans and services to other health care professionals. In addition, a need for a system to determine which patients will receive occupational therapy services, in priority order, now exists.

The practice of occupational therapy in the acute care system has been a mainstay of the profession (Dellarosa et al., 1991). It is important to study the thought processes of occupational therapists working in this setting as there is a limited understanding of the intellectual and emotional processes involved in clinical reasoning (Neuhaus, 1988). Examining the ways in which therapists make decisions when they achieve successful treatment and consultation can lead to a better understanding of the practice of occupational therapy as well as enable therapists to pass along strategies to future practitioners (Burke & DePoy, 1991). More cost effective occupational therapy can be the outcome.

CHAPTER 2

REVIEW OF THE LITERATURE

The literature review for this research discusses the theoretical basis and background for this study, clinical decision making in occupational therapy and research being conducted in the area of clinical reasoning.

Theoretical Framework

A frame of reference has been defined as "a conceptual structure around which a program, organization, or project is developed and organized" (Pedretti, 1990). An occupational therapy frame of-reference should have an effect on the occupational therapists' decisions and thus the treatment and treatment goals.

The theoretical framework used for this study was the Occupational Performance frame of reference. Pedretti (1990) and the American Occupational Therapy Association (1974) defined occupational performance as "...the individual's ability to accomplish the tasks required by his or her role and related to his or her developmental stage. Roles include those of a 'preschooler', student, homemaker, employee and retired worker. Occupational performance includes self-care, work and play/leisure time performance."

Self-care, work and play/leisure activities are defined as performance skills. Occupational therapists must evaluate, utilize and optimize a person's performance skills in order to achieve a person's maximum occupational performance. The therapist must also take into account the performance

components which include sensory-integrative functioning, motor functioning, psychological functioning and cognitive functioning. Areas of deficits in both performance skills and performance components should be addressed in the treatment methods and program in order to assist a patient in achieving maximal independence and level of functioning.

This study identified factors that influence the clinical reasoning and decision making of therapists as it pertains to an individual's occupational performance and explored how these factors are integrated into the treatment plans developed by occupational therapists who work in the acute care hospital setting.

Background

In 1982, Congress passed the Tax Equity and Fiscal Responsibility Act that placed a payment cap on annual revenues per each hospital Medicare inpatient case. This was changed in 1983 by the Health Care Financing Administration with the introduction of the prospective payment system (PPS) which provides payment to hospitals before care is given. The amount to be paid is determined by diagnostic-related groups (DRGs) (Draper, et al., 1990; Cassidy, 1988; Kahn, et al., 1990). The PPS contains incentives to decrease length of stay, substitute lower-cost services and procedures thus leading to the concern that the quality of care provided to Medicare patients may be affected (Burke & Cassidy, 1991; Cassidy, 1988; Jenkins, 1986; Kahn, 1990).

Occupational therapy has been greatly influenced by the changes occurring in the health care system (Cassidy, 1988). The use of the DRGs has required that ancillary services such as occupational therapy be held accountable for the efficacy and cost effectiveness of their services (Burke &

Cassidy, 1991; Dellarosa, et al., 1991). This has made it essential for occupational therapists to be able to determine and defend who will receive occupational therapy services as well as articulate and justify their treatment goals.

Due to the shortage of therapists and the rapid turnover of patients, occupational therapy provides limited services in the acute care setting and cannot always handle the large number of referrals that are received (Burke & Cassidy, 1991; Cassidy, 1988; Dellarosa, et al., 1991; Howard, 1991). It has been stated that in the acute setting, some patients may not benefit as greatly from occupational therapy services (Boyle, 1990; Cassidy, 1988; Dellarosa, et al., 1991). Potts and McCann (1992) expressed the need for occupational therapists to be able to prioritize their caseload and time according to the patient's treatment goals. These are factors that point to the need for a system in which a determination about the distribution of occupational therapy services. It has been proposed that one of the roles of the occupational therapists in the acute setting should be to provide for the triage of patients in response to this need (Burke & Cassidy, 1991, Dellarosa, et al. 1991). The decision as to who should receive occupational therapy services should be the result of an occupational therapy assessment (Cassidy 1988). Many occupational therapy departments have implemented patient priority systems to determine who will receive occupational services (Potts & McCann, 1992).

Occupational Therapy Decision Making

The occupational therapy diagnostic process has been described as having two stages (Rogers & Holm, 1991). Stage 1 is comprised of the assessment in which the therapist defines the patient's functional problems,

while Stage 2 is accomplished through intervention and reassessment and focuses on the resolution of problems. The occupational therapy diagnosis requires a sequence of decisions and results in a conclusion concerning the need for occupational therapy intervention.

Pelland (1987) described treatment planning as the "core of occupational therapy practice." The treatment plan should be based on an occupational therapy frame of reference as this will help determine treatment goals and methods that are appropriate for the patient.

The need for practitioners to discuss the application of theory to practice and examine how the profession's theory and philosophy are applied in clinical practice has been discussed in the occupational therapy literature (Cassidy, 1988; Fox, 1981). In a study conducted by Paulazzo (1992), occupational theory was shown to be an influential factor in guiding the clinician in decisions regarding the treatment of patients. Cassidy (1988) stated that occupational therapists must clarify their theoretical base in order to demonstrate occupational therapy's specialized body of knowledge.

