Occupation-Centered Practice

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- [Nika] I'm very honored to introduce today's speaker Dr. Wendy Stav joining us to speak on occupation-centered practice. Dr. Stav received a Bachelor of Science in occupational therapy from Quinnipiac University, and a PhD in occupational therapy from Nova Southeastern University, as well as a specialty certification in driving and community mobility. For more than 20 years her work has focused on driving and community mobility with involvement at the state and national levels, including AOTA's Older Driver Initiative, coauthorship of AOTA official documents, book chapters and articles and collaboration with the American Medical Association, the American Association of Motor Vehicle Administrators Older Driver Working Group. Dr. Stav was named to the AOTA Roster of Fellows in 2009 for her contributions to the advancement of driving and community mobility practice, and she received the Maryland Occupational Therapy Association Award of Merit for similar contributions to driving rehabilitation practice. In recent years, her scholarship has explored occupation-centered practice, including contribution to a model of occupation-based practice, clinic makeover studies to enhance occupation-centered practice, and the development of assessment to measure occupation in practice. Welcome, Wendy, and thank you so much for joining us today.

- [Wendy] Thank you so much. Welcome everybody on this afternoon of hopefully some growth and learning. I'm so excited to be here today to talk about this topic, because I've been living it and stewing on it for the last few years and I'm ready to let it out. So hopefully, it can be really enlightening for each of you. During today's class we are going to talk about occupation-centered practice to the point that you can explain the value of occupation-centered practice in occupational therapy, recognize the different occupation-centered approaches from other therapeutic methods used in practice, and then distinguish the elements of occupation-centered practice and how to capitalize on each of those to optimize the infusion of occupation in practice. So we do need to start with a short history lesson, because we have to really establish why we care so much about occupation, why it is even still relevant. So are our

understanding and our appreciation for occupation dates very, very far back to the 1700s when Philip Pinel in France recognized that the process of doing was really health promoting for his patients and at that point really generated some of the initial ideas that doing could be used therapeutically in a health perspective to help people return to health.

Ultimately, when our original founding fathers met in 1917, they infused a lot of these ideas into the incorporating documents for AOTA, which was then the National Society for the Promotion of Occupation, Occupational Therapy, sorry. The ideas that were infused back then was that there was this very reciprocal relationship between occupation and health, and that if you engaged in occupation, it could improve your health. If your health was not so good, it was more difficult to engage in occupation. And vice versa, if you didn't engage in occupation, that could actually decrease your health. So these ideas have been very long-standing. Adolf Meyer, who was involved in our profession very, very, early on, he wrote the original philosophy of occupational therapy and was a very firm believer in this connection between occupation and doing, and it didn't only have to be, you know, back in the early days, it wasn't just about patients cooking in the kitchen or working in the fields or doing some housekeeping around the hospitals. He even recognized that it was any type of occupation, any type of doing even if it was leisure. So long as it was meaningful, it could be really health promoting. And he said in the original philosophy of occupational therapy that our role consists in giving opportunities, rather than prescriptions. There must be opportunities to work, opportunities to do and to plan and create, and to learn to use material. So from very, very early on in our profession it was established that occupation was really a therapeutic medium. We've had several leaders throughout the history of our profession, who've continued to push this idea for us.

One of the most famous quotes in all of occupational therapy was from Mary Reilly's Slagle lecture, which she delivered in 1961 when she said, "Man, through the use of his

hands, "as energized by his mind and will, "can influence the state of his own health." So she was saying that the actual doing, using your hand to engage, and it's meaningful to you and important to you because it's energized by your mind and will can actually improve your health. We heard other people say those same sorts of ideas. Ann Fisher's Slagle lecture in 1998, she mentioned to us that, "The term occupation "conveys the powerful essence of our profession, "enabling people to seize, take possession of, "or occupy the spaces, time, and roles of their lives. "Occupation is activity that is both purposeful "and meaningful to the person who engages in it." Throughout the years there have been other Slagel lectures and other really critical writings, many of which I'll talk about in this lecture, that really reinforce this idea. Glenn Gillen, in his 2013 Slagle, was talking about the fork in the road. We're at this critical juncture. Which way are we gonna go? Are we going to go towards occupation, or are we going to go a little bit more towards medical model and we have to pick our path, but it really makes sense for us to sort of hold on to our roots, because it is what makes us unique. So we've had lots of our leaders telling us about the importance of occupation, and it's sort of our value. But it helps, I think also, to understand and dig a little bit deeper into some of the definitions of occupation.

So there are many, many definitions of occupation. If you read the AOTA Practice Framework, I believe there are around eight definitions of occupation in there. They're all listed. I've chosen some of my favorites to sort of highlight the value of occupation and how it plays out therapeutically for us. So the first definition is from the Willard and Spackman book. They say that, "The things that people do "to occupy their time and attention, "meaningful, purposeful activity, "the purposeful activities that individuals choose "or need to engage in and the ways in which "each individual actually experiences them." So some of the important language in this definition, and again, this is from the Willard and Spackman book, is that occupation includes the meaningful and purposeful activity. That's the key. It's not doing for the sake of doing. It's meaningful to the person that is engaging and there's something purposeful out of it.

It's those activities that people really choose or need to engage in. Another definition, which speaks to me, is from the World Federation of Occupational Therapists, which reads, "The every day activities that people do "as individuals in families and with communities," so it really speaks to how micro or macro that engagement is, "to occupy time and bring meaning and purpose to life. "Occupations include things people need to, "want to, and are expected to do." And again, we see this really important element about meaning and purpose. It's not doing for the sake of doing. A couple more definitions that I really like. This is one of my favorites. It's from our neighbors to the north in Canada. They define occupation as activities of everyday life, named, organized and given value and meaning by individuals in a culture. Occupation is everything people do to occupy themselves, including looking after themselves, enjoying life and contributing to the social and economic fabric of their communities.

Again, in this definition we're getting back into value and meaning. That's a critical piece of how we define occupation. The bottom half of this definition, by the way, speaks to how the Canadians classify their occupations as self-care, leisure, and productivity is sort of where that language came from. And finally, a couple of theorists who I really respect, Ann Wilcock and Liz Townsend, their definition of occupation states that "It refers to all aspects of actual human doing, "being, becoming, and belonging. "The practical every day medium of self-expression "or of making or experiencing meaning. "Occupation is the activist element of human existence, "whether occupations are contemplative, "reflective and meditative, or action based." And again, we have ideas about meaning and purpose, and there's some active engagement. So there are definitely some common threads in how we are defining occupation, some important elements. It's important to recognize what that is and be able to have a strong, confident definition, and appreciation for what occupation is, because, as I tell my students, occupation is our secret sauce. It is what makes us different and unique relative to all of the other professions that are out there providing healthcare. So we need to be able to express that unique perspective and unique

value. So not only is it a good idea to help explain what we do, but according to AOTA when they define occupational therapy, they point out at the very beginning of the definition of what occupational therapy is that it's "The therapeutic use of everyday life "activities or occupations."

So if this piece, oops, let me bring my little pointer, this piece up top here, "The therapeutic use," oh, there it is, "The therapeutic use of everyday life activities "or occupations with individual or groups "for the purpose of enhancing or enabling "participation in roles, habits, and routines." So this early part in this definition is critical. This definition comes from the Occupational Therapy Practice Framework. It's important to note this because that document is written and explained so clearly for the purpose of outside readers, people like healthcare administrators and third-party payers. And they'll look to that document and they'll say, "What is occupational therapy? "What are the occupational therapists "working in my healthcare facility?" Or, "What services am I paying for? "What's my expectation that I should be paying for?" So if a third-party payer reads this definition, it's their expectation that this professional is using occupation as their therapeutic medium. So it's really important that we recognize the importance of how other people recognize occupation as well. So how do we do this? How do we, you know, it's been laid out. It's been defined. It's put out there is an expectation that we're using occupation in practice. But what does really that look like?

So there are several terms that are out there, some of which are used interchangeably, but I wanna point some of them out, because it'll help us to wrap our heads around what our expectations are and also what's realistic and what's not realistic. So the very first definition of occupation-based, that is the highest complete concentration of occupation. It's when we are facilitating therapy through the use of occupation as a therapeutic medium during intervention. And we're only using occupation. So I would consider occupation sort of the Holy Grail. It's like a vision statement. It's a place

where you want to get, but it's not likely that any of us will ever get there where we're only using occupation as our therapeutic medium. It's not very realistic. The other side of that spectrum, I'm gonna jump down to the bottom, is preparatory. Those are approaches that build skills to ultimately participate in occupation. So the reason why we can't only use occupation-based approaches is because sometimes we have to do preparatory. Sometimes we have to work on a person's balance or strength or coordination or cognition, and we're working on those individual skills, because they're not ready to do the occupation-based.

So I'm gonna jump back into the middle now, because a mixture of these approaches is really occupation-centered when I have a focus on occupation as my end goal. But it's not the sole approach that I use to achieve my goal. So occupation-centered is really the most realistic, and it's achievable by all of us, but it does include our eye is on the prize with thinking about occupation as our end goal. Hopefully, we're also using some occupation as a therapeutic medium, but this is sort of a continuum. I also wanted to point out, I don't know if any of you have read the proposed fourth edition of the OT Practice Framework. They'll be voting on it in the spring at the next representative assembly meeting at conference. The term preparatory methods is actually being replaced with interventions to support occupations. So that term preparatory won't be part of our lexicon anymore if they approve it like that. So another way to look at this same idea about how are we putting occupation in practice, Julie McLaughlin Gray wrote in 1998 about different sort of strategies of how occupation is infused in practice. She acknowledged that anytime we use activities that hold meaning and cultural and developmental relevance to the client that really facilitates our treatment and facilitates improvement. So we should be using approaches and activities that are personally meaningful and culturally and developmentally relevant. She recognizes also or she states that we should keep occupation at the center of practice, and that we should be infusing occupation into our therapeutic process.

There's two real ways to do that. One is to use occupation as means. So we're incorporating occupation into the intervention. It's really our therapeutic medium. It's the means to achieve our goals, and also occupation as ends. So that's my goal. My end goal is to support engagement and occupation. I might have to use several different approaches to get there, but occupation's always, always on our mind. So it's lovely that we recognize the meaning and value of occupation, but we shouldn't use occupation just because we've done it for a long time, or just because historically it's been there, or some very important and learned people told us to do so. We should be using occupation in practice because it works, because it's very effective at generating positive health outcomes. So I did a very really brief search of AOTA's evidence-based practice resources, and all the systematic reviews. This is just a sampling from a very quick, probably 10-minute search for what are all the studies that recognize this link between occupation and positive health outcomes.

So the first systematic review looked not at occupation in a healthcare situation, but looked at participation in occupations and activities among community dwelling older adults. That systematic review had 99 articles in it and looked at a range of occupational engagement, religious activities, social participation, exercise, cognitive gains, maybe healthy eating, I can't remember all of them. But it also looked at a range of health outcomes, looking at mortality rates and use of healthcare resources and progressions in dementia and depressive symptoms. In these 99 articles that were reviewed all of them showed that by engaging in occupation for older adults there were positive health outcomes for every area of occupation with one single exception that caregiving is actually detrimental to your health, not child rearing, but caregiving, like if you're caring for an aging or ill spouse is actually detrimental to your health.

So the other studies were done looking specifically at people receiving occupation-centered interventions. And I looked through a range of the resources, the evidence-based practice resources, and found it really spanned multiple populations.

So with the mental health population, they found that using occupations in practice generated better outcomes with people who had mental illness. In folks who have dementia, they found that using occupation in practice, reduced their cognitive decline, improved their performance and enhanced their behavior. So again, more positive outcomes. Similar finding were in the pediatric study where they found that social and emotional skills were improved when using occupations at the Tier 1, universal, and whole population level, so using occupation can have a more global outcome as well. And the last one I found, because I stopped looking, was a study done following stroke interventions following stroke and found that occupation-centered interventions folks had improved cognitive performance.

So again, occupation's important. It's part of our history. Lots of people have been talking about it, but we should be using it because it works. When we're in a time where people might be questioning what we're doing, is it effective? What makes us different? It's time for us to really stand out and say, "Let me highlight what I can bring to my client care "that's different than all the other disciplines." Okay, so once we've established what occupation is and how we can use it in practice, we have to take a step back and look a little bit at the realities. Some of those realities are that in the current state of practice we, as a profession, are really shifting more towards a medical model-based practice. That's true in other countries as well, not just in the United States. So there've been some some studies done as to why this is. Why aren't we using occupation in practice? So, one study done by Che Daud, Judd, Yau and Barnett, they said that there were issues with limited equipment. So the therapist didn't have that the stuff. They didn't have the materials that they needed to be able to execute these occupation-based practice. Sometimes they said, "We have these very high "productivity demands. "My rehab manager is expecting me to be X-amount productive "and it's just too difficult within the time constraints "that I have to go and get all the equipment "and get everything I need and clean it up," and so on. So that was also a barrier. Sometimes people said that their facility dictated what their goals

were. So in the electronic medical records, there was a pulldown menu and you just had to choose from those goals, so that really limited the ability to be very client-centered and look at occupations. Physician orders was also a problem. Sometimes the insurance companies dictated what you could or couldn't do. And space was also a big issue.

So if someone doesn't have the physical space in a clinic for more equipment and more movement and more mobility, that limits the ability to use occupation. Colaianni and Provident found some, a couple of different barriers, including a lack of education and professional development. So the therapist said, "I don't really know, "I don't really feel comfortable doing it. "I don't have enough training "to specifically use occupation." And also there was some client opposition to occupation-centered care. The clients really recognized exercise per se as what was really important. In a couple of studies that I've done, I did a couple of clinic makeover studies in an effort to try to increase the use of occupation-based practice. So we went into a clinic. We literally locked up the weighted dowels and the Theraband and the putty and the hand bike, and the range of motion arc. We locked them up and we brought in about $1500 worth of occupation-based materials and did this study that should have been really great.

At the end there were some issues. But one of the barriers was this overwhelming culture of exercise and what therapists were accustomed to doing and they were sharing a gym with PT, and they actually felt like they weren't doing as good a job because they weren't doing exercises, even though we were studying client outcomes and there was no difference in client outcomes. I don't want you to think that using occupation doesn't create better outcomes. We were actually using a set, we were using the FIM as our outcome measure, because that's what previous clients had. So the FIM wasn't sensitive enough to pick up on improvements. They also said they didn't really know what to do. They weren't sure how this should all play out and how to document it. So we decided for the next study we did something very similar, but we

added an education piece to really train the therapist how to select the different occupations, how to document about it. But we ran into pretty big issues with client acuity, because the landscape of healthcare is changing and patients with worsening acuity are coming in to healthcare facilities and traveling out to the next level of care pretty quickly. So the client acuity levels were so low that they just weren't able to engage in occupation. So there's lots of reasons why you might come across some roadblocks. Oh, I just got a weird window pop up. There's lots of reasons why you might get stuck and why you can't engage in occupation or use occupation in practice. So that brings me to, where do we go from here? How do we get unstuck? How do we get out of this rut? So a colleague of mine and I worked together and we created this theory. Or she actually created this theory about occupation-based practice, and what it is and what does it look like. Remember, earlier on I talked about occupation-based as the fullest concentration of occupation using only occupations. Since that's sort of the end goal, that's why the term occupation-based is used. She identified these four constructs.

You know, her concern initially was yes, we should all be occupation-based, but how do we know we've gotten there? How do we know how we're doing in terms of using occupation in practice, because we don't even really know what it looks like. So that was the purpose behind this study. She identified these four constructs of authentic occupation, meaningful and purposeful value, therapeutic intent and engaged participation. So if all four of these constructs are really fully at the highest level toward occupation-based practice, then our practice as a whole will be occupation-based. Again, it's not necessarily realistic to be all-in, but I wanna go through each of these and show you sort of what that looks like. So the first construct is authentic occupation. So that means what you're doing should be an actual occupation. It should be an actual doing of an occupation versus simulated performance. Ideally you're using the materials and the items that are consistent with that occupation, not simulated materials or gesturing. So if you're talking about brushing your hair, you use

an actual hairbrush, not pretending to just brush your hair. And finally, the context in which it's performed should be consistent with the occupation. So if you see each of these circular arrows almost as a meter and... ideally you want it to be full like it's a speedometer on a car. You wanna be going very, very fast and have that circle sort of filled up. But that's not always possible, but that's what your goal is.

So I'm gonna show you a little example and sort of break this down further. So if I'm working towards using authentic occupation, my scenario is a client who has a distal radius fracture with decreased pronation. So I could choose an exercise like this and put a weight in her hand and allow gravity to really pull down on her forearm and increase her pronation. I'm going to achieve my goal of increasing her pronation, but I really need to ask myself, is this actual doing of an occupation? And the answer is no. Am I using occupation items? Well, she's just holding a weight, so there's no items associated even with this occupation. And is the context consistent with the occupation? So if you're sitting in a therapy clinic, the context is not going to be authentic. So we could take this up a notch and do something like have a person pour beads from one container into another. And again, I'm getting that increased forearm pronation. That's my goal.

So if ask myself those same questions, is there actual doing and not simulated? Well, this is at least a simulated activity, so it's sort of halfway there. Are there materials or items associated with the occupation? Well at this point, we can't even identify what the occupation is. And is the context consistent with the occupation? Well, pouring beads from one bucket into another really isn't an occupation. But if we're in the clinic, maybe that's not so bad. If I take it to the next level, and now we have somebody repotting a very sad orchid, which was in bad shape and needed repotting desperately, we're, again, getting that really great forearm pronation in that right arm. But if I ask myself these questions again, is there actual doing versus simulated movement or gesturing? Yes, there's actual doing. This person's actually pouring dirt to repot a

plant. Are there materials being used? Are they consistent with the occupation? So there's actual dirt. She's holding an actual plant. There's a pot to plant this orchid in. And how about the context? Well, it's not perfect because we're still in a therapy clinic. Ideally, if I want authentic occupation to be fully realized, we would be maybe outside in a garden or in a raised flower bed. But that's how I can really bring an authentic occupation into therapy and add the meaning and add the purpose through authentic occupation, which brings me to the next construct, which is meaningful and purposeful value.

So in this construct the client identifies the meaning versus a therapist choosing it or maybe even the therapist convincing the client that it's important. It has some purpose. So the person is either creating something or executing a task versus just carrying out an exercise. And finally, what's being done should be associated with the client goal. So let's walk through another case again. So this person has a brain, this is a simulation scenario, person has a brain injury and they're working on isolated finger control. So my first option is maybe some Theraputty exercises. So I have to ask, is this meaningful to the client? Probably not. Is the person creating an item or executing a task? No, they're just doing an exercise. And is this associated with the client goal? Yeah, probably because I'm getting the finger, the thumb to move and that's part of our goal. I could make it a little bit more purposeful. And so I ask myself these questions again.

So I pull up this very simplistic game on a phone and the person plays that game and then I ask myself, is this meaningful to the client? Did they identify this? Probably not, this is an adult client and the game is really like a pediatric preschool game. Is the person executing a task or creating an item? Well, they're actually doing something now, so that's good. We're getting partway there. And is it associated with the goal? Sure, she's moving her fingers around. She's moving her thumb and I'm getting that active range of motion which I really want. I can take it a step further and have my

client engaged in a meaningful, competitive game with the therapist, and now we look at, does the client identify meaning? Well, if the client chose the app and this is the game that I always play, then yes, the client generated that meaning. Is there an execution of a task? Yes, because she's actually playing a game and I'm still getting those same probably a little bit more authentic finger movements, so it's associated with my client goal. So that's two of the constructs. The next construct is therapeutic intent. So this means that you're addressing the skill or the occupation in need of development, rather than doing something else that's not related. So you should be addressing a relative weakness, and it should be therapeutically beneficial. I know this seems a little obvious, but a lot of what I've seen in clinics is, say in a skilled nursing facility, all the folks lined up in wheelchairs all probably with different diagnoses and different skill levels, but all doing weighted dowel exercises together, not even in a group, just doing all the exercises. I've seen people sitting in wheelchairs with their lower extremity elevated because of some orthopedic injury working on a puzzle. So we have to be really careful that we're not just filling in those therapy minutes that we're doing something that is really intentionally therapeutic.

So let me give another scenario. This is a client with impaired balance. So we have one option, the person can play cards. We have to ask ourself, is this what the person needs to work on? No, it would fill some time, but it's not what the person needs to work on, