Involvement of Adult Rehabilitation Patients in Setting Occupational Therapy Goals

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Key Words: accreditation • ethics, professional • goals, setting • patient advocacy • patient involvement

Objective. This preliminary study was designed to determine whether occupational therapists involve patients and their families in a goal-setting process and, if so, to identify the methods used.

Method. Thirty registered occupational therapists practicing in adult physical rehabilitation settings were audiotaped during an initial evaluation. Researchers reviewed corresponding documentation and interviewed each subject. Twenty-three patient and family involvement criteria were generated from standards developed by accreditation commissions and health care professions.

Results. Data revealed that although subjects did involve patients and families in a goal-setting process, a number of criteria were not attempted, thus much potential for involvement was unrealized. Subjects with scores above and below one standard deviation from the mean were identified to determine which patient participation criteria had the highest discrepancies. Discrepancies included (a) verbal preparation of the patient and family for initial and ongoing treatment, purposes and procedures of evaluation and treatment, and potential outcomes of treatment, (b) attempts to elicit the patient's concerns, and (c) collaboration with the patient to establish treatment goals.

Conclusion. Factors that might have influenced subjects' use of a patient participation approach included the application of a specific theory or technique, time constraints, patient's age, and assumptions about the patient's cognitive status.

The individual and patients' rights movements have promoted patient involvement in health care for 30 years (Countryman & Gekas, 1980; Gibson, 1991; Kyler-Hutchison, 1988). The importance of patient and family involvement in occupational therapy is reflected in their inclusion in facility accreditation criteria (American Occupational Therapy Association [AOTA], 1988; Commission on Accreditation of Rehabilitation Facilities [CARF], 1992; Joint Commission on Accreditation of Healthcare Organizations [JCAHO], 1992) and in other professional standards such as occupational therapy practice models and the AOTA evaluation criteria for Level II fieldwork (1987). However, there is limited research exploring the degree to which these standards for patient involvement are being met by occupational therapists. This study investigated whether therapists are involving patients and families in a goal-setting process and, if so, to what extent and with what methods.

Literature Review

In the 1960s, society's emphasis on individual rights led to the concept of a patient's right to informed consent...
and the public’s questioning of ethical issues in health care practice (Kyler-Hutchison, 1988). Persons began to view themselves as consumers rather than recipients of health care and, therefore, demanded more control over the health care decisions affecting them.

In the 1970s, the American Hospital Association responded to society’s continued demand for change by establishing a model patient’s bill of rights. Countrman and Gekas (1980) identified two factors essential to the development of this document. First, when persons are provided with information about their illnesses, they become more knowledgeable about their conditions and are more receptive to their proposed treatment plans. Second, provision of this information increases persons’ abilities to participate in the decision-making process and, therefore, results in more satisfaction with the outcome of treatment. In a further response to demands for more effective treatment, accrediting commissions established guidelines that require health care providers to include patients in the treatment planning process.

Multiple themes exist as overlapping ideals espoused in the current literature on facilitating patients’ control (e.g., consumerism, empowerment, patient autonomy, self-care, and locus of control). A review of these ideals and specific patient participation approaches yielded the following common values and techniques: (a) an attitude of the health care professional toward the patient as an equal partner (Anderson, Funnell, Barr, Redrick, & Davis, 1991; Gibson, 1991; Roberts & Krouse, 1988; Rost, 1989; Weiss, 1986), (b) application of specific communicative methods such as exploration of issues, clarification of patients’ comments, and empathetic listening (Anderson et al., 1991; Gibson, 1991; Greenfield, Kaplan, & Ware, 1985; Ord, 1990; Roberts & Krouse, 1988; Weiss, 1986), (c) orientation of persons to the treatment process through provision of information regarding diagnoses, schedules, treatment expectations, and potential outcomes (Greenfield et al., 1985; Harden, Hales, Amen, Lewis, Miliken, & Orman, 1986; Ord, 1990; Weiss, 1986), and (d) patients’ explicit identification of problems and development of their own goals to encourage the acceptance of responsibility for their own health care (Anderson et al., 1991; Gibson, 1991; Harden et al., 1986; Ord, 1990; Weiss, 1986). Many of these common values and techniques are compatible with Carkhuff’s (1973) approach to systemic problem solving, which is based on the philosophy that an effective helper must involve persons in order to help them develop their own problem-solving skills.

Patients’ involvement in their own health care is a deeply rooted premise of occupational therapy. However, specific methods for patient involvement are not provided in the literature. Traditional as well as current occupational therapy literature addresses the concept of patient involvement in issues such as patients’ rights, ethical treatment, and professional standards (Hasselkus, 1991; Willard & Spackman, 1947). An ethical, professional therapist has been identified as one who motivates and facilitates the active participation of a patient (Gifford, 1980; Kyler-Hutchison, 1988; Payton, Nelson, & Ozer, 1990; Rogers, 1983; Willard & Spackman, 1947).

Active patient involvement is achieved through the use of a therapist’s knowledge and skills that (a) help give structure and meaning to a person’s world (Baum, 1980), (b) encourage patients to produce changes in their own health status (Baum, 1980; Willard & Spackman, 1947), and (c) increase a patient’s autonomy and effectiveness in making health care decisions (Kyler-Hutchison, 1988; Rogers, 1983). Ultimately, these efforts afford patients the opportunity for control over their own health care. When patients are actively involved in establishing their treatment goals, they are more likely to have interest in and work toward those goals (Payton et al., 1990). Kyler-Hutchison identified this ongoing engagement between therapist and patient as a key factor in formulating mutually beneficial decisions.

Work on patient participation in program planning in rehabilitation by Payton, Nelson, and Ozer (1990) frames this current study. They described patient participation as a process of collaboration and a relationship between health care practitioner and patient in which the practitioner uses knowledge and skills to provide patients with the means to control their own health care. The degree of success is contingent upon both parties accepting responsibility for the process.

Purpose

Currently, there is limited research that addresses occupational therapists’ fulfillment of patient participation standards established by accreditation commissions (e.g., CARF, JCAHO) and by the profession. Therefore, this preliminary descriptive study explored methods used and the extent to which occupational therapists working in adult physical rehabilitation settings involved patients and their families in a goal-setting process.

Method

Subjects

Thirty registered occupational therapists at adult rehabilitation facilities were recruited for the study according to their geographic convenience to researchers and on the basis of the availability of the subjects’ newly admitted, consenting patients and of the researchers at the time of the procedure. The subjects (4 men and 26 women) practiced in 10 different facilities located in three states. Their years of practice ranged from 1.2 to 24 years (M = 7.1). Twenty-two subjects held bachelor’s degrees and six held entry-level master’s degrees in occupational therapy. Two held bachelor’s degrees in occupational therapy and master’s degrees in other fields. All facilities except one were
Table 1

Raw and Percentage Scores of Therapists’ Effort to Involve Patients in Goal Setting (N=30)

<table>
<thead>
<tr>
<th>Patient Participation Criteria Items</th>
<th>Attempted</th>
<th>Not Attempted</th>
<th>Not Applicable</th>
</tr>
</thead>
<tbody>
<tr>
<td>Part A: Patient Evaluation</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Introduces occupational therapy services</td>
<td>19 (63.3%)</td>
<td>11 (36.7%)</td>
<td>0</td>
</tr>
<tr>
<td>2a. Verbally prepares patient for initial and ongoing treatment (1, 3, 5)</td>
<td>15 (50.0%)</td>
<td>15 (50.0%)</td>
<td>0</td>
</tr>
<tr>
<td>2b. Presents assessment purposes and procedures to patient, family, and significant others (1)</td>
<td>C-19 (63.3%)</td>
<td>1 (3.3%)</td>
<td>0</td>
</tr>
<tr>
<td>2c. Presents assessment purposes in a manner consistent with the patient, family, and/or significant other’s level of understanding (1, 4, 5)</td>
<td>1-10 (33.3%)</td>
<td>1 (3.3%)</td>
<td>0</td>
</tr>
<tr>
<td>2d. Discusses how the individual is to participate in goal setting and program planning, unless contraindicated by circumstances unique to the individual (3)</td>
<td>19 (63.3%)</td>
<td>10 (33.3%)</td>
<td>1 (3.3%)</td>
</tr>
<tr>
<td>2e. Discusses the significance or potential outcomes of treatment</td>
<td>1-0 (0.0%)</td>
<td>1 (3.3%)</td>
<td>0</td>
</tr>
<tr>
<td>Part B: Chart documentation</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1a. Documents the patient and/or family’s participation in goal setting (2, 3)</td>
<td>28 (93.3%)</td>
<td>1 (3.3%)</td>
<td>1 (3.3%)</td>
</tr>
<tr>
<td>1b. Documents the patient and/or family’s rating of goal significance (1, 4)</td>
<td>0 (0.0%)</td>
<td>1 (3.3%)</td>
<td>0</td>
</tr>
<tr>
<td>1c. Documents/weights goals in language acceptable to both therapist and patient (4)</td>
<td>1 (3.3%)</td>
<td>19 (63.3%)</td>
<td>5 (16.7%)</td>
</tr>
<tr>
<td>2a. The treatment plan is designed to achieve stated goals (2)</td>
<td>25 (83.3%)</td>
<td>1 (3.3%)</td>
<td>4 (13.3%)</td>
</tr>
<tr>
<td>2b. The treatment plan is developed to the extent possible, by the patient and family (2)</td>
<td>10 (33.3%)</td>
<td>18 (60.0%)</td>
<td>2 (6.7%)</td>
</tr>
</tbody>
</table>