The need to teach and to conduct research in the process of clinical reasoning has been well documented since Rogers addressed the issue in her Eleanor Clarke Slagle lecture in 1983 (Burke & DePoy, 1991; Cohn, 1991; Fleming, 1991; Gillette & Mattingly, 1987; Pelland, 1987). The increased attention and interest in how clinicians think and make decisions has also been reflected in more recent literature (Burke 1989; Burke & DePoy, 1991; Cohn, 1989; Fleming, 1991b; Gillette and Mattingly, 1987; Neistadt, 1987; Neuhaus, 1988).

Clinical reasoning has been described as applied phenomenology, as more than just the application of a theory or the ability to give a reason for a

clinical decision (Mattingly, 1991b). Clinical reasoning has also been described as a mental process (Cohn, 1991) and as being largely tacit in that it is possible to know more than it is possible to articulate (Cohn, 1991; Mattingly, 1991b). It addresses many of the unstated thoughts and formulations that therapists develop when they work with patients (Burke & DePoy, 1991). Parham (1987) stated that "professional thinking involves being able to clearly and critically analyze the reasons for the decisions and actions we take. An ability to articulate the theories behind what we do is crucial..." (p. 555).

Burke and DePoy (1991) acknowledged that being able to determine which of the patient's needs should be addressed and knowing how to develop the most meaningful treatment is not just determined by a set of explicit rules--intuition, judgement, empathy and common sense are all part of the clinical reasoning process that plays a role in how the therapist develops and evaluates individualized treatment plans. Designing a successful treatment process for a patient goes far beyond grading tasks to increase motor and cognitive skills (Mattingly, 1991b).

Research on Clinical Reasoning and Decision Making

One of the first studies on the clinical reasoning process of occupational therapists was conducted by Rogers and Masagatani (1982). The reasoning process of occupational therapists when determining functional problems and treatment goals was examined. The study was limited to the initial assessment and involved ten occupational therapists who were observed twice each during their initial contact with patients. Prior to the initial contact, the occupational therapists were interviewed about their knowledge of the patient

and asked what they planned to do during the session. A researcher attended the session and took notes. The sessions were also audiotaped. After the session, the occupational therapists were interviewed and asked to reflect on their thoughts throughout the session. The occupational therapists were asked to discuss their assessment decisions as well as the rationale for those decisions. Further questioning determined the clinical reasoning of the occupational therapists. This interview was also audiotaped. The data were then analyzed qualitatively using the constant comparative method. The interviews revealed what the therapist thought about during the initial assessment and reflected what the therapists had done and why they had done it.

A six-stage model of treatment planning was developed from these data and included the following stages: obtaining information already available, selecting standard assessments, implementing assessment plans, defining patient problems, specifying treatment objectives, and evaluating the assessment.

The study concluded that, overall, the occupational therapists in this study had difficulty articulating their reasoning processes. They also found that the medical diagnosis and the therapist-patient relationship were key factors in the therapists' reasoning processes during the initial assessment session. This study showed that the reasoning process used by occupational therapists could be studied using a qualitative method.

Fondiller, Rosage and Neuhaus (1982) performed a study that explored the values held by occupational therapists and how this influenced clinical reasoning. The study was qualitative and used an interview format. A case study was given to nine practicing occupational therapists and 12 open-ended

questions were asked of each therapist during an in-depth interview. The questions addressed the factors that occupational therapists considered during the assessment and treatment of the patient, the expected outcome of occupational therapy and qualities they considered to be most important to the treatment process. The interviews were audiotaped and reviewed a total of three times--twice by the person who conducted the interview and once by another interviewer involved with the study.

The results of the study indicated that the current health care system conflicted with the therapists' values. Interviews revealed that the therapists viewed the therapeutic relationship and holistic approaches to be hindered by the present state of the health care system that results in shorter hospital stays and decreased time available to spend with patients. Other values held by the therapists were the therapists' training, ongoing work experience, and the subject's thinking at that point in time. Since the goal of this study was exploratory the small sample size was appropriate (Fondiller, et al., 1990). The use of interviews in this type of qualitative research was useful as it allowed for the collection of in-depth information (Kielhofner, 1982a; 1982b; Oyster, Hanten & Llorens, 1987).

In a study funded by the American Occupational Therapy Association/American Occupational Theory Foundation, the clinical reasoning of 14 occupational therapists who were working in an acute care hospital was examined (Mattingly & Gillette, 1991). The method used was largely based on the assumption that the ability for one to "think while doing" greatly affects the quality of the practitioner's work. The study was qualitative and combined ethnographic and action research.

The study served as a way for the occupational therapists to reflect on their actions and describe their clinical reasoning processes. Factors that influenced their clinical reasoning process included the values and beliefs that guided their practice as well as the belief in their skills and competencies as they interacted with patients. The data were collected through the observation and videotaping of the treatment sessions and in-depth interviews with the participants. During the interviews, the therapists were asked to tell the story of the session including the dilemmas, decision making and surprises. They were also asked to describe their rationale and theoretical assumptions in making decisions. The subjects attended meetings with the research team throughout the study in which they viewed the videotapes and analyzed them along with the research team. The results of this study showed that as the occupational therapists were allowed the opportunity to reflect on their practice, the more skilled they became in making their thinking processes more explicit. This, in turn, increased their self-confidence when presenting cases to other health professionals.

From this study, Fleming (1991b) postulated that the therapist-subjects in the study attended to the patients on three levels--as the person with a physical ailment, the patient as a person, and the person as a social being in the context of family, environment and culture. He also identified different types of reasoning strategies that the occupational therapists used while solving problems in day to day practice. He found that occupational therapists used procedural reasoning when the therapist thought about the patient's physical ailment and how to treat it while interactive reasoning was used to help improve the therapists' understanding of the patient. Conditional reasoning

was used to help the patient in the process of dealing with a life affected by injury or disease.

