Occupational Therapy Groups in Health Care: Case Illustration

ZHAW Zurich University of Applied Sciences
School of Health Professions
Institute of Occupational Therapy

December 18, 2015 Professor Sharan L. Schwartzberg
Tufts Faculty

Sharan L. Schwartzberg, EdD, OTR/L, FAOTA, CGP, FAGPA

Graduate School of Arts & Sciences
Professor of Occupational Therapy (primary appointment)
Professor of Public Health & Community Medicine and Professor of Psychiatry (secondary appointments)
Learning Objectives

1. Appreciate the history of group work in occupational therapy
2. Understand trends in current practice of occupational therapy group work in the US.
3. Understand the value of interprofessional education in group leadership and as educational strategy to integrate research into the learning and practice.
History of Groups in OT

• Groups have been used in occupational therapy treatment since the 1920’s.
• Group courses have been a part of occupational therapy education since the 1960’s.
• 2011 ACOTE standards state that OT and OTA students must demonstrate the ability to design and/or implement group interventions.
History of Groups in OT

• In 1983, Duncombe & Howe found that 60% of Occupational Therapists surveyed used groups as a treatment modality.
• In 1993, they found that 52% of Occupational Therapists surveyed used groups as a treatment modality.
• Revised OTPF(2014) added group as an intervention implementation method.
**Current Practice and Perceptions of Group Work in Occupational Therapy**

Susan M. Higgins, OTD, OTR/L; Sharan L. Schwartzberg, EdD, OTR/L, FAOTA, CGP, FAGPA; Gary Bedell, PhD, OTR/L, FAOTA; and Linda W. Duncombe, EdD, OTR/L, FAOTA

Tufts University Boston School of Occupational Therapy

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**History and Background**
- Groups have been used in OT treatment since 1920’s.
- Groups have been part of OT education since 1960’s.
- ACOTE standards—OTIOTA students must demonstrate ability to design and implement groups.
- Changes in the demographics of the profession:
  - In 1990, 6% of OTs worked in MH.
  - In 2010, 3% of OT practitioners work in MH.
  - In 1990, 9% of OTs worked in SNFs.
  - In 2010, 10% of OTs and 45% of OTAs work in LTOSNFs.
- Changes in healthcare policy:
  - Medicare Prospective Payment System (PPS) signifi cantly limited OT Services.
  - HCFA mandates only 25% of treatment provided in group format.
  - CMS determined that group therapy does not meet the intensity required for inpatient rehabilitation.

**Surveys of Group Practice**
- Duncombe and Howe (1985) found 60% of OTs used groups in practice.
- 1993 replication study found 52% of OTs used groups in practice.
- LaFemina Fiss & Effgen (2007) found 41% of pediatric PTs used groups in practice.
- Camden & colleagues (2012) identified groups could be a method of providing services in a pediatric program.

**Research Purpose**
- Identify barriers, supports, opportunities, & limitations to providing group treatment in different practice areas.
- Ascertain future educational needs.
- Recommend methods to increase group training & group work in occupational therapy practice.

**Research Objectives (for OTs and OTAs)**
- Describe types of group education.
- Describe current group practice by type & frequency.
- Identify theoretical frameworks used in practice.
- Identify barriers, supports, opportunities, & limitations to providing group treatment in different practice areas.
- Identify resources for improving & promoting groups in practice.

**Methodology**
- 20-question Qualtrics survey - basic demographics, level/type of group education & training, group interventions used, & perceptions of group as intervention implementation method.
- Web-based survey distributed using snowball sampling through state associations via email invitation.

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**Results**
- **N=273, 85% return rate**
- **Section 1 – Demographics**
  - 85% Occupational Therapists, 24% Occupational Therapy Assistants.
  - 35% 20+ years of experience.

**Practice area by role.**

**Use of groups by role and years in practice.**

**Section 2 – Group Training**
- 69% received formal coursework on group therapy & group work.
- 4% reported group education was not at all important.
- Group Training Themes – prepares for group facilitation, improves ability to develop group programs, provides foundation for specialized skill, & increases confidence.

**Section 3 – Group Interventions**
- 50% used group. 50% did not use group, mean - 56 groups per week.
- 29% did not use specific theoretical framework.
- Common approaches - MOHO, sensory based interventions, CBT, task oriented, developmental, cognitive disabilities & Functional Group Model.

**Section 4 – Perceptions of Group**
- 22% strongly agreed groups were effective at their setting.
- Benefits of groups – increases interactions, develops sense of personal causation, provides safe & accepting environment, increases skills & goal development, increases motivation & support, offers effective way to reach more individuals.
- Skills, knowledge, & supports to increase group use – insurance reimbursement, build skills in group leadership.
- Strategies to support group participation – time, support of management.

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**Discussion**
- Demographics correspond to AOTA Workforce Survey.
- Groups continue to be valued form of intervention by OTs.
- Benefits of group – environmental (time, cost-effective) & client focused (peer role modeling, support, improved communication & social performance).
- Barriers – reimbursement, lack of support by setting, lack of time, space & staff.

**Limitations**
- Convenience sample, state association members, limited representative sampling.

**Conclusion**
- Groups continue to be used as form of intervention but substantial barriers exist in certain settings (SNF/LTC).
- Greater training emphasis needed on groups across lifespan.
- Further research needed into group use by role & experience.
- Continuing education opportunities needed to improve knowledge & skills in group theory & practice.

**References**
Demographics of OT

• Demographics of the Profession
  – 1990
    • 5% = mental health
    • 29% = schools (included EI)
    • 16% = skilled nursing facilities
  – 2010
    • 3% = mental health
    • 22% = schools (5% EI)
    • 16% OT = skilled nursing/long-term care
    • 46% OTA = skilled nursing/long-term care
Healthcare Policies

• Medicare Prospective Payment System (PPS) and the Balanced Budget Act of 1997, included cost containment directives.

• Medicare significantly limited reimbursement for occupational therapy services.

• HCFA mandated only 25% of treatment could be provided in group format.
Healthcare Policies

- CMS standard of care for inpatient rehabilitation facility (IRF) patients is individualized therapy; group therapy does not meet the intensity required for inpatient rehabilitation.
- Many skilled nursing facilities, inpatient hospitals, and outpatient facilities have stopped billing for group under the group therapy code (91750).
Research

• Purpose

To determine occupational therapy practitioners’ current practice trends and views of group treatment, to identify supports and benefits of group treatment, to identify future educational needs, and to make recommendations to increase group work in occupational therapy practice.
Research Objectives

• To describe types of group education of occupational therapists and occupational therapy assistants.
• To describe current group practice by type and frequency, provided by occupational therapists and occupational therapy assistants.
• To identify theoretical frameworks on which current occupational therapy and occupational therapy assistants' group practice is based.
• To identify barriers, supports, opportunities, and limitations to providing group treatment in different practice areas.
• To identify resources for improving and promoting groups in practice.
Methodology

• 20-question survey:
  1) Basic Demographics—role, years in practice and practice area;
  2) Group Education and Training—education/training in group work and group theory, and perceived importance of group training in education;
  3) Group Interventions—use of groups, types of groups, theoretical frameworks used in groups, and barriers and limitations to group use;
  4) Perception of Group Treatment—effectiveness of group interventions, benefits of group intervention, and skills, knowledge, supports and strategies to increase group use for current practice.
Survey Methods

• Survey distributed through state associations via email invitation.
• Survey open for 8 weeks, reminder sent at week 5.
• Analysis –
  – Frequency distributions, cross-tabulations, and chi-square tests using Qualtrics (2014) reporting tool.
  – Open-ended questions and responses analyzed and categorized using Berg’s (2001) content analysis process.
Results

• 323 responses –
  – 276 completions
  – 3 did not agree to consent process
• n=273
• 85% return rate
Results

Role

OT

OTA
Results

Experience

- 20+ years
- 16-20 years
- 11-15 years
- 6-10 years
- 3-5 years
- <2 years
Results

Practice Area by Role

Percentage of Respondents

Practice Area

Hospital  Rehab.  Psych.  CMHC  SNF/LTC  Comm.  School  HH  OPT  PP  Other

 experiencia OT  OTA
Results

• Section II – Group Training
  – 69% received formal coursework on group theory and group work.
  – Only 4% reported group education was not at all important.
  – Group Training Themes - prepares for group facilitation; improves ability to develop group programs; provides foundation for specialized skill; and increases confidence.
Results

- Section III – Group Interventions
  - 50% used group, 50% did not use group.
  - Mean 6 groups per week.
  - 29% did not use specific theoretical framework.
  - Common approaches – MOHO, sensory based interventions, CBT, task oriented, developmental, cognitive disabilities and the Functional Group Model.
Results

Types of Group Intervention

Percentage of Responses

Types of Groups

Exercise  ADL  iADL  Task  Verbal  Sensory  Psycho-Ed  Support  Social/Comm.  Psychotherapy  Wellness
Results

Figure 3. Barriers to group treatment.
Results

• Section IV – Perceptions of Group
  – 22% strongly agreed that groups were effective at their setting.
  – Response categories: increases interactions; develops sense of personal causation; provides safe and accepting environment; increases skill and goal development; increases motivation and support; and offers effective way to reach more individuals.
Results

Figure 4. Benefits of group treatment.
Results

• Skills, knowledge, and supports to increase group use included:
  – insurance reimbursement,
  – staff support of groups,
  – skill in group application,
  – strategies to support group participation,
  – training for other disciplines,
  – time,
  – support of management,
  – increased staff.
Results

• Identified strategies to help improve group skill:
  – continuing education workshop,
  – inservice education,
  – resources/funding,
  – role modeling/observation,
  – training for paraprofessionals.
Results

• 51% of occupational therapists utilized groups in practice, compared to 39% of the occupational therapy assistants.

• Highest group use in – community programs, psychiatric hospitals, school settings and community mental health settings.

• Lowest group use in – skilled nursing and long term care facilities.
Results

Use of Groups by Role and Years in Practice

Percentage of Respondents

Years in Practice

0-2 3-5 6-10 11-15 16-20 20+

OT
OTA
Discussion

• Survey included OT’s and OTA’s.
• Limitations –
  – members of state associations,
  – snowball sampling,
  – privacy policies,
  – not representative sampling.
• Demographic numbers correspond to 2010 AOTA Workforce survey.
• More OTA’s employed in long-term care/skilled nursing facilities than any other practice area.
Discussion

• Groups continue to be a significant form of intervention implementation.
  – OT’s appear to use groups more in treatment than OTA’s.
  – Group use increased with level of experience.
  – Groups used more in school settings and community practice.
Discussion

- Reported benefits of group treatment:
  - 1) environmental benefits, which include time and cost-effective forms of treatment,
  - 2) client benefits, which include peer role modeling and support, improved communication and social performance, and feedback and advice from peers.
Discussion

• Barriers to group intervention:
  – reimbursement,
  – lack of support by setting,
  – lack of time,
  – lack of space for running groups.

• Only four respondents identified that changes were needed in insurance reimbursement to increase group use.
References


Designing Oral Health Group
Schwartzberg
Psychiatric morbidity and oral health: What we know

- Poor oral health status is common
- Relationship between oral health status, morbidity, and quality of life
- Common problems: dental phobia, limited access to health care, difficulty following routines, side-effects of medicine & substances

✓ Psychiatric patients more vulnerable to dental neglect and poor oral health
✓ Dental fear is one of the most difficult patient management problems
✓ Members of multidisciplinary team key

(Cormac & Jenkins, 1999)
Psychiatric Conditions and Group Format

Cognitive functioning
- Limited attention span and poor concentration
- Concrete and disordered thinking
- Difficulty problem solving and following directions

Psychosocial functioning
- Emotional lability
- Withdrawal or hyperactivity
- Need for group structure, clear boundaries and emotional support
Inpatient Milieu and Group Implications

- Short term
- Interruptions during group for medical interventions
- Unpredictable group membership
- Wide range of functioning, age, conditions, cultural orientation, ability to communicate (verbal and written)
Group Format

- Parallel process
- High degree of leader involvement to support task and emotional needs of members
- Simple steps with positive outcomes
- Success orientation
- Inclusion: boundary maintenance, limit setting, bridging concerns, member-centered
Need for Project

• Oral health group held on consistent basis
• Dental students with knowledge of oral health promotion and maintenance
• Occupational therapists with group leadership skills, knowledge of group process & dynamics, activity analysis & adaptation, and functional implications of psychiatric illness.
Integrating Interprofessional Education, Practice & Research

Oral health education provides an opportunity to promote oral health for individuals with special needs

- Reinforces multi-disciplinary team-based approach to patient care
- Stresses Importance of functional assessment
- Facilitates skills to manage physical and behavioral challenges

Oral health research – highlights the needs of underserved populations, guides intervention strategies
Group Structure

• Oral health education group co-led by volunteer students and
  – occupational therapy staff -- to help facilitate
  – dental school faculty member -- to shape content & administer schedule

• “Lunch & Learn” didactic component coordinated by both dental and OT faculty
  – Review aspects of oral health and oral-systemic connections
  – Teach principles of health communication/ health literacy
  – Highlight functional assessment and MH needs of the patients

• Oral Health Survey Research Project
Project Description

- Social and clinical factors → essential factors in determining the health outcomes of oral disease (Locker, 1995; Locker et al., 2000)

- This study was designed as a continuation of the pilot study examining oral health in acute inpatient psychiatric population
  - addresses knowledge gap between oral health education programs and the perceived social impact of oral health on psychiatric inpatients

- Initial study included 75 subjects. This study is an update that includes data collected from an additional 127 subjects
Purpose

- To increase understanding of oral health status in acute inpatient psychiatric population and its impact on their quality of life.
- To inform group program development for psychiatric inpatients.
- To examine the usefulness of OHIP-14 as a screening tool for oral health status in this population.
- To generate hypotheses for future research.
Procedures

➢ Recruitment: Pratt 2 of an Inpatient Psychiatric Unit in a hospital in Boston.
➢ At the start of each Oral Health Group on Pratt 2, dental students invited participants to fill out the OHIP-14 questionnaire. Scripted oral explanation of the study along with consent information and written copy of the explanation given to the participants.
➢ Group session:
  Psychoeducational format
  Led by 2 dental students under the supervision of their Professor, Senior Occupational therapist on the Unit.
➢ Each participant filled out OHIP-14 anonymously
  ■ Provided gender and age
  ■ Subjects 76-204 provided perceived diagnosis
Methods

Participants
- 202 inpatient participants were recruited from the Pratt 2 patient population
  - Gender: Female 108, Male 73 (21 did not indicate gender)
  - Age Range: 19 - 80 (mean age: 44.5)
- Subjects 76-202 provided space to record perceived diagnosis
  - MDD=52, Schiz.=9, Others=6, Not Reported=48, Unclear=12
## OHIP-14 Dimensions

<table>
<thead>
<tr>
<th>Dimension</th>
<th>Topics of question (two per dimension)</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Functional limitations</td>
<td>Problems with pronunciation &amp; worsening taste</td>
</tr>
<tr>
<td>• Physical pain</td>
<td>Pain in mouth &amp; discomfort while eating</td>
</tr>
<tr>
<td>• Psychological discomfort</td>
<td>Feeling tense &amp; self-conscious</td>
</tr>
<tr>
<td>• Physical disability</td>
<td>Unsatisfactory diet &amp; interrupt meals</td>
</tr>
<tr>
<td>• Psychological disability</td>
<td>Difficulty to relax &amp; embarrassment</td>
</tr>
<tr>
<td>• Social disability</td>
<td>Irritability with others &amp; difficulty doing usual jobs</td>
</tr>
<tr>
<td>• Handicap</td>
<td>Less satisfying life and total inability to function</td>
</tr>
</tbody>
</table>
Data Analysis

- Data was analyzed using SPSS and MS Excel.

- Item means were calculated for all subjects to determine which dimensions had the most impact.

- Summary scores were calculated to determine which participants were most impacted by oral health.

- Median split was used to create a high impact group of participants based off of summary scores. Item means, T-tests and effect sizes for the High Impact group (HIG) was calculated to determine the differences by age and gender.
T-tests done for total sample to detect differences between age, gender and diagnosis.

Item means were calculated for the high impact group to determine which dimensions had the most impact on participants with the poorest oral health.

T-tests and Cohen’s d was calculated → differences based on age and gender in the High Impact Group (HIG).
Results

Dimensions most impacted in the total sample and HIG group were:
- Physical Pain
- Psychological Discomfort
- Psychological Disability
Comparison of Total Sample

Comparison of Total Sample and High Impact Group
Means by Dimension

- Functional Limitations
- Physical Pain
- Psychological Discomfort
- Physical Disability
- Psychological Disability
- Social Disability
- Handicap

Mean Scores

Total Sample
High Impact Group
Discussion & Implications

- Psychological discomfort is most impacted dimension, considerations for how this might affect perceived diagnosis and overall oral health.

- Plans to compare subjects within the HIG to determine more implications as well as comparison to initial cohort of subjects to determine more trends.

Healthy People, 2010. Centers for Disease Control and Prevention Health Resources and Services Administration Indian Health Service, National Institutes of Health.


Appreciation

Thank you to Susan M. Higgins, OTD, OTR, Academic Fieldwork Coordinator and Lecturer, Tufts University, Department of Occupational Therapy for her contribution to this presentation to the understanding of current group work practice in the US.