Note: The following codes identify sources for the patient participation criteria items: (1) American Occupational Therapy Association. (2) Joint Commission on Accreditation of Healthcare Organizations. (3) Commission on Accreditation of Rehabilitation Facilities. (4) Payton et al. (1990). (5) Other professions.

C = consistently, I = inconsistently.
for each criterion item attempted, not attempted, or not applicable (in which the opportunity did not arise for subjects to attempt an item).

The authors recognized that some of the criteria are more important to goal setting, and some are interconnected. For example, therapists must elicit a patient’s concerns (Item 3b) before asking the patient to establish priorities (Item 3d).

The rating scale was more detailed for two of the criteria on the form (see Table 1, Part A, Items 2b–2c), which were evaluated on the basis of the consistency of subjects’ attempts. For Item 2b, a score of inconsistent was given to subjects who presented less than half of the assessment purposes and procedures to the patient, family, and significant others. For Item 2c, a score of inconsistent was given if fewer than half of the assessment purposes and procedures were presented in a manner compatible with the patient’s and family’s level of understanding.

Procedure

The first two authors collected the data in three sequential steps. In the first step, each subject was observed and audiorecorded while he or she administered an initial occupational therapy patient evaluation. A maximum of two sessions was audiorecorded to provide consistency in the number of interactions between the subject and patient. This maximum was set because of the time constraints of research. In the second step, the patient’s corresponding initial evaluation chart note was reviewed to determine whether the patient’s participation in goal setting was documented by the subject. In the third step, each subject was interviewed to gather demographic information, assess reported knowledge and current use of participation approaches, and identify factors that might have influenced the use of a particular patient participation approach.

Subjects’ use of patient participation in a goal-setting process was determined by a review of audiorecorded initial patient evaluations and the corresponding records to identify criteria met on the PPEF. A minimum of 72 hr after each audiorecording, the two researchers reviewed the audiorecords together and then compared their independent PPEF scores of the evaluation. After two trials, guidelines for rating subsequent tapes of other subjects were established. As other issues arose, score discrepancies were discussed and agreements were reached. Percentages were used to demonstrate the range of PPEF scores of the total sample and to identify those scores falling above and below one standard deviation from the mean. The percentage scores of applicable criteria determined the extent to which each subject promoted patient participation, with a potential range from 4.3% to 100%. Scores for each PPEF item and subjects’ comments were then analyzed to identify what methods were used to promote patient and family participation in a goal-setting process (see Table 1).

Data Analysis

The data obtained were analyzed primarily with an a priori method of concept coding. The coding was based on the PPEF. Triangulation of data, through the use of evaluations, interviews, and record reviews, was used to gain a more comprehensive perspective on subjects’ attempts to involve patients and their families in a goal-setting process.

Results

Analysis indicated that all subjects involved their patients or families in a goal-setting process by attempting at least 1 of the 23 PPEF criteria items. The total number of items attempted by subjects ranged from 3 to 15, with an average of 9.3 methods. However, these raw scores are not a true representation of subjects’ efforts because they do not reflect Not Applicable criteria. Of the 30 evaluations, the number of applicable items ranged from 13 to 23. Therefore, percentages of attempted criteria items were calculated on the basis of the raw scores and the corresponding number of applicable items for each evaluation. These percentages ranged from 17.4% to 78.9%, with an average of 43.3%.

Extent of Involvement

As reflected in the wide range of percentage scores, the extent to which subjects involved their patients varied greatly. Because the percentages were calculated on the basis of those criteria applicable to individual evaluations and because the criteria were not equally weighted, individual subject’s scores could not be compared. Therefore, meaningful correlations could not be calculated between subject’s scores and factors that might have influenced their attempts to involve patients and families. Eight of the 30 subjects received a score of Not Applicable for at least one criterion item. Three of these eight were among the highest scoring subjects, and one was among the lowest scoring subjects.

No subjects’ scores fell above or below two standard deviations from the mean. Therefore, subjects’ percentage scores for applicable criteria that fell one standard deviation above and below the mean were analyzed. Six subjects’ scores fell above one standard deviation from the mean, ranging from 60.9% to 78.9%, and three subjects’ scores fell below one standard deviation from the mean, ranging from 17.4% to 26.1%. Of the six highest scoring subjects, two subjects documented contraindications to their patients’ participation in treatment. Of the six subjects with scores above one standard deviation, their corresponding patient’s average age was 45.3 years.
and diagnoses included (a) general weakness secondary to alcoholism, (b) head injury, (c) anoxic brain injury, (d) multiple sclerosis, (e) surgery secondary to an aneurysm, and (f) surgery secondary to a spinal cord injury. Of the three subjects with scores below one standard deviation from the mean, the patients' average age was 78.3 years and their diagnoses included: (a) left cerebrovascular accident, (b) right cerebrovascular accident, and (c) diabetes or hypertension. Of the three lowest scoring subjects, only one documented contraindications to a patient's participation.

The six highest scoring subjects' average age was 35.7 years, with a range of 1.2 to 20 (m = 9.3) years of practice vs. an average age of 35.3 years, with a range of 4 to 13 (m = 8.3) years of practice for the three lowest scoring subjects. Five of the highest scoring subjects held bachelor's degrees in occupational therapy and one held a master's degree in another field, vs. one of the low scoring subjects who held a master's degree in occupational therapy.

Five of the six highest scoring subjects attempted to give an introduction to occupational therapy services (Part A, Item 1) and verbally prepared patients for initial and ongoing treatment (Part A, Item 2a). All six consistently presented assessment purposes and procedures to patients, family, and significant others (Part A, Item 2b). Two of the three lowest scoring subjects did not introduce occupational therapy services, and none of them verbally prepared the patient for initial and ongoing treatment. Only one subject in the lowest scoring group presented assessment purposes and procedures, and it was done inconsistently. Although five of the six highest scoring subjects attempted to inform patients of the nature and potential outcomes of treatment (Item 2c) and elicit patients' concerns (Item 3b), none of the three lowest scoring subjects attempted these items.

On items specifically related to goal setting, all of the six highest scoring subjects collaborated with their patients to establish goals (Item 4c), four explored or explained additional goals (Item 4e), and five stated goals in a language acceptable to the patient (Item 4f). Of the three lowest scoring subjects, none attempted to collaborate with the patient to establish goals, and none explored or explained additional goals. Five of the six highest scoring subjects involved the patient or family or both in the formulation of the treatment plan, to the extent possible (Part B, Item 2b). Only one of the three lowest scoring subjects received a score for attempting this item.

Method of Involvement

Table 1 outlines the methods used by all 30 subjects to involve patients and families in goal setting. Methods used most consistently (more than 60%) included (a) explanation of occupational therapy services and of assessment purposes and procedures, (b) presentation of information in a manner consistent with the patients' level of understanding, (c) collaboration with patients to establish goals, (d) explanation of relevant goals not identified by the patient, (e) documentation of participation of patients or families or both, and (f) inclusion of patients' goals in treatment plans. Those methods most consistently not attempted related to (a) explanation of how patients are to participate in goal setting and program planning, (b) elicitation of and response to patients' concerns, and (c) documentation of patients or families' rating of goal significance.

Of the 30 subjects, 22 (73%) reported that they had studied problem-solving or interviewing approaches or techniques. Ten studied techniques designed specifically to involve patients in setting their own goals. Of those 10 subjects, none received one of the top five scores. One of the 10 was among the five lowest scoring subjects. Of the 30 subjects, 10 reported that they currently use a specific theory or technique to involve patients in setting treatment goals. Of those 10, 4 were among the highest scoring subjects. Some of their reported theories or techniques included (a) a model of human occupation, (b) an occupational behavior approach, (c) an interactive technique, (d) patient- or family-directed treatment versus therapist-directed treatment, and (e) patients' verbal acceptance of responsibility for treatment.

Discussion

Findings indicate that occupational therapists working with adults in physical rehabilitation do involve patients and families in a goal-setting process. However, on average, they used fewer than one half of the 23 PPEF criteria items. These results indicate that therapists do not maximize patients' and families' potential for involvement.

Although some of the subjects reported prior exposure to or training in how to involve patients, this did not seem to ensure the use of patient participation approaches. Investigation of methods used by subjects to involve their patients helped to identify influential factors and trends. One factor that seemed to affect results was subjects' reported current use of a theory or technique to involve patients in goal setting. Those reported theories and techniques were chosen by individual subjects and not stipulated by the respective facilities. One subject's reported technique was to try to determine the patient's deficits, verbalize these to the patient and make sure the patient agreed with them, then ask which goals the patient would like to address. During goal exploration, the therapist would remind the patient of identified deficits.

The finding that the high number of "not attempted" items related to elicitation of patients' concerns (Part A: Items 3a, 3b, 3d, 3e, and 4e) may indicate that therapists are not aware of the importance of exploring a problem and the relationship between acknowledging patients'

The use of Not Applicable for scoring items might have influenced results. Because of a decrease in the denominator used to establish percentage scores and no penalty for situations beyond the subjects’ control, some subjects’ scores might have been inflated.

A patient’s age also might have affected how he or she was involved in the goal-setting process. The difference in patients’ average age between the highest and lowest scoring groups was 30 years (i.e., highest scoring average of 43.3 years, lowest scoring average of 73.3 years). Because of the use of Not Applicable for scoring criteria items and the unequal weight given to items, meaningful correlations between subjects’ scores and patients’ ages could not be calculated. Therefore, conclusions could not be drawn about how patients’ ages may relate to their participation or therapists’ efforts to involve the patient. Further study is needed to determine if there is a correlation between patients’ ages and their involvement in treatment. None of the other factors, such as patients’ conditions and therapists’ educational degrees or years of practice, seemed to influence the highest and lowest scores.

During interviews, some subjects reported time constraints as a deterrent to promoting patient involvement, but the average time spent during evaluations was 20 min shorter for the six therapists with the highest scores. Subjects also reported patients’ low cognitive status as a deterrent. However, this assumption regarding patients’ cognitive status may be premature when assessing a patient’s ability to participate. For example, the highest scoring subject documented contraindications to the patient’s participation but still made attempts to involve the patient throughout the evaluation.

In general, the highest scoring subjects seemed to consistently incorporate the following methods or techniques into their evaluations. They (a) gave more situation-specific examples while explaining occupational therapy services and presenting assessment purposes and procedures, (b) verbally related the evaluation test items and procedures to potential treatment and outcomes, and (c) probed for more information regarding patients’ concerns and desired goals. Overall, these subjects seemed to make more of an effort to ensure that patients understood their situations and how their functional abilities had been affected. In this way, they facilitated patients’ involvement and, therefore, enhanced patients’ control over their health care.

Summary and Limitations

Some of the following limitations are threats to external validity and may have weakened generalizability of results:

1. A nonprobability convenience sample was used.
2. The PPEF does not have established validity or extensive reliability measures but is assumed to be appropriate and relevant on the basis of the literature review.
3. The presence of the audiotape recorder might have affected subjects’ performance during the evaluation (Gelso, 1974). To control internal validity, the specific purpose of the study was kept from both the subjects and patients. It was explained to subjects that the recorder was necessary because of the complexity of the information obtained and the need to rely on concrete data rather than on memory (Gorden, 1987).
4. Use of Not Applicable items on the PPEF and, therefore, use of different denominators to calculate percentage scores, prevented comparison between subjects and calculation of correlations between subject’s scores and factors that might have influenced their attempts to involve patients and families.
5. Although the two data collectors established agreement on scoring of PPEF criteria items, this consensus may not be a valid measure for some items due to its subjective nature.

The predominant finding was that although therapists do involve their patients and families in a goal-setting process, they are not consistently involving patients to the maximum extent. Because maximizing patient involvement may help to ensure effective, ethical treatment, studies identifying ways to involve patients in their own health care are needed.

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MA: Human Resources Development Press.


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