When assessing a patient, a physician tends to emphasize three aspects--the disease, the person and the predicament (Albert, Munson & Resnik, 1988; Fleming, 1991a), and tends to address the disease aspect first during assessment (Fleming, 1991a). When occupational therapists assess a person's physical disability, the reasoning strategies most often employed were similar to those of physicians, but as they thought about other aspects of the person and his or her situation, they used other forms of reasoning (Fleming, 1991a). Occupational therapists addressed the predicament and attempted to reduce the effect on the person's future life given the consequences of the disease or disability whereas it was found that physicians are concerned more with the disease (Fleming, 1991a). The goals of the occupational therapist are concerned with individualizing treatment, facilitating independent functional performance, and creating a future new life for that person.

A study conducted by Paulazzo (1992) identified and addressed which of six factors occupational therapists perceived as influencing their clinical reasoning. A closed end questionnaire was used to generate data on the influence of education, experience, philosophy of the facility, socio-cultural concerns, occupational therapy theory and intuition on seven stages of clinical reasoning. One hundred eighteen practicing occupational therapists participated. The data were analyzed using three demographic variables--gender, years of experience, and level of education.

The seven stages of clinical reasoning examined were: deciding which tools to administer, analyzing and interpreting results, deciding if a person can

be treated by an occupational therapist, developing treatment plans, deciding how to implement treatment plans, deciding when and if to re-evaluate the patient, and deciding when to terminate treatment. The results of the study showed that experience and intuition were perceived as highly influential in guiding clinical reasoning. The philosophy of the facility and occupational therapy theory were also perceived to be influential factors in the clinical reasoning process of the participating occupational therapists.

Paulazzo's study determined some of the factors that influenced clinical reasoning yet did not address how or if the patient or societal influences played a role. How the patient engages in the therapy process is also an important factor in effective therapy and reasoning process (Mattingly, 1991b). The societal influence of reimbursement for health care has impacted occupational therapy in definition, practice, management, ethics and the profession's response (Howard, 1991). Implications for further research include the influences of the patient's wishes and/or input into the treatment plan as well as the effects of the DRGs and reimbursement practices.

The implementation of the PPS has had a great impact on the health care system, occupational therapy, and the delivery of its services. Patients who are hospitalized are sicker than they were previously, they are hospitalized for shorter periods of time, and there is a shortage of occupational therapists. It is no longer feasible for all patients to receive occupational therapy services in the acute care hospital setting. Occupational therapists are now faced with the need to prioritize both patients and treatment goals, articulate their clinical reasoning and decision making process to justify their services.

Summary

The current state of the health care system has made it necessary for occupational therapists to be able to prove the efficacy of therapy as well as to articulate their goals and defend their services. The demand for occupational therapy in the acute care hospital setting has been affected by the rapid turnover of patients, decreased lengths of stay, the increased acuity of patients referred to occupational therapy and the shortage of occupational therapists.

The literature indicates that there is a need to investigate the clinical decision making and clinical reasoning of occupational therapists. Given the current state of the health care system, it has become more important to investigate how patients are prioritized and how treatment goals are determined. In order to do so, it is important to determine and examine factors that are underlying the decisions of occupational therapists regarding treatment goals and delivery of occupational therapy services.

CHAPTER 3

METHODOLOGY

This chapter presents the methodology and procedures used in this study as well as the data and results. Survey methodology was used. Data were collected by individual personal interviews.

Questions

The questions that were addressed in this study were:

1. What are the influences occupational therapists identify as underlying their decisions regarding the delivery of occupational therapy services?
2. What are the influences occupational therapists identify as underlying their decisions regarding treatment goals?
3. Are there consistencies among the decisions made by occupational therapists in the acute care hospital setting when determining who will receive therapy?
4. Are there consistencies among the decisions made by occupational therapists in the acute care hospital setting when determining treatment goals?

Subject Selection

Subjects were therapists who had acquired a minimum of two years of experience in an acute care hospital setting and had a Baccalaureate or Masters degree in occupational therapy. Age, sex and ethnicity were not controlled. The subjects were selected from a list of occupational therapists currently practicing in the acute care hospital setting. The researcher

developed a list of occupational therapists who met the research subject criteria and then randomly selected ten subjects from that list. This list of therapists was compiled from the list of acute care facilities as listed in the 1993-1994 Membership and Facilities Directory of the Occupational Therapy Association of California. The acute facilities in the San Francisco Bay Area were contacted and a list of currently practicing occupational therapists obtained.

Procedure

The subjects were initially contacted by telephone to determine if they were willing to participate in the study. After the subjects agreed to participate, an interview time was arranged. Ten registered occupational therapists currently working in an acute care hospital setting in the San Francisco Bay Area were interviewed. A statement of participation in research was provided to the subjects.

Data were gathered through a structured interview (see Appendix A). The interview format consisted of nine questions. The interview was audiotaped. The audiotapes of the interviews were transcribed and reviewed by the researcher.

Demographics

Demographic data were gathered from the first three questions of the interview. The ten participants for this study were registered occupational therapists currently working in the San Francisco Bay Area. Nine of the participants held either a B.A. or B.S. in occupational therapy, and one had a M.A. in occupational therapy. Two of the participants had additional degrees in

other fields. The occupational therapy experience of the participants ranged from two and one half years to 23 years. The participants' experience in an acute care hospital setting ranged from two to 16 years (Table 1). All participants were currently working in an acute care hospital setting. The ratio of occupational therapists to number of acute beds ranged from 1:100 to 1:350 (Table 2). The average ratio was 1 to 174.

Questionnaire Data for Questions Four through Nine

Question 4: How are decisions made regarding who will receive occupational therapy services?

All ten subjects stated that the decision as to whom will receive occupational therapy services was made by physician referral. Eight stated that, in addition to physician referral, ancillary staff such as physical therapy and speech therapy also made referrals though it was ultimately decided by the physician if a patient was to receive the occupational therapy services. One occupational therapist stated that he had the authority to make the ultimate decision whether to see patients or not. Two occupational therapists reported that they generated referrals during multidisciplinary floor rounds or after observing patients on the acute care floor whom they felt might benefit from occupational therapy services.

Six of the participants stated that there were automatic referrals for occupational therapy services per certain diagnosis such as total hip replacements, coronary artery bypass grafts and cerebral vascular accidents.

TABLE 1

Demographic Data on Subjects (N=10)

THERAPIST	ACADEMIC DEGREE	YEARS OF OT EXPERIENCE	YEARS OF EXPERIENCE IN ACUTE HOSPITAL
A	BS in OT	18	14
B	BS in OT	9.5	6.5
C	BS in OT	9	7
D	BS in OT	5	4
E	MA in OT	14.75	13.5
F	BS in OT	2.5	2
G	BS in OT BS FINE ARTS MA CULTURE	23	16
H	BS in BIOLOGY BA in OT	7	5
I	BS in OT	8	8
J	BS in OT	4.5	4.5

TABLE 2

Ratio of Occupational Therapists to Beds Among Subjects (N=10)

THERAPIST	# ACUTE OTs	# ACUTE HOSPITAL BEDS	RATIO*
A	1	350	1:350
B	2	200	1:100
C	2	245	1:122.5
D	2	300	1:150
E	2	300	1:150
F	4	800	1:200
G	1	300	1:300
H	1.5	300	1:200
I	2	305	1:152.5
J	2	300	1:150

* Average ratio = 1 OT per 174 beds.

Question 5: How is it decided which patient has priority in the situation when there are too many patients and not enough time?

All ten occupational therapists reported that these decisions were made by individual occupational therapists though there were some set guidelines to follow. Six of the occupational therapists stated that evaluations had priority over all treatments. Five of the occupational therapists stated that after evaluations, prioritization was made according to diagnosis while four reported it was dependent on who could benefit the most from therapy. Two reported that patients for whom therapy can be reimbursed were always given priority.

Question 6: How are treatment goals decided and prioritized for each patient?

Treatment goals were determined by the initial assessment as reported by ten therapists. Six therapists stated that there were standard protocols for certain diagnoses that pre-determined the treatment goals.

Five therapists stated that treatment goals were decided by the discharge plans for each patient. They stated that it was important to know the placement that was planned for the patient after the stay in the acute care setting in order to determine appropriate goals.

Five therapists stated that the patients' prior level of functioning helped to determine treatment goals, while four therapists reported that the length of stay influenced their short term goals and long term goals. One therapist stated that treatment goals were based on the clinical judgement of the therapist who determines the physical and social needs of the patient.

Question 7: What factors influence the decisions regarding the prioritizing of patients and treatment goals?

The factors that therapists reported as influencing the delivery of occupational therapy services and how patients are prioritized were the number of evaluations that were ordered per day as reported by six therapists, and discharge dates and plans as reported by eight therapists. Two therapists reported a patients' progress, a patient's level of safety and reimbursement issues as being influential.

Eight occupational therapists reported that discharge plans were influential when determining treatment goals while seven reported reimbursement issues, eight reported culture, seven reported intuition, three reported a patient's cognitive and psychological status, six reported the wishes of the patient, two reported theory, three reported philosophy of the facility, and one reported socioeconomic status as being influential factors.

Question 8: How do these factors influence the decision as to which patients will be seen?

The date of discharge was a factor when prioritizing patients as reported by four of the occupational therapists, while one reported that a patient was given a higher priority if they had missed treatment the previous day. Two of the occupational therapists reported that it was standard practice for a person who is going to a rehabilitation unit or a skilled nursing facility not to receive any occupational therapy services prior to discharge from the acute care floor.

One occupational therapist reported that the delivery of occupational therapy services was based on a first come, first served basis. Other factors that the occupational therapists said influenced their decisions regarding

prioritization in the delivery of occupational therapy services included safety (including dysphagia), a patient's progress and whether or not a patient was to be transferred to another unit within the hospital.

Six of the occupational therapists stated that evaluations had priority over treatment in the instance when there were too many patients and not enough time to see them all. Four of the occupational therapists reported that patients were simply not seen while another reported that patients were seen by an occupational therapy aide if the caseload was too high for the therapist. Three of the occupational therapists stated that it was standard practice to decrease the time of treatment sessions if necessary in order to see more patients within a day.

Question 9: How do these factors influence decisions in regards to treatment planning?

Nine of the occupational therapists stated that discharge plans were influential when determining treatment goals. For example, whether or not a person was to return home versus discharge to a skilled nursing facility was a factor when deciding the importance of family training and ADL retraining as opposed to therapy that emphasizes goals of increasing endurance or basic functional mobility. Five of the participants stated that, at times, occupational therapy orders were solely for the purpose of completing an evaluation on the day of discharge in order to determine discharge placement and that no actual treatment was given to that patient.

