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## Application of the Kawa Model in Geriatrics Recorded September 10th, 2019

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- [Host] Today's course is Application of the Kawa Model in Geriatrics presented by Dr. Jennifer Lape. She received her Bachelor of Science in Psychology from the University of Pittsburgh and both her Master of Occupational Therapy and Post-professional Doctorate of Occupational Therapy from Chatham University in Pittsburgh, Pennsylvania. Her doctoral project focused on the use of multisensory environments to manage negative behaviors in clients with dementia. She is currently an assistant professor of occupational therapy at Chatham University where she teaches the evidence based practice courses in the post-professional occupational therapy program. In her 19 plus years of clinical practice, she's worked in a variety of practice settings including pediatrics, acute care, home health and skilled nursing with the majority of her practice in geriatrics, in the roles of clinician, clinical consultant, legal consultant and manager of rehab services. She's authored peer reviewed articles related to evidence based practice with a variety of populations as well as a text on research in evidence based practice. She has presented at the state, national and international levels and her scholarship interests to-date include sensory processing and the use of multisensory environments to increase quality of life for clients with dementia, evidence based practice, strategies to improve collaboration among multi-disciplinary rehab teams and the Kawa model. Welcome Dr. Lape. So happy to have you.

- [Jennifer] Thank you. All right, so today we will be talking about application of the Kawa model in geriatrics and that'll include a variety of settings that I'll be touching on. So the learning outcomes for today are to list the components of the Kawa model and their meanings. List the steps in using the Kawa model with a geriatric client regardless of the setting, and to describe the current research on the application of the Kawa model in geriatric settings including longterm care, home care, and community based settings. So first, I just wanna talk a little bit about, what the model is, not assuming that anyone has any prior knowledge of this. So the Kawa model is a holistic conceptual model of practice. It was developed by a group of Japanese and Canadian

occupational therapists. And in this model, a river is used to symbolize one's life. So the various parts of the river symbolize things like one's strengths or barriers, social or physical environment and supports. The model emphasizes the interaction between an individual and his or her context and inter-relation of the self and others.

So, this model originated in the Eastern world and Western models typically focus on the individual, but the Kawa model focuses more on the context that impact and shape the realities and challenges that shape our daily lives. The therapist who developed this model felt that it was needed since all cultural contexts aren't the same. For example, in our Western world, we focus on the individual and independence is highly valued here. But in the Eastern world where this model originated, there is more focus on being interconnected and independence doesn't necessarily hold the same importance or value there. So we have to remember that we treat clients from variety of cultures and it's important to recognize the impact of culture on the care experience and we should not project our own values onto our clients. So the various parts of the river include the water, the river banks and bottom, rocks and driftwood or debris, and they each represent different aspects of one's circumstances. And today I will review each of those elements. So first we will talk about the river flow or the water itself. And so the water in the river represents life's flow or one's subjective view of themselves, their well-being and their context. And just as it is with a river, the flow of that river is impacted by components of it.

So the walls, the rocks, bottom and driftwood. And so if you think of your life as a river, birth is where the river begins, when the water flows down from the mountains to create that river, and then death is when the rivers ceases to flow, so it dries up or the river releases into the ocean. And you have to remember in this process that great flow doesn't necessarily mean independence. So again, that's our Western view. And in some Eastern cultures, greater value is really placed on inter-dependence and belonging. And so the goal of occupational therapy is to then increase that flow in the

river. And this will mean something different to each client, depending on his or her culture and their circumstances. So next we'll talk about the river walls and bottom. And that represents the social and physical environments and contexts, in one's life. And so those could be positive or negative, just depending. So for example, thinking about social context, that could include family members or co-workers or friends and those people could serve as supports or a hindrance in the situation.

So just to give you an example, a friend who might drive you to appointments or help you with shopping or listen to your concerns after you've just had hip surgery could be a great support, but a co-worker who might not collaborate very well on an assigned team project could be viewed as a hindrance. And you have to remember that in non-Western cultures, social relationships are really the primary determinant of life flow. And then, if we're thinking about more of the physical environment, that could be in our home environment or work environment where we're doing leisure activities. So the physical surroundings and those could also be positive or negative. And so some examples, some negative examples would be, imagine if you had some sort of physical disability, that impaired your ability to get around, and so negative aspect could be not having a ramp, a lack of handicapped parking, a toilet seat that is too low or even cooking utensils or pots or pans that are stored out of reach. And so with more positive social and physical supports, water flow can increase, which can help to displace the rocks in your life. And the rocks are the problems which I will address next. So rocks represent life's problems or the obstruction of water flow, and the size and composition of those rocks symbolize the degree of impact.

