Health reform promotes the delivery of patient-centered care. Occupational therapy’s rich history of client-centered theory and practice provides an opportunity for the profession to participate in the evolving discussion about how best to provide care that is truly patient centered. However, the growing emphasis on patient-centered care also poses challenges to occupational therapy’s perspectives on client-centered care. We compare the conceptualizations of client-centered and patient-centered care and describe the current state of measurement of client-centered and patient-centered care. We then discuss implications for occupational therapy’s research agenda, practice, and education within the context of patient-centered care, and propose next steps for the profession.


Much of client-centered theory in occupational therapy mirrors principles of the wider patient-centered movement in health care. The Patient Protection and Affordable Care Act of 2010 (ACA; Pub. L. 111–148) emphasizes patient centeredness as both an outcome in and of itself and as a means to improve health outcomes (Millenson & Macri, 2012). To this end, occupational therapy has the philosophical underpinnings to provide expanded and more effective client-centered care that emphasizes the active engagement of the client and recognizes the greater contexts of his or her life. Yet, the emphasis on patient centeredness also poses challenges to traditional thinking in occupational therapy around client centeredness that must be addressed for the profession to keep pace with health reform.

In this article, we describe client centeredness as most often defined in occupational therapy and patient centeredness within the broader health care system, and illustrate similarities and differences between them. In addition, we discuss how occupational therapy can help inform the evolving conceptualization of patient centeredness by sharing perspectives from a rich foundation of client-centered theory and practice, including measurement of client-centered care. We then outline implications for occupational therapy research, practice, and education.

Origins of Client-Centered and Patient-Centered Care

Occupational therapy has long considered client centeredness a key component of practice. Aspects of client centeredness, such as acknowledging the importance of the client’s perspectives in treatment planning, have been present in occupational therapy values since the very beginning of the profession (Bing, 1981). Eventually, the profession worked to formally define client centeredness and describe what it means to provide client-centered therapy (Kyler, 2008; Law, Baptiste, & Mills, 1995; Law & Mills, 1998; Townsend, Brittenell, & Staisley, 1990), with the earliest formal reference to client-centered practice appearing in 1983 (Canadian Association of Occupational Therapists [CAOT] & Department of National Health and Welfare, 1983). The formalization of the working
concept of client centeredness, led by Canadian occupational therapists, marked the beginning of a growing literature on client-centered theory and practice.

Similarly, the roots of the modern patient-centered care movement can be traced back several decades to initiatives involving care for children with special needs, early medical homes, and patient advocacy in the 1960s and 1970s (de Silva, 2014; National Quality Forum [NQF], 2014). The patient-centered care movement gained prominence when the Institute of Medicine (IOM; 2001) cited patient-centered care as one of six aims in its seminal report on improving health care quality, and momentum has continued to build since then.

Health Reform and Patient Centeredness

Patient centeredness was already part of the national conversation on improving the quality of health care when the ACA was signed into law in 2010, so it is not surprising that the ACA contains multiple elements directly related to patient-centered care. Indeed, the text of the ACA mentions the term patient-centered several dozen times and includes variations on core concepts for building a more patient-centered system. The overall national strategy to improve health care as outlined by the ACA includes improving patient centeredness as a key priority. Measurement of patient centeredness is described as a critical outcome for quality of care, and quality improvement approaches, incentive programs, and payment reform initiatives are all tied to patient-centered measures that are either in use or to be developed.

As implied by its name, the patient-centered medical home, one model of primary care promoted by the ACA for payment and practice reform, is defined by inclusion of many of the core components of patient centeredness. In addition, the ACA specifies that training of all health professionals should emphasize patient-centered care. The ACA also created the Patient-Centered Outcomes Research Institute (PCORI), which has a national research agenda focused on patient-centered outcomes and has been funding projects related to this agenda since 2012 (PCORI, 2012). Because patient centeredness is a crucial focus of the ACA in particular and of health care transformation more generally as a dimension of the patient experience component of the Triple Aim (Berwick, Nolan, & Whittington, 2008), occupational therapy practitioners need to be cognizant of how the profession’s concepts of client centeredness dovetail with and differ from patient centeredness.

Comparing Client-Centered and Patient-Centered Care

Occupational therapy primarily uses the term client rather than patient to identify recipients of service (American Occupational Therapy Association [AOTA], 2014; CAOT, 2013), but it is recognized that terminology may vary by practice setting, such as “residents in housing, patients in medical settings, or students in educational settings” (CAOT, 2013, p. 116). Despite some controversy concerning the ethical, legal, and practical implications when the use of client versus patient gained traction in the 1980s (Reilly, 1984; Sharratt & Yerxa, 1985), use of client implies active participation and may serve to reinforce a more collaborative therapeutic process (CAOT, 2013; Herzberg, 1990).

One of the most widely cited definitions of client-centered practice in occupational therapy is from the Canadian Association of Occupational Therapists which described client-centered practice as “collaborative approaches aimed at enabling occupation with clients who may be individuals, groups, agencies, governments, corporations or others” that requires “occupational therapists demonstrate respect for clients, involve clients in decision-making, advocate with and for clients in meeting their needs, and otherwise recognize clients’ experience and knowledge” (CAOT, 1997, p. 49; CAOT, 2002, p. 180). Multiple concepts are embedded in this definition, including respect, collaboration and shared decision making, and valuing of the client’s contributions.

Summion and Law’s (2006) literature review of the conceptualization of client centeredness in occupational therapy confirmed the key concepts incorporated in the CAOT definition but also highlighted the role of open communication between practitioner and client and the importance of giving hope as core elements of client centeredness. Moreover, this literature review added nuance to the concept of shared decision making by stressing that the transfer of power to the client is what enables an equal partnership between the client and practitioner.

AOTA’s (2014) Occupational Therapy Practice Framework: Domain and Process (3rd ed.) refers to several of the same concepts of client-centered care. The Framework includes values, beliefs, and spirituality as important client factors and recognizes that cultural and temporal contexts and the social environment influence participation. The Framework also identifies collaboration between practitioner and client as central to the occupational therapy process and underscores the importance of understanding the goals of the client in planning intervention. Furthermore, the Framework recognizes family members and caregivers as clients in the occupational therapy process. Taken together, the CAOT (2013) definition, Summion and Law’s (2006) review, and the Framework suggest that occupational therapy’s view of client-centered care contains the core concepts of respect, client’s values, beliefs, experience, and contexts that influence participation; active collaboration throughout the occupational therapy process, with the balance of power weighted toward the client; open communication; inclusion of family; support for participation in care and self-management; and the provision of hope and possibility.

Patient-centered care descriptions contain many similar views. Multiple definitions of patient-centered care exist in the literature, and the core concepts embedded in these definitions are often comparable to one another. The NQF, a nonprofit, nonpartisan organization that reviews and endorses quality measures, recently tasked a work group with defining patient-centered care as a precursor to understanding measurement of the delivery of patient-centered care. Drawing on foundational work from leaders in the patient-centered care movement, including the IOM, the
Figure 1. Intersection between core components of client-centered care and patient-centered care.

Client-Centered Care

- Respect for values, beliefs, experience, and contexts
- Collaboration and shared decision making
- Open communication and information sharing
- Support for self-management
- Inclusion of family

Patient-Centered Care

- Hope and understanding of what is possible
- Access to care
- Coordination of care across time and settings

The concept of hope is central to rehabilitative and primary care services as well. Occupational therapy’s method of communicating and supporting hope could inform emerging conversations about how to recognize and support realistic hope within chronic illness management (Hudon et al., 2012). As occupational therapy and the health care system focus on health in a more convenient and in the form preferred by the patient, information sharing and communication, shared decision making, individualized care that is coordinated across settings and time, support for self-management, and access to care that is convenient and in the form preferred by the patient. Although a universally accepted or endorsed definition of patient-centered care does not exist, these core components align with prior seminal work on patient-centered care (Cronin, 2004; de Silva, 2014; NQF, 2014).

Figure 1 depicts the similarities and differences between the core concepts of occupational therapy’s perspective of client-centered care and patient-centered care in health care more broadly. Both perspectives appreciate the multidimensional nature of providing this type of care. A general convergence of concepts exists despite some differences in terminology, suggesting a great deal of overlap between client-centered and patient-centered care. However, the areas in which the concepts diverge provide a chance for occupational therapy to examine potential gaps in its view of client centeredness and offer opportunities for the profession to contribute to refining the health system’s conceptualization of patient-centered care.

Care coordination and team-based care underlie many proposed directions for revamping the health care system and represent an opportunity for occupational therapy (Moyers & Metzler, 2014). Occupational therapy’s concepts of client-centered care do not currently emphasize collaboration and coordination of care beyond the practitioner–client dyad. As it stands, occupational therapy’s view of client centeredness, although highly aware of the rich contexts and environments of the client, does not incorporate the context of the wider health care team. An explicit recognition of how occupational therapy interacts with others involved in care (e.g., physicians, nurses, physician extenders, physical therapists, speech–language pathologists, teachers, employers, social workers) is necessary to facilitate better collaboration and thus more coordinated care. Coordination may be particularly important for transitions between rehabilitation and the community (Cott, 2004).

Further, client-centered care also does not clearly acknowledge access to care as a core component; access includes the ability to seek and receive care according to patient needs and preferences. Although barriers to access to care are implied to an extent within occupational therapy’s view of the greater contexts and environments that affect a client, an explicit appreciation is warranted that occupational therapy services need to be available when and how a client requires them for care to be truly client centered (Gupta & Taff, 2015; Pitonyak, Mroz, & Fogelberg, 2015). One element that client centeredness may add to patient-centered care is the notion of hope and belief in possibilities; occupational therapy’s concept of understanding what is possible is not an explicit part of patient-centered care. As the emphasis on shared decision making in health care grows, it will be essential for providers to be equipped with the skills and understanding to address hope as it influences health and well-being. Occupational therapy can provide insight concerning how to acknowledge and address the hopes of patients and their loved ones because this approach is frequently part of occupational therapy service delivery (Spencer, Davidson, & White, 1997).

For example, in rehabilitation, patients often have to reconcile the incompatibility of their physical or mental capacity with their perceptions of themselves in the past or in the future (Wood, Connelly, & Maly, 2010). As they explore new roles and possibilities, hope may promote optimum achievement. Having hope during rehabilitation has been shown to increase participation in life roles and life satisfaction after discharge (Berges, Seale, & Ostir, 2012; Kortte, Gilbert, Gorman, & Wegener, 2010; Kortte, Stevenson, Hoosey, Castillo, & Wegener, 2012; Popovich, Fox, & Burns, 2003). Rehabilitation clinicians can aim to work collaboratively with the patient and caregiver to facilitate care decisions by providing them with the knowledge and strategies needed to maintain hope and achieve desired goals.
holistic, long-term way, hope may become a critical health concept (Mattingly, 2010) and thus may provide an opening for occupational therapy practitioners to share how their methods build on and are steeped in hope for “living life to its fullest.”

Measuring Client-Centered and Patient-Centered Care

Measurement of patient outcomes and experience is playing an increasing role in health care transformation efforts. Measurement is both a major theme of the ACA and the focus of the IMPACT Act of 2014 (Pub. L. 113–185), which mandates reporting of quality data by all postacute care settings. Leland, Crum, Phipps, Roberts, and Gage (2015) described a useful framework for quality measurement and value-based care to help position occupational therapy for the future. Because patient centeredness is now viewed as a critical component of quality and value in health care (ACA, 2010; Berwick et al., 2008; IOM, 2001), it is useful to look at additional detail on the current status of measurement of client-centered care and patient-centered care and on opportunities for future work in this area.

NQF endorsement is widely viewed as the gold standard in health care quality measurement; for example, the IMPACT Act requires that measures be NQF endorsed when possible. The NQF evaluates measures of patient-centered care that include patient-reported experience with care, patient-reported or clinician-assessed functional status and health-related quality of life, communication, cultural awareness, and other miscellaneous processes and outcomes related to patient centeredness (NQF, 2015). The Consumer Assessment of Health Providers and Systems family of surveys from the Agency for Healthcare Research and Quality are one example of NQF-endorsed measures of patient experience (www.ahrq.gov). Setting-specific measures of functional status that are already in use for public reporting by the Centers for Medicare and Medicaid Services have been recommended for NQF endorsement (NQF, 2015).

In addition to measures used for research, public reporting, and payments, quality improvement tools exist to help facilities, departments, and providers assess their current status in providing patient-centered care and create prioritized action plans to increase patient centeredness. For example, the Institute for Patient- and Family-Centered Care provides multiple resources and practical tips for providing patient-centered care (http://www.ipfcc.org/tools/downloads-tools.html), and Planetree offers a practical improvement guide for hospitals (http://planetree.org/wp-content/uploads/2015/03/Patient-Centered-Care-Improvement-Guide-10.10.08.pdf).

Because no universal definition of client-centered care or patient-centered care exists, it is not surprising that approaches to measurement vary. A recent review of the measurement of patient-centered care examined both what is generally measured and how it is measured; findings suggest that despite a proliferation of tools to measure patient-centered care through surveys of patients and clinicians and clinical observations, which tools perform best is not clear, and a single tool is unlikely to capture all aspects of patient-centered care (de Silva, 2014). Even if a universal definition existed, operationalizing all aspects of the core components into measureable behaviors that reflect both clinical practice and patient experience remains a challenge (de Silva, 2014; Epstein, Fiscella, Lesser, & Stange, 2010; NQF, 2015; Stiefel & Nolan, 2012). Furthermore, development is needed of measures that address non-English-speaking patients, that are appropriate for care settings outside of hospitals and ambulatory care, and that adequately track change over time (de Silva, 2014; Hudon et al., 2012; NQF, 2014). Reconciling care that results in positive patient satisfaction with negative clinical outcomes is also a limitation of some patient-reported experience measures (Epstein & Street, 2011). Involving patients in measurement development is one strategy to address some of these issues (de Silva, 2014).

Because many of the core concepts of patient-centered care and client-centered care overlap, some measures of patient-centered care may be appropriate for measuring client-centered care. Occupational therapy also has measures unique to the profession that address aspects of client-centered care; the best known is the Canadian Occupational Performance Measure (COPM; Law et al., 1990), which was designed with client-centered practice in mind and is used both as a tool for collaborative goal setting for occupational therapy and as an outcome measure. The COPM has been shown to be reliable and valid for research and practice with many client populations (Carswell et al., 2004; Dedding, Cardol, Eyssen, Dekker, & Beelen, 2004; Enemark Larsen & Carlsson, 2012; Eyssen et al., 2011). Other assessments, such as the Client-Centered Rehabilitation Questionnaire (Cott, Teare, McGilton, & Lineker, 2006) and the Client-Centredness of Goal Setting (Doig, Prescott, Fleming, Cornwell, & Kuipers, 2015) scale, were designed specifically to address one or more aspects of client-centered care. Occupational therapy has a responsibility to consider appropriate measures of client centeredness for research and practice but also the opportunity to contribute to development and evaluation of measures of patient-centered care based on prior work in this area.

Implications for Research, Practice, and Education

For occupational therapy to demonstrate its value within the evolving health care system, the profession must consider how the ever-increasing focus on patient-centered care may shape research, practice, and education. Occupational therapy should continue to include client-centered care as part of its overall research agenda. Refinement of the definitions of client-centered care and core concepts is necessary (Kyler, 2008). Careful consideration should be given to the convergence and divergence in concepts and terminology between client-centered and patient-centered care so that occupational therapy can share its perspectives and remain relevant in the ongoing conversations around patient centeredness in health care. A refined definition and delineation of core concepts grounded in occupational therapy theory will also enable further use of existing reliable and valid measures of client-centered and patient-centered care and spur development of new measures as
Occupational therapy practitioners need with several of the core components. Addressing patient-centered care because quality improvement teams tasked with can provide keen insight on interdisciplinary rehabilitation settings. The promotion of primary care in the ACA creates opportunities and challenges for occupational therapy’s involvement in primary care (Metzler, Hartmann, & Lowenthal, 2012). For occupational therapy to capitalize on the elevation of primary care’s role in health system and payment reform models, including patient-centered medical homes and accountable care organizations, the profession needs to align client-centered care with the principles of patient-centered care that have been associated with chronic disease management (Hudon, Fortin, Haggerty, Lambert, & Poitras, 2011; Hudon et al., 2012; Wagner et al., 2005).

As health and wellness programming for primary and secondary prevention at the population level also becomes more prominent because of these models of care, occupational therapy has the potential to contribute through its expertise on habits, roles, and routines. Although the ACA addresses the importance of patient-centered care and the health of populations, core components of both patient centeredness and client centeredness are heavily focused at the individual level. Consideration of how these core components translate to the population level will be necessary for successful implementation of programs and payment systems aimed at enhancing population health, such as wellness promotion models and accountable care organizations.

The increased importance of patient-centered care in health reform has implications for occupational therapy education. The ACA endorses training in patient centeredness for all health professions and interdisciplinary approaches to care delivery. Moreover, an Interprofessional Education Collaborative Expert Panel (2011) report identified effective delivery of patient-centered care as one of the four domains of core interprofessional competencies. Therefore, the occupational therapy profession must explore the most effective methods to train future practitioners not only in how to practice patient-centered occupational therapy but also in how to work on interprofessional teams that promote patient-centered care.

Because emphasis on completing certain aspects of training outside of practice silos is becoming more common in health care education, and because patient centeredness cuts across professions, interprofessional training in patient-centered practice is a possible future direction for occupational therapy education. Although some occupational therapy programs already include a form of interprofessional education, references to interdisciplinary education and knowledge are limited in the current Accreditation Council for Occupational Therapy Education (2012) standards and model curricula (AOTA, 2008a, 2008b) and are nonexistent in the “Blueprint for Entry-Level Education” (AOTA, 2010).

As a profession with a knowledge base in client centeredness, occupational therapy has an opportunity to be a leader in this area. Current occupational therapy education provides practitioners with skills for collaborative goal setting, client education, and support for clients in participation, as well as an understanding of the greater contexts that affect the client, all of which contribute to patient-centered care. However, the profession needs to be able to clearly articulate how current training fosters patient-centered care using language not specific to occupational therapy so that practitioners can communicate these abilities to other professionals.

Next Steps for Occupational Therapy

Recognition is growing that high-quality health care is contingent in part on the patient’s experience of care and that patient-centered care may improve outcomes (de Silva, 2014; Fredericks et al., 2015; IOM, 2001; NQF, 2014; Rathert et al., 2013; Stiefel & Nolan, 2012). The shift toward value-based reimbursement in health care challenges occupational therapy practitioners to demonstrate their unique

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contributions to patient care and resulting outcomes. Occupational therapy’s long-standing philosophy of client-centered care is one strategy to help showcase its value, but the profession must be aware of limitations in how client-centered principles currently translate to practice (Gupta & Taff, 2015).

Occupational therapy needs to be part of the discussion around patient-centered care not only for the sake of demonstrating the profession’s worth in a system undergoing a sea change toward value but also for the sake of our clients. We have expertise to share with other health professionals, researchers, and policymakers. The profession should disseminate its insights to share with other health professionals, researchers, and policymakers. The profession should disseminate its insights into client centeredness, further develop its understanding of and research agenda around client centeredness, and ensure practitioners’ continuing competence in core components of client-centered care to align occupational therapy with the priorities of health reform. ▲

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References


ETHICS COMMISSION

Public Disciplinary Actions, July 2015

The Ethics Commission has taken the following recent disciplinary action. According to Section 1.3 of the Enforcement Procedures for the Occupational Therapy Code of Ethics, with the exception of those cases involving only reprimand, the American Occupational Therapy Association “will report the conclusions and sanctions in its official publications and will also communicate to any appropriate persons or entities.”

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<td>Brian M. Sexton, OT</td>
<td>Suspension of Membership until December 31, 2015 Violation of Principles 50, 6B, 6D, and 7 of the Occupational Therapy Code of Ethics and Ethics Standards (2010).</td>
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Please contact Deborah Slater, Ethics Program Manager, at dslater@aota.org, with any questions concerning this information.

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