Nine of the occupational therapists reported reimbursement for services was a factor that influenced treatment planning. They reported that insurance is often the determining factor in a patient's length of stay and thus placement

after discharge from the acute hospital setting. They stated that as a result of reimbursement policies, the acuity level of patients is now much higher. It was reported that this affects treatment goals as a therapist no longer has the time to achieve goals of independence, but rather goals are set to assist a person to function at a moderate to minimum assistance level.

Three participants remarked that they felt increasing pressure to achieve more in a shorter amount of time, and it was necessary to carefully document treatment goals and results for reimbursement purposes. One therapist stated that they sometimes deferred a patient's treatment until the person was discharged to a rehabilitation floor in order to save costs. Three therapists remarked that with the decreasing lengths of stay, there was an increasing need to emphasize family training and home exercise programs. One participant remarked that there was never the time to address leisure activities.

Eight of the occupational therapists reported that a person's culture was influential when determining treatment goals. They reported that it was important to incorporate a patient's cultural preferences into treatment and to be careful not to impose their personal beliefs on a patient. Four of the occupational therapists gave the example that family training should be emphasized with Asian and Hispanic families as they tend to be more involved in the patient's care both during and after a stay in the acute hospital. Three occupational therapists reported that they have experienced cultures in which a person is encouraged to remain in the "sick role" and thus goals of reaching independence with activities of daily living may not be achievable.

Seven of the occupational therapists reported that intuition based on experience was a major factor when determining treatment goals, and they have found that they increasingly rely on intuition as lengths of stay in the

acute care hospital setting have been decreasing. One occupational therapist stated that intuition was not a factor in treatment planning because of the use of set protocols in that facility and "things were not open to discussion."

Six of the participants reported using set protocols for certain diagnoses to guide the development of treatment goals. Two reported being required to use clinical pathways that emphasize a "cookbook approach to therapy."

The wishes of the patient were reported as influential factors when setting treatment goals by six of the participants. Three therapists reported that a standard part of the initial evaluation was to ask a patient to set some goals regarding their treatment, and that these goals were taken into account when appropriate.

Two of the occupational therapists reported using the Occupational Behavior frame of reference to guide their treatment planning, one reported using the Model of Human Occupation, and three reported having an eclectic approach rather than utilizing one theory or frame of reference. The remaining four occupational therapists did not report theory as a factor that influenced the setting of treatment goals.

Three of the occupational therapists felt the philosophy of the facility was influential when determining treatment goals. To provide quality care, viewing the patient as a customer and effecting patient transfer as soon as possible were examples of the philosophies that the participants reported as influential in treatment planning.

Results

The influences that occupational therapists identified as underlying their decisions regarding the delivery of occupational therapy services were the

number of evaluations ordered per given day, reimbursement practices, date and place of discharge, the patient's progress, safety of the patient and how beneficial the services were expected to be or found to be to the patient.

The influences that occupational therapists identified as underlying their decisions regarding treatment goals were initial assessment, standard protocols, discharge plans, reimbursement, culture, intuition, a patient's cognitive and psychological status, socioeconomic status, the wishes of the patient, theory, and the philosophy of the facility.

The data indicate that there is consistency among occupational therapists in the acute care hospital setting when determining who will receive services. The therapists consistently reported that the decision as to whom would receive occupational therapy services was made by physician referral and referrals from ancillary staff such as physical therapy.

The data also indicated that there is consistency among the decisions made by occupational therapists in the acute care hospital setting when determining treatment goals. There was consistency among occupational therapists in that nine of the ten therapists mentioned discharge plans and reimbursement and eight reported cultural differences as being influential. Intuition and the use of set protocols were mentioned by seven and six occupational therapists respectively.

CHAPTER 4

DISCUSSION, IMPLICATIONS, AND RECOMMENDATIONS

This chapter presents a discussion of the results and the implications of the study as they may apply to the field of occupational therapy.

Recommendations for further research are also presented.

It has been stated in the literature that occupational therapy is a limited resource and that there is a need for a system to prioritize patients and thus distribute occupational therapy services (Cassidy, 1988). Pelland (1987) stated that treatment planning is the "core of occupational therapy practice". The purpose of the study was to determine the methods used by occupational therapists to decide which patients will receive services and to identify the factors which influence how occupational therapists prioritize treatment goals in the acute care setting. The objectives for this pilot study were to examine the way in which occupational therapists determine who will receive occupational therapy services, to gain some insight into factors that influence the treatment planning and clinical reasoning of occupational therapists and to explore whether consistency exists among occupational therapists when determining who will receive therapy and when determining treatment goals in the acute care hospital setting.

A structured interview was used to gain insight into factors that influence treatment planning and delivery of occupational therapy services in the acute care hospital setting and to examine whether consistencies exist among occupational therapists' decisions when determining treatment goals and when prioritizing patients to receive care.

These preliminary results indicate that the decision regarding who would receive occupational therapy services was consistently made by physician referral and referrals from ancillary staff such as physical therapy. Though recruitment of patients by occupational therapists was mentioned, it did not seem to be common practice among the therapists interviewed. The practice of automatic referral of patients to occupational therapy on the basis of diagnosis was also a factor, although this decision was ultimately made by the physician.