So remember, if it's a very large rock, that would be something that would have a very significant impact to one's life or something that would be very small, could have a very minor impact. And it's important to note that this is the perception of the individual or the client. So not the doctor and not the therapist's perspective. So I'll just give you a quick example about this. So I was treating a client with multiple sclerosis and before

using the Kawa model with her, I would have predicted that her physical limitations were the biggest problem, obstructing her flow. But after I applied the Kawa model, I soon realized that her anxiety related to overextending her husband was what she perceived to be her biggest concern. And on the other side of that, after I discussed this with her husband, he verbalized that he was worried about letting her down and not doing enough. So, obviously things that he was dealing with would affect his ability to care for her and vice versa. And these rocks can exist throughout life. So that would be something like a congenital disease. They could appear suddenly.

So examples might be cancer or heart attack, or suddenly losing a job. Rocks can be minimized or worn down in some cases. So, maybe you can't eliminate it, but they can be minimized. And that could be through using social supports in the environment or environmental modification to minimize the impact. And then some rocks could resolve completely. So, for example, that could be like remediation of skills following a knee surgery. So, once you go through the rehab, you're back on your feet and you resume your normal life roles, your normal way of doing things. So, other examples of rocks could include other illnesses or injuries, financial difficulties, work stress or demands and even things like death of a family member or other loved one. And now we'll discuss driftwood and debris in the river. So that would represent personal attributes or resources. And these can be positive or negative. So the driftwood can be positive if it helps to shift or push those rocks out of the way, so widening that flow in your river or driftwood or debris can further obstruct or jam up the river so that the water cannot flow. So that they could work both ways. And examples of driftwood or debris could be things related to your values or your character.

So being dependable or loyal, having good integrity, being sincere or kind or very devoted. Other driftwood include personality traits, so being extroverted or introverted, being very conscientious or agreeable. It could also be represented through things like knowledge or experience. So this could be things like the academic degree you hold or

the experience that you have as an OT, prior therapy for an injury. So maybe you've experienced this before and so you know what to expect this time. Other skills including like advocacy or leisure skills like gardening, financial planning. And driftwood or debris can also include material assets. So things like money or the availability of adaptive equipment or adequate transportation. And just to give an example of how debris or driftwood could be positive or negative depending upon the situation, I'll give the example of being agreeable. So being agreeable could help to shift rocks away or it could further obstruct the flow.

So for example, being agreeable could decrease conflict in your life, which could typically be seen as a positive. So you might have less stress or anxiety if there's not a lot of conflict in your life. But it could also further obstruct flow, since someone who might be agreeable, might tend to over commit, they might not be a good advocate for themselves to get the necessary supports they need. So, driftwood and debris could be positive or negative in that way. And then finally, the space between those rocks or between the obstructions, that space is really where occupation, and the focus of occupational therapy intervention is. So you wanna look at those spaces as opportunities for expanding flow and well-being. And this model really helps us view the client holistically. So we can see their problems, but they're tied tightly with one's context, supports and barriers. And as an occupational therapist you have to think about how you might widen those spaces so the water can flow better. And sometimes in a medically-based care, we focus exclusively on problems and our contrived solutions, things that we always do with little attention to the client's own strengths and social and environmental supports. We also sometimes view things from our perspective rather than theirs.

And this model promotes the reframing of the client's problems in a more positive light, where the client has some control over his or her circumstances. And to illustrate this point, I'll give the example that I did this activity with a group of therapists, in order to

educate them on how to use this model with a client. So, the purpose of the activity was merely educational. I wasn't necessarily expecting the therapists themselves to get something out of it. And so each therapist had sketched out their own model and then they began sharing with each other. And this was a group of therapists that had worked together for a number of years and so they knew each other pretty well. But they began to disclose things, personal things about themselves that they had never disclosed before. And some of it was pretty private information, pretty sensitive things. But they felt that it was really easy for them to share by saying this is my rock and then discussing what the problem was. And that was just a more positive way to frame it rather than saying this is my problem. And they could look at those problems that they were disclosing in light of all of the positive things and the supports that they had in their life to perhaps address that.

So now I'm gonna move into discussing the steps that you would use if you were going to use the Kawa model with an individual geriatric client. So these steps would apply, whether you're in longterm care or home care or community based setting of some sort. So, there are six steps and I'll review them briefly here and then go into a bit more detail on the next slides. So the first step, it really involves drawing or creating that model with some other mediums. So you're having the client construct their river model, putting the rocks in, and the driftwood. Everything as they see their life in that first step. In the second step, you're asking them to clarify so that you truly understand their perspective. So you'd be asking clarifying questions and prompting them to explain details of their model. In the third step, the issues are prioritized according to the client's perspective.

So what you deem to be the most important to address might not be the client's. And the fourth step, after you've prioritized and determined what you're going to be working on, then you further assess those focal points of OT intervention and that can be accomplished with standardized or objective assessments as needed. Then you

would provide the treatment. And the last step is to evaluate the outcomes of that intervention. And this process really mirrors that of the OT practice framework, where the client is assessed, goals are established, treatment is provided and then the outcomes are evaluated and then the process may begin again depending upon the status at that time.