Relying on physicians to make referrals may lead to conflicts of belief in that occupational therapists tend to view a person's condition and the consequences of the disability while physicians often view the disease aspect first when assessing a patient (Fleming, 1991a). Therapists reported that it is becoming more standard to use standard protocols for a given diagnosis which does not allow for the individualizing a treatment plan. For example, one therapist stated that there is never time to address leisure activities which is a skill necessary to allow a person to achieve maximum occupational performance.

Cassidy (1988) stated that decisions regarding who will receive therapy should be based on the occupational therapists' assessment of who will benefit the most from therapy. In this preliminary study, four of the ten therapists stated that priority was given to patients whom they felt would benefit the most from therapy when there were too many patients and not enough time to see them all. The current state of health care may no longer allow therapists to prioritize their patients by this criterion as reimbursement practices may ultimately influence the length of stay of a patient as well as their discharge destination. Other factors reported as influential when prioritizing patients

were the number of evaluations per given day, reimbursement and the progress and safety of a patient. Culture, theory and education were not seen as influential factors when deciding which patient would receive occupational therapy services.

Pelland (1987) has described treatment planning as the "core of occupational therapy practice." The treatment plan should be based on an occupational therapy frame of reference as this will help determine treatment goals and methods that are appropriate for the patient. When asked which factors influenced treatment planning, the occupational therapists reported initial assessment, standard protocols, discharge plans, reimbursement, culture, intuition, a patient's cognitive and psychological status, socioeconomic status, the wishes of the patient, theory, and the philosophy of the facility as being influential. There was consistency among occupational therapists regarding factors that influence treatment goals in that nine of ten therapists mentioned discharge plans and reimbursement and eight reported cultural differences. Intuition and the use of standard protocols were mentioned by seven and six occupational therapists, respectively.

Seven therapists stated that intuition based on experience was a factor when determining treatment goals. This coincides with a study conducted by Burke and DePoy (1991) that acknowledged the ability to determine how a patient's needs should be addressed and how to develop the most meaningful treatment is not just determined by a set of explicit rules--intuition, judgement, empathy and common sense are all part of the clinical reasoning process that plays a role in how the therapist develops and evaluates individualized treatment plans. According to Mattingly (1991b), designing a successful

treatment process for a patient goes far beyond grading tasks to increase motor and cognitive skills.

Implications

During the interview process, it became apparent that the current trends in health care were affecting the clinical reasoning and decision making process of the ten therapists who were interviewed. Howard (1991) has stated that reimbursement for health care has impacted occupational therapy in definition, practice, management, ethics and the profession's response. All ten participants reported that the current trend is to encounter patients who are more sick than was the case previously. The patients are seen for therapy for a shorter amount of time. These conditions have resulted in the need for therapists to adjust their thinking and definition of the role of the occupational therapist in the acute care hospital setting. Seven participants mentioned feeling that the occupational therapist is increasingly given the role of evaluator or consultant rather than that of treating clinician.

Current reimbursement issues are creating the pressure to discharge patients as soon as possible and thus clinicians are forced to make decisions regarding placement after discharge during the initial evaluative session. Participants in this study reflected that it is becoming increasingly more important for therapists to precisely document progress in order to justify the delivery of occupational therapy services, and that patients often are not in therapy for a sufficient amount of time to reach the goals that the therapist believes the patient has the potential to achieve.

One participant reflected that it is becoming increasingly crucial for occupational therapists to act as advocates for patients and thus become more

vocal and assertive. Three therapists remarked that it would be difficult for the newly graduated occupational therapist to be effective in the acute care setting due to the fact that therapists must rely more on intuition and experience to define goals as a result of decreased lengths of stay and increased acuity of patients. New graduates may find it difficult to find mentors or co-workers with whom to consult as the number of occupational therapists per number of hospital beds is decreasing (the average ratio of the ten hospitals in this study was one therapist per 174 acute beds) and often there is only one acute care occupational therapist employed by the hospital.

The sample size of this study was small and thus generalizations for occupational therapists working in all acute hospital settings cannot be made. However, this pilot study provided some insight into the factors that influence the treatment planning and clinical reasoning of therapists. In today's health care atmosphere, it has become crucial for occupational therapists to justify their services and prove the cost effectiveness of their treatment as well as to articulate their thought processes regarding decisions made about the delivery of occupational therapy services.

Recommendations for Further Research

As a result of this preliminary study, a number of recommendations for further research can be made. Future research could be focused on exploring:

1. Factors that influence treatment planning and delivery of occupational therapy services in other settings such as skilled nursing facilities and rehabilitation hospitals.
2. Factors that influence treatment planning and delivery of occupational therapy services in other geographic areas.

3. How DRGs and/or capitation have affected quality of care in the acute care hospital setting.
4. How DRGs and/or capitation have affected the clinical reasoning of occupational therapists in the acute care hospital setting.
5. The role of the occupational therapist in discharge planning.
6. The effectiveness or outcomes of clinical pathways and standard protocols when determining treatment goals.
7. The perception of new occupational therapy graduates on their roles in the acute care hospital setting.
8. The effectiveness of family training and home exercise programs after discharge from an acute care setting.

REFERENCES

- American Occupational Therapy Association (1974). The roles and functions of occupational therapy personnel. Rockville, MD: Author.
- Boyle, M. A. (1990). The changing face of the rehabilitation population: A challenge for therapists. The American Journal of Occupational Therapy, 44, 941-945.
- Burke, J. P. & Cassidy, J. C. (1991). Disparity between reimbursement-driven practice and humanistic values of occupational therapy. The American Journal of Occupational Therapy, 45, 173-176.
- Burke, J.P. & DePoy, E. (1991). An emerging view of mastery, excellence, and leadership in occupational therapy practice. The American Journal of Occupational Therapy, 45, 1027-1032.
- Cassidy, J. C. (1988). Access to health care: A clinician's opinion about an ethical issue. The American Journal of Occupational Therapy, 42, 295-299.
- Cohn, E. S. (1989). Fieldwork education: shaping a foundation for clinical reasoning. The American Journal of Occupational Therapy, 43, 240-244.
- Cohn, E. S. (1991). Clinical reasoning: Explicating complexity. The American Journal of Occupational Therapy, 45, 969-971.
- Dellarosa, D. M., Chan, R. S. K., Toggia, J. P., & Finkelstein, N. (1991). ADL assessment in acute care: Simultaneous grading of physical and verbal levels of assistance. Occupational Therapy Practice, 2(2), 38-45.
- Draper, D., Kahn, K. L., Reinisch, E. J., Sherwood, M. J., Carney, M. F., Kosecoff, J., Keeler, E. B., Rogers, W. H., Savitt, H., Allen, H., Wells, K. B., Reboussin, D. & Brook, R. H. (1990). Studying the effects of the DRG-based prospective payment system on quality of care. The Journal of the American Medical Association, 264, 1956-1961.

Fleming, M. H. (1991a). Clinical reasoning in medicine compared with clinical reasoning in occupational therapy. The American Journal of Occupational Therapy, 45, 988-996.

Fleming, M. H. (1991b). The therapists with the three-track mind. The American Journal of Occupational Therapy, 45, 1007-1014.

Fondiller, E. D., Rosage, L. J., & Neuhaus, B. E. (1990). Values influencing clinical reasoning on occupational therapy: An exploratory study. Occupational Therapy Journal of Research, 10(1), 41-55.

Fox, J. V. D. (1981). Occupational therapy theory development: Knowledge and values held by recent graduates. Occupational Therapy Journal of Research, 1(1), 79-93.

Gillette, N. P. & Mattingly, C. (1987). Clinical reasoning in occupational therapy. The American Journal of Occupational Therapy, 41, 399-400.

Hightower-Vandamm, M. D. (1985). Occupational therapy's journey: The implementation, challenge, and expectation. The American Journal of Occupational Therapy, 39, 785-790.

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

Jenkins, L. (1986). A perfect match? Nursing Times, 3, 39-40.

Kahn, K. L., Rubenstein, L. V., Draper, D., Kosecoff, J., Rogers, W. H., Keeler, E. B. & Brook, R. (1990). The effects of the DRG-based prospective payment system on quality of care for hospitalized medicare patients. The Journal of the American Medical Association, 264, 1953-1955.

Kielhofner, G. (1982a). Qualitative research: Part one: Paradigmatic grounds and issues of reliability and validity. Occupational Therapy Journal of Research, 2(2), 67-79.

Kielhofner, G. (1982b). Qualitative research: Part two: Methodological approaches and relevance to occupational therapy. Occupational Therapy Journal of Research, 2(3), 150-164.

Mattingly, C. (1991a). The narrative nature of clinical reasoning. The American Journal of Occupational Therapy, 45, 998-1005.

Mattingly, C. (1991b). What is clinical reasoning? The American Journal of Occupational Therapy, 45, 979-986.

Mattingly, C. & Gillette, N. (1991). Anthropology, occupational therapy, and action research. The American Journal of Occupational Therapy, 45, 972-978.

Matus, V. W. (1987). DRGs: Implications for care of the neurologic patient. Critical Care Nursing Quarterly, 10(1), 77-84.

Neistadt, M. E. (1987). Classroom as clinic: Clinical reasoning in occupational therapy education. The American Journal of Occupational Therapy, 41, 631-637.

Neuhaus, B. E. (1988). Ethical considerations in clinical reasoning: The impact of technology and cost containment. The American Journal of Occupational Therapy, 42, 288-294.

Oyster, C. K., Hanten, W. P. & Llorens, L. A. (1987). Introduction to research: A guide for the health science professional. Philadelphia: J. B. Lippincott Company.

Parham, D. (1987). Toward professionalism: The reflective therapist. The American Journal of Occupational Therapy, 41, 555.

Paulazzo, M. A. (1992). Influences of clinical reasoning of practicing occupational therapists. Unpublished master's thesis, San Jose State University, San Jose, CA.

Pedretti, L. W. (1990). Occupational therapy: Practice skills for physical dysfunction (3rd ed.). St Louis: C.V. Mosby.

Pelland, M. J. (1987). A conceptual model for the instruction and supervision of treatment planning. The American Journal of Occupational Therapy, 41, 351-359.

Potts, E. J. & McCann, A. G. (1992, September). Acute care: Moving toward a specialty. Physical Disabilities, pp. 2-3.

Rausch, G. & Melvin, J. L. (1986). A new era in acute care. Occupational Therapy Journal of Research, 10(1), 41-55.

Rogers, J. C. & Holm, M. B. (1991). Occupational therapy diagnostic reasoning: A component of clinical reasoning. The American Journal of Occupational Therapy, 45, 1045-1053.

Rogers, J. C. & Masagatani, G. (1982). Clinical reasoning of occupational therapists during the initial assessment of physically disabled patients. Occupational Therapy Journal of Research, 2(4), 195-219.

Scott, S. J. (1984). The medicare prospective payment system. The American Journal of Occupational Therapy, 38, 330-334.

Trombly, C. (1989). Occupational Therapy for Physical Dysfunction. Baltimore, MD: Williams & Wilkins.

APPENDIX A
INTERVIEW FORMAT

INTERVIEW FORMAT

1. What is your academic degree?
 2. How many years have you been practicing occupational therapy?
 3. How many years have you been practicing in the acute care hospital setting?
 4. How are decisions made regarding who will receive occupational therapy services?
 5. How is it decided which patient has priority in the situation when there are too many patients and not enough time?
 6. How are treatment goals decided and prioritized for each patient?
 7. What factors would you say influence your decisions regarding the prioritizing of patients and treatment goals? (For example theory, education, intuition, philosophy of the facility, the wishes of the patient, cultural influences).
 8. How do these factors influence the decision as to which patients will be seen?
 9. How do these factors influence the decision in determining treatment goals?
-

APPENDIX B
STATEMENT OF PARTICIPATION IN RESEARCH
AND
REQUEST TO USE HUMAN SUBJECTS IN RESEARCH

A campus of The California State University

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

STATEMENT OF PARTICIPATION IN RESEARCH

RESPONSIBLE INVESTIGATOR: Nora S. Hirose

TITLE OF PROTOCOL: A Study of the Factors Which Influence Treatment Planning and Delivery of Occupational Therapy Services in the Acute Care Hospital Setting.

I have been asked to participate in a research study investigating the methods used by occupational therapists to determine which patients will receive services and the factors that influence how occupational therapists prioritize treatment goals in the acute care hospital setting. The results of the study should give some insight into the clinical reasoning process used by occupational therapists.

Please read the following information:

- 1) I will be asked to participate in an interview at a prearranged time setting that will take approximately 45 minutes to one hour. The interview will be audiotaped and later transcribed for analysis.
- 2) There is no perceived risk associated with this study.
- 3) The results of the study may be published, but no information that may reveal my identity will be included.
- 4) Any questions regarding the research may be directed to Nora Hirose at (510) 215-1942. Complaints about the procedure may be presented to Dr. Lela Llorens, Ph.D., OTR, FAOTA (Chair, Department of Occupational Therapy) at (408) 924-3070. Questions or complaints about research, subject's rights, or research-related injury may be presented to Serena Stanford, Ph.D. (Associate Vice President of Graduate Studies and Research) at (408) 924-2480.
- 5) My participation is voluntary. I may refuse to participate in this study or in any part of the study without prejudice to my relation with San Jose State University or any participating institutions.

By signing this, I have agreed to the aforementioned terms. A copy will be provided me.

Subjects signature

Date

Investigator's signature

Date

San Jose State University
Human Subjects-Institutional Review Board

Request to Use Human Subjects in Research Cover Sheet

Date Submitted: 5/8/93 Project Period: From APRIL 1993 To MARCH 1994
 Funded By: NORA S. HIROSE
 Name: NORA S. HIROSE Department: OCCUPATIONAL THERAPY
 Phone Number: Work _____ During _____ Home 510-215-1942 During _____
 Address: 6058 RALSTON AVE RICHMOND CA 94805
 Faculty _____ Student X Staff _____ Non-SJSU (contact) _____
 Title of Proposed Project: A STUDY OF THE FACTORS WHICH INFLUENCE TREATMENT PLANNING AND DELIVERY OF OCCUPATIONAL THERAPY SERVICES IN THE ACUTE CARE HOSPITAL SETTING
 Abstract: THE PURPOSE OF THE STUDY IS TO a) INVESTIGATE THE METHODS USED BY OCCUPATIONAL THERAPISTS TO DETERMINE WHICH PATIENTS WILL RECEIVE SERVICES AND b) INVESTIGATE WHAT FACTORS INFLUENCE HOW OCCUPATIONAL THERAPISTS PRIORITIZE TREATMENT GOALS IN THE ACUTE CARE HOSPITAL SETTING. THE STUDY WILL BE QUALITATIVE AND WILL INCLUDE INTERVIEWS WITH TEN REGISTERED OCCUPATIONAL THERAPISTS WORKING IN THE BAY AREA IN AN ACUTE SETTING. THE OBJECTIVE IS TO GAIN SOME INSIGHT INTO FACTORS THAT INFLUENCE THE TREATMENT PLANNING AND CLINICAL REASONING OF OCCUPATIONAL THERAPISTS.
 Number of Subjects: 10 Age of Subjects: 25 OR OLDER
 Type of Subjects: REGISTERED OCCUPATIONAL THERAPISTS
 Proposed Research Method: QUALITATIVE
 What Kinds of Data Will Be Collected: INTERVIEW
 Is a copy or description of each data collection instrument attached: YES ✓ NO _____
 Are procedures to protect confidentiality delineated: YES ✓ NO _____
 Are agreements from participating institutions (on their letterhead) included: YES _____ NO ✓
 Is a consent form attached: YES ✓ NO _____
 Is it on SJSU letterhead? YES ✓ NO _____
 Possible Risks: NONE

Category of Risk:

A. Research involving only minimal risk to human subjects:

Probability and magnitude of harm or discomfort are no greater than encountered in daily life.

B. Research involving reasonable risk to human subjects:

Risks to the subject are reasonable in relation to anticipated benefits to the subjects and the importance of the knowledge that may reasonably be expected to result.

Please submit two copies of the completed protocol and supporting materials to: San Jose State University, Human Subjects-Institutional Review Board, Admin. Bldg., Room 150, San Jose, CA 95192-0025. For questions call the HS-IRB at (408) 924-2479.