So let's talk a little bit more about step one. And that is construction of the client's individual river model. So I've included the link on this slide to a PDF. This is a guide for the Kawa model. It's called the Kawa model made easy. So it is free and available for download with that link and you can use this guide. It is a great resource and has suggested guiding questions and prompts that you would or that you may be able to use if you're actually trying to get the client to draw out or sketch out their own model. The model can be used as a qualitative assessment tool, so to gain further information about the client. And there is no particular order that you need to ask the questions or have the client put things into the drawing. So you could ask about rocks first and then you could move into things related to social and physical supports, which would be the river walls or bottom. Then you might go back to rocks if something comes up. It really should just be a fluid process, more like a discussion. So, sort of what feels right to you and what seems appropriate with the client. The activity can be used as part of the occupational profile.

So many questions about the home situation or environment, caregivers or other barriers can be asked in the context of creating the Kawa model. The model allows you to see all of these elements as interconnected and from the client's perspective rather than a short answers to separate questions, which is typically what we see on an OT evaluation. Like how many storeys is your home? How many steps are there? Do you do your own laundry? So those sorts of things we might see on an evaluation and we would be answering those questions. But this allows you to sort of put it together into a story and everything is in one picture. Questions usually progress from general to



specific. So for example, a general question might be, if your life was a river, how would you describe your flow right now? And then a more specific question might be, why do you feel that way? Tell me more about your difficulties. So that's sort of where you get into the details and start to probe a bit more. And this activity might be therapeutic rather than just an assessment.

So in my experience, this process has been extremely helpful in developing rapport with the clients. And many of my clients have commented about the depth of the discussion and how it was helpful to share the details with someone who they felt could help them. And many commented that they felt the metaphor helped them to share something they may not have otherwise shared. And that was what, some of the therapists had said as well. So in this step, you really just describe each element of the model and invite the client to add to the drawing. So on this next slide are some examples of guiding questions and these are just examples, the guide has many more and the authors actually suggest developing your own best questions based upon your clientele and experiences. So kind of what works best for you. And I know myself, regardless of what setting I'm working in or what the valuation form or computer system looks like, I have sort of developed over the years the order of questions that I ask about the patient and the way that I would ask those questions. And so using the Kawa model is much that same way. So you would sort of develop a flow as you get used to doing this.

So some examples of questions about the river flow would be if your life was a river, how would you describe your flow right now? What does your typical day look like? What do you enjoy? River flow questions can focus on the past, present and future. They might focus on the client's work history, their past medical history, their life roles, self care or leisure activities as well as other occupations which can all contribute to their river flow. The flow may also consider river flow of key people in their lives. So like a spouse, children or caregivers. Because if people that are key people in their lives

have a disrupted flow in their own river, then it's probably going to trickle down and affect the client as well. Questions related to the river walls and bottoms could include, can you describe where you live or work? Who do you spend most of your time with? Cause remember the river walls and bottoms relate to the physical environment and the social environment. So the physical environment, many evaluations already include these sorts of questions, which I mentioned briefly before, but asking within the context of the Kawa model will allow you to see if the client perceives their environment to support or hinder their performance and also if they're open to modifying their environment.

So, I know with a number of elderly clients that I see, sometimes the modification that is needed that would allow them to perform some occupation or task as they wish, requires modification of something in the home. And sometimes they're very resistant to change. Like, it's always been that way or this piece of furniture always sat here and so I can't possibly move it. So you wanna know if they're open to change. And thinking about the social environment that could represent friends and family, classmates, colleagues, pets, deceased relatives or other acquaintances or any other social supports that the client considers significant in their lives.

Questions relating to the rocks. That could include, are you having any difficulties right now? Is there something about your life that you'd like to change? Or are there any things that you're worried or concerned about? The rocks can typically be categorized into occupational performance difficulties, fears or concerns, perhaps inconvenient circumstances that are outside of occupational therapist's control and other impairments or medical concerns. And just the same as with the rocks, you also would want to consider key people in the client's life and what rocks they might be dealing with, since that can impact your client. And this is interesting that you will seldom see a client reduce his or her difficulties to component. So when you're having a client sketch this out, you'll very seldom see them draw a rock like, I think my strength is

poor or my balance is poor. Typically they will be speaking more about occupations that are important to them that they can't do for some reason. And this is a positive thing because this also aligns with the increased focus on functional outcomes that we're seeing related to billing and reimbursement in many of the settings where elderly are commonly seen. So things like home care and longterm care. So they're looking for more functional outcomes. And so this would guide you to focus on those things rather than simply components like strength or rage emotion or such.

And then some questions related to driftwood or debris would be, tell me about your education or other specialized skills you might have. How would you describe yourself? How do you cope with stress or a few challenges? And the driftwood can often be tackled by finding out about the clients rocks and then what makes their river flow. And then asking questions which would reveal their advantages or abilities in handling those situations. So, for example, if a client's rock was they were unable to work or they were unable to get back to work right now, then you could ask questions, can you drive or do you have someone to take you there? So thinking about all of the requisite skills that would be needed in order for them to be able to work. Or perhaps you're talking about their paid occupation. So if they're an occupational therapist, you could ask them, what do you think makes a good occupational therapist? So what kind of qualities do they believe are important and then which qualities do they have or which qualities might be something that would need to be worked on. So that wraps up sort of the initial creation of the model with the client.

And then we move into step two, which is where you would ask for clarification on the client's river model. And I have to say that the guide lists these two steps as separate and often I see them as a bit more integrated when I'm actually doing this because sometimes I ask more probing questions sort of as we go rather than having the client just sketch everything out and then going back. So it's, kind of up to you, just sort of what feels right in that situation, but know that it's certainly okay. The procedures are

flexible if you feel like you're intermixing these two steps. So in this step is where you would use probing questions to determine the meaning of different aspects of the drawing, the relationship among various elements and the impact of each element. And this is where in the process that it can really positively impact the client and care provider relationships. So trust could be built. And this really involves your therapeutic use of self. So your ability to pull those details out and make the client feel comfortable with discussing that and sharing with you. So examples of probing questions could include, why do you have less space in this area or why is there more space over here? Why is this rock so large? Tell me about that. Or how does this impact your ability to do X,Y and Z participate in this role that you've said is important to you? And again, this is all to make sure that you understand from the client's perspective, rather than what your perspective would be on the situation.

Then step three is prioritizing issues according to the client's perspective. So this involves looking at those spaces between the obstacles. So where is that opportunity, where OT would intervene. And even in areas where there is no gaps, so where maybe a bunch of rocks are clustered together or they're jammed against the side of the riverbanks and the wall, where an opportunity could be created. And this process usually guides the practitioner to be more occupation-based. And as I said before, using this model typically allows the client to identify more significant medical concerns within their social and physical context. And so, the client will seldom identify components in isolation as they're sometimes viewed in the medical model. And sometimes in this step is where the occupational therapy goal setting can be started.

And then in the fourth step, this is where you further assess. So you've prioritized in step three and now you know what the priorities are and you're further assessing those points where OT is going to intervene. And this is from the client's perspective and you then might want to use objective measures, to obtain further details on specific deficits or concerns that'll be addressed in OT treatment. So this could include examples like

using the Barthel Index or the Modified Barthel to quantify ADL performance, completing a home assessment to further determine barriers related to access or safety, or even using manual muscle testing to quantify a decrease in strength. And these objective measures might be indicated related to being able to objectively document your outcomes. They might also be necessary for reimbursement or per facility policy. So this is where you can sort of marry this process using the Kawa model with more objective measures. And so all of the standardized or objective tools that you already use or have in your toolkit, you can pull those out and use those to then further measure those elements that the client has said are important and those which you will be addressing in your treatment. And then you would finalize the goals in this step.

And in some cases you may also be able to use the Kawa model itself to show changes. So you might administer the Kawa model at evaluation and have the client sketch it out and then again, have them go through that process again prior to discharge or at various points along the treatment continuum. And sometimes looking at the drawing side by side, you can see that the first one is very jammed up. And then if OT intervention was successful or the client perceives it to be successful, then there are more spaces and there is better flow to their river. And then in the fifth step, that's where you'd actually complete your intervention. And this is where the rocks can be addressed in several ways. And so depending on the situation you might use just one of these techniques or a variety of them. So the rocks can be addressed directly through remediation of skills. So this could be things like increasing strength, endurance or balance to return to former roles or ways of performing tasks. So this could be in like the example of after a knee surgery. So you are restoring those skills, they're getting back those components skills and they're able to complete tasks exactly as they were before.

So the rock is now completely removed. You can also address an intervention by adjusting or widening the riverbanks and bottom. And that could allow the client to adapt to new circumstances or deficits. So maybe there are some new deficits that cannot be removed completely. And so adaptations to the physical environment could include something like adding a ramp or using a universal design. And then the last thing you could focus on the driftwood or debris. And so that could be those attributes which are already existing within the client or a skill that is newly acquired, something that you would teach them during therapy to shift or wear away part of the rocks. And so examples of that could include, teaching them to use adaptive equipment for a dressing task, a new communication device or using a powered wheelchair. And just remember throughout this process, the goal is always improved life flow or water flow. And it doesn't always mean independence.

So, being sensitive to what the client feels is most important related to their circumstances and their culture. And then the last step, is to evaluate the outcomes of occupational therapy intervention. So remember, that success is measured by comparison of the client's performance before and after. And this is by the client's own criterion. And you can do that by comparing if you have them do two different models before and after and also have a collective discussion about that. So sometimes that discussion can be fairly powerful especially, for a client who might not feel they've made many gains. But sometimes to really see that out there and to process that with them, they can realize that there are positive aspects to their situation and they have made positive gains. You can also re-administer the objective measures as needed. So those things like the Barthel or manual muscle testing or the COPM, things of that nature. And at this point it could result in further goal setting and more intervention if their maximum potential has not been achieved. And here on this slide, is just an example of a Kawa model. I did a workshop with some therapists so this is just an example from one of them. And so in this workshop we actually just made these handouts. Already on there was the river bottom and sides and then we asked them to

put the rocks and driftwood and other supports around. And so, you can see that this person actually labeled there. So, it isn't a requirement. It can be labeled. They can put initials for different things. They could not label it and just discuss it with you. But you can see, this was a person who had a severe car accident a number of months before that. And so, you could see she was dealing with other injuries and severe anxiety, a broken leg, someone else passed away during the car accident. So there was a tragic loss. And then you can see her supports of the therapy that she was currently receiving, church community or school community, other family support and other personality attributes which she determined might be helpful in addressing her barriers.

So you can see in this example, it was a cross section of the river which was created. And you'll see some other examples as we go through here. So there really is no right or wrong way to do it. So just some considerations in using the Kawa model. You really wanna think about how you can integrate this into existing evaluations or facility or company procedures. And really this could easily be part of the gathering of information for the occupational profile. So instead of thinking about this like something additional that you would do, I would think about this from the perspective of how does this integrate and how can this enhance what you're already doing. You might think about assessing additional skills during this process. So for example, you might look at how the client constructs the model. Do they construct it slowly with a lot of thought or is it more haphazard and quickly? And this may be meaningful culturally. So are they detail-oriented? Does the speed of completion provide insight into how they might pace other activities in their life? How do they view productivity? You also might think about assessing cognitive functions. So just basic things like, can they think abstractly? Do they understand the metaphor of the river? Can they follow directions? You can assess things like dexterity and fine motor skills if you're actually having them draw out the model. Visual spatial integration, so where are the items placed and does that placement align with what they're verbalizing to you about it? And then you might also assess things like activity tolerance or sitting tolerance while

they're doing the activity. Who draws or does it have to be drawn? So typically the client would be drawing their model out if they are willing. Some clients get a little, maybe they're a little intimidated by the process. Or initially I've worked with clients where they think it has to be some very high quality drawing and they're a little self-conscious about that. Certainly the therapist could draw the model for the client, but if you're doing that, you wanna make sure that you're verifying the client's perspectives throughout.

So asking those questions like, is this rock big enough? Where should this be placed? Things of that nature. You could also, instead of drawing, you can have the client use other items to construct their rivers. So I've seen therapists use felt pieces or colored paper pieces. I've seen them use actual rocks or sticks, party or even food items. But if you're doing any of these things, you might want to take a photo of that model for comparison. So that then if you do another one later, you can compare them. Or if you wanna have a discussion with the client and reflect back, you'll have something to look at.

There's also an application, it's for ILS only and it hasn't been updated recently, so I'm not sure what the plans of that are but I have used that in a number of instances. So I just wanted to mention that it is out there at least currently. You wanna consider the prerequisite skills that are required. So the client would need to have some level of cognitive skills in order to be understanding the metaphor. And you can involve caregivers as well in this process because they certainly might have something to add to the model. So that could be a way that you could use it. You could also have the client create multiple models to represent various points in time. So a example, what was their model prior to their illness or injury? What is their current model? And then what is their expected model at discharge? And another option of that would instead be to have them draw the model more longitudinally. And so there's an example of that coming up. So where they'd kinda start and have things earlier in life and then progress



onward to their current situation. You can also use alternative metaphors. So for example, I've used with clients a metaphor of a football field or a garden. And so, in a garden the rocks could be weeds or in the football field the rocks could be the opposing players. So, if a different metaphor resonates with your client, you certainly aren't tied to using just the river.

You also might need to adapt if a client has a visual impairment that's where maybe a more verbal discussion, still using the Kawa as a platform for that discussion, but maybe you just wanna discuss it rather than actually constructing it out on paper. And then for documentation, the model can serve as a way to organize and gather information which you can record narratively. And in some cases you might find that your before and after Kawa models can also be used to supplement those narratives. So some pros of the model are that it is client-centered. It promotes teamwork, collaboration and engagement of the clients in the therapy process. Research supports the model as an effective way to identify strengths and barriers, much more so than simply asking. The model guides the client to really consider all aspects of their situation, including the environment, their social supports and personal attributes. The model can be used as a before and after assessment. The discussion should really accompany that, as I mentioned before. And a client might have limited progress, but looking at the model and having this discussion could make them realize the progress that they have made.

The model can serve as a representation of well-being. It can be used to look beyond performance in just a few areas, where the client might be struggling and consider broader aspects of well-being or quality of life according to the client's perspective. It's culturally sensitive, as I've already mentioned and the procedures are extremely flexible. It can be client-led and there's no set order for drawing or asking the questions. Cons of using the model. Some deem this a con, it is less focused on impairment. So, while this guides us to be more occupation-based, this sometimes

could be a challenge where the expectations of the medical model of care is sometimes more focused on impairments. An important part of using this model successfully is really tying occupation to those impairments that most people are expecting to see in the medical documentation. And also tying those occupations to discharge planning in the documentation. The loose structure can be a challenge for some new users, but with more experience, it's just like any other OT assessment procedures. It becomes more fluid, it flows naturally and you develop the questions and flow that work for you and your clientele in your setting.

And finally, the final con is that emotional information elicited during discussions, may be difficult to manage. So in my experience, I've discovered things about clients past or present situations that I might not have discovered under typical assessment conditions. So for example, one client divulged details about physical abuse earlier in her life. She reported to me that she was 71 years old and no one had ever asked her about her past or how it shaped who she was today. It was a difficult situation for me to handle, but discussing this with her brought up a lot of emotions and allowed her to acknowledge why she was resistant to having caregivers come to her home or having the therapist assist her to bathe. And in the end, sharing this ended up being a positive experience with her though it took a lot of discussion with her family, her nurses, her medical doctor and the psychologist.

And then here is just an example of application of the Kawa model with an elderly client. So this was a 78-year-old female. She was in the nursing facility due to a fall at home and a hip fracture. And she was very tearful upon the evaluation. She was very frustrated even with the suggestion to complete simple tasks such as getting dressed or learning to use a sock aid and she would cry a lot. I hadn't used the Kawa as part of her evaluation or in establishment of her occupational profile in the beginning, but I then decided to use it as a treatment activity since we seemed to be making no progress due to her crying. I had also spoken to the doctor and her nurse and they

were looking at a medication change possibly for depression. So when I used the model with her, the support she identified were similar to what I already knew from her evaluation. She had supportive husband, her daughter who resided with her, one-level home, she was cognitively intact and she had a high prior level of function. But the barriers were different.

Previously, I was focused on her physical limitations only related to her hip fracture. And so you can see on her drawing, hers is more longitudinal. You can just see, so this would be like where her birth was and then down to her current situation. And several rocks along the way were associated with her son. Her son had lost a job at one point. He got arrested for driving under the influence at another point. He came to live with her and her husband at yet another point. So this was a pressure that she had always managed, but in the face of dealing with her own medical issues currently it became overwhelming for her. And so the client reported great relief at having disclosed her concerns. We were able to schedule a home assessment to look more closely at her home and what we could do to support her there. We did education with her husband and her daughter. A referral was made, a psychologist and social services to assist her with the issues with her son. And her husband was not in the best of health. And so we were able to arrange for meals on wheels, a home health aide and some caregiver assist for her husband, so that was something she didn't have to worry about. And now I wanna move into talking briefly about some research related to the Kawa model.

So this first study that I'm gonna talk about was in a skilled nursing facility. The facility was 120 beds and the study was looking at using the Kawa model to improve interprofessional collaboration in the nursing facility. So interprofessional collaboration for the purpose of this study was defined as individuals from a variety of health care disciplines that work together with patients, their families, carers and communities to develop the highest quality of care across settings. So the research supports that the benefits of professionals collaborating together, can be beneficial to both clients and

care providers. So for clients, everyone from different disciplines is collaborating, there's a stronger continuum of care, there's increased quality of care and higher care satisfaction. And then for the providers, the healthcare providers themselves, when they collaborate with each other, they report improved communication, efficiency, perceived quality of care and job satisfaction. So most of the research out there prior to this focused on the impact of interprofessional collaboration. So, who benefited and how they did. But there's not a lot of research about the specific tools or models that can be used to improve this collaboration. So in other words, everybody thinks collaborating is a good idea, but there aren't many specific tools out there. Many health professionals lack formal training in how to collaborate and research suggests that the Kawa model can be an effective tool for collaboration and team building.

So there is two projects out there that suggest the Kawa model can be used to have rehab professionals, so PT, OT and speech collaborate. And the purpose of this current study that I'm talking about was to really look at, can it expand to a more diverse group of professionals. So there were 10 participants in this study. There were six nurses, an activity coordinator, an administrator, a rehab director who was also an OT and a social worker. So this was a typical interprofessional team at this facility. And we used pre and post surveys to determine how they felt about the process. So, we administered a pre-survey. One of the questions we asked on there is, are you familiar with the Kawa model? And none of the 10 participants were, including the OT. We then provided education on the model much like I did in the beginning today, reviewed all the components and did a PowerPoint presentation. We then had team members draw their individual Kawa models just so they could sort of get the feel for the process and understand it from their own perspective. And then we had them apply the model to a hypothetical client case. And the case had details that would pertain to all of the disciplines. So for example, things related to the financial situation, which might be more important to administration or social work. Things about how the client presented physically, which might be more related to the therapist or the rehab director. Or things

related to medications which would be more pertinent to nursing. Something related to wounds that would be more pertinent to the wound nurse. So we had things built into the case study that would be pertinent to all of the team that was there. And so they constructed the client's Kawa model and then they did a post-survey. So what you see here on this slide, is the Kawa model that the team created collectively. So they took turns contributing and so at first, it seemed that the process began in parallel. So each team member was only putting things in the drawing that was within their scope of practice. But then the process quickly became integrative as the professionals began to leave their concerns and thoughts about supports and barriers together. And it really created a complete picture of the client so that they could problem solve and determine next steps.

And then the results were that all participants agreed or strongly agreed that the model provided a common language for interprofessional collaboration. 90% felt this process could increase collaboration in their facility. The participants that had more experience in the setting indicated that they were more likely to use the model in future practice. And the whole session lasted about one and a half hours. And they all felt that it was sufficient information to promote its use. So that's good news that, more information might not be needed. So a relatively short session could sort of bring all the professionals up to speed on this process. So the next step would be including an actual client and caregivers in a similar type of study. Now we wanna move into home care and caregiving. So the existing research in home care and the caregiving realm is developing and I'm just gonna highlight several studies here.

So in one, the Kawa model was used with 10 disabled families and the process unveiled concerns related to finances and intra-family relationships. So they used family workshops and those workshops facilitated what they called storytelling about the life span experiences of each family. So the model may be an effective way to elicit detailed information about the family relationships that could impact the client. As

noted previously, the model was shown to be effective in promoting a client-centered exchange between the client and care provider and to improve interpersonal collaboration. So using the model with both client and caregivers and interprofessional team members might be useful in care planning and discharge planning. Another study suggested an integrated model for the client and caregiver or creating two distinct models, one for the client and one for the caregiver since both are interconnected.

So for example, an elderly client might be concerned about overburdening his daughter who works and also has a family of her own, but the daughter may be worried about her father, the client's limited financial resources to access additional help at home. Therefore, she might overextend herself, which could result in additional stress and anxiety for herself. And if she has additional stress and anxiety, she might not be an effective caregiver. So that process help you to appreciate both perspectives and consider that in treatment. In another study, the Kawa model improved understanding and this is understanding by the caregiver of what occupational therapy is and that our scope extends beyond ADL's to social and physical environments. I thought this was a really important point to make 'cause so many times we reduce what we do to components and we appear similar to other disciplines.

So, I feel like we're always trying to explain to people what we do and this study show that this process could bring the focus back to occupation and really allow the caregiver to understand our purpose and scope. The Kawa model has also been used as an interview tool for caregivers to increase the focus on positive benefits of caring. So remember that care giving can be extremely stressful and using the Kawa as a platform for discussion could allow the caregiver to consider positive aspects of the care experience, such as the time that they get to spend with the loved one or giving back to someone who previously helped them. And then the final thing I wanted to mention is, I'm part of a study currently that is exploring application of the Kawa model in home care related to fall prevention and falls self-efficacy. So really using that Kawa

model to have the client consider their situation related to falls and fall risk factors and then developing an individualized plan to prevent future falls. So that's something that's currently in progress. And then here is just a brief example of application of the Kawa with a caregiver. So the caregiver was a 45-year-old female. She was extremely stressed on the first two visits, so on the third visit, the caregiver was asked to sketch out her Kawa model while the client, who was her mother was being treated. So while the OT's priority was the client, it became apparent that the client's daughter was her primary support and she was observed to be stressed. She sometimes reacted harshly to the client, which was impacting the clients' well-being.

So during wrap-up of the session, the therapist scanned the drawing and asked for clarification of various elements, and then the following supports and barriers were identified. So the client was a physical therapy assistant, so obviously had some good skills to be able to care for her mother there. She had supportive friends, parents and co-workers but she was dealing with the mother's issues, her father was elderly, loss of her home, she was then living with her parents currently, she was not involved in an intimate personal relationship and she had lots of financial worries. So you can see, this is her drawing and it looks very different from some of the other ones we've seen today. So, again, there's no right or wrong way. And so what we ended up doing this case was through discussion, we discovered that her work had an employee assistance program so she was referred there. She was able to identify a friend who was an accountant to seek some financial advice. We worked on obtaining additional supports in the home for the mother including some paid care givers. And then she also identified a neighbor that could provide some intermittent caregiver relief so that she could get out and spend a little more time socially and developing those relationships. And then we also suggested adaptations to allow her and her mother to participate in some church activities that they previously enjoyed together. So really creating a positive experience for them rather than just all of the interactions being about the mother's care.

And now moving into the final bit of research I want to discuss, which is how the Kawa was applied in community based practice. So this was in a YMCA and so these were clients that were attending the local YMCA and they were community dwelling. They were individuals who were active in the community and not currently experiencing a severe disruption in their life flow, but they were believed to be at risk for disruption due to their advancing age. So we were looking at their ability to age in place. Research tells us that most older adults desire to age in place, but many lack the knowledge or preparedness to do so. So they aren't always aware of the resources or have those skills to prepare. And unpreparedness can decrease current well-being and limit potential.

So in other words, you can't wait until something happens to make plans, to age in place you need to prepare ahead of time. So the research tells us that individualized and being client, having individualized plans and client-centeredness can improve the outcomes, so the same plan won't work for everybody. And that well-being can be improved by preventative and wellness education and education that is specific to aging and age-related role changes. So there were seven subjects in this study and we provided one-on-one assessment and education to each subject. And we did the Kawa activity as an outcome measure, the psychological general well-being index which is a tool that's already available out there and then a survey that we designed.

And so in the beginning, there were just a few sessions with each client. All the sessions were individualized. So we administered all of the assessments in the first session. And then we used information and insights gained from the Kawa activity to design a participant-specific educational intervention, which took place in those sessions two, three, four that you see there. It consisted of didactic teaching, discussion, we reviewed handouts and printed resources, demonstration of how to access online resources and developed a written plan and to-do list for implementing



strategies to age in place. And things that we included depending on what the client needed were things like home modification, fall prevention strategies, health and wellness strategies, strategies related to sleep and rest, the ability to access community resources, tips for living with low vision, medication management, adjusting to changing roles and such. And then at the end, we administered those same tools again as well as we did the Kawa activity. And 86% of the participants demonstrated improved well-being on both of the quantitative measures. 100% demonstrated improvement on the positive well-being subset. So there's a number of subsets to this tool. And the mean scores for the group demonstrated improvement in all subsets of well-being. So that's pretty important considering we didn't actually enter the client's home, we didn't observe any of these changes. We were simply providing them with education and using the Kawa as a platform, to help them understand their situation and action that needed to be taken.

And then other important things, education and creating the plan led to decreased concern or ability to envision positive changes. So a lot of the clients verbalized they felt better doing it. They felt relieved to have a plan in place. Having an organized plan generated immediate action. So a lot of the clients reported that they made some of the changes already. They were getting started on it. And adding resources didn't always remove the barriers because sometimes they couldn't be removed. It was something that was going to continue to exist, but it increased space or opportunity for improved life flow around that. Their family and caregivers strongly supported participation in the projects. So many commented about how their family was thrilled that they were doing this. They thought it was great that they were getting this information and starting to plan. And the Kawa model was effective in this setting for improving communication and really being able to identify those strengths and barriers and build rapport. And you can see this as an example of one of the clients from the study. So on the left was the pre-education and on the right is the post. And so in the beginning the rocks or barriers represent a recent loss of a spouse. He was over

involved in volunteer activities. He lacked rest and he was having difficulty just really tackling that grieving process. And then post intervention, additional driftwood was applied to force the large barrier of grief a bit aside and represented his plan to seek counseling and support and to utilize his social and community supports to really make space and room around those barriers.

And finally just to wrap up, hopefully you now have a clear understanding of the Kawa model and how you might apply it in geriatrics, whether that be in longterm care or home care or community based settings. There is research to support the Kawa model as an intervention activity or an assessment tool for elderly clients and their caregivers. The model has been found to promote interprofessional collaboration and continuity of care and this has been used with rehab teams and interprofessional teams. So just know that this model is not restricted to OT, so folks can use it outside of OT. The process of using the model should help guide you to be more client-centered and occupation-based in your treatments and activities. The model has also been noted to reveal connections between a client and his or her context that might be missed if you just stick to medically-based assessments, and I provided several examples of that today.

And finally, the Kawa model increases the ability to provide culturally competent care. So rather than imposing your view of the client and his or her circumstances, you are really truly finding out what is meaningful and valued in their life. So hopefully you can see that the amount of research on the Kawa model is increasing as there is more research across settings. And much of the research to date is smaller scale studies and more research is needed. So if you find yourself using the model, you may want to consider sharing your outcomes. And I've been a part of several of the studies that I discussed today, so I'd be happy to share more information or collaborate if you have an interest. So are there any questions?

- [Host] Hi Dr. Lape, there is a question that came in. Do you include the Kawa model in documentation and how would you document this? That's from Hannah.

- [Jennifer] Yes, so I have included that in documentation. And so in some cases, like if it's somewhere where we have a paper chart I'll actually retain the drawings there. But some of the facilities and some of the places where I work we have electronic documentation, so I find I'm putting in more of a narrative. And so just like we would use some other assessments, we'd say the COPM and then we would narratively describe what we discovered from that. I would say, completed the Kawa activity with the client, results indicate, significant barriers include, whatever. Her spouse is unable to help her at home. She isn't able to access the home. There's environmental barriers, whatever. Supports that might be used are. So I just sort of describe it narratively like that. And I find that in the documentation, I don't get so much into the exact Kawa terminology because then I feel like we'd have to translate that and it really isn't necessary. So I just sort of name the activity that I used to elicit that information and then just sort of frame it like strengths, barriers, social supports, environmental supports, like that sort of terminology.

- [Host] Okay, great. I don't see any more questions coming in so she has shared her email today so please feel free to reach out if you think of something at a later time. Thanks again Dr. Lape for joining us today and talking about the Kawa model.

- [Jennifer] Thank you.

- [Host] I hope everyone has a great day. You join us again on [continuedandoccupationaltherapy.com](http://continuedandoccupationaltherapy.com). Bye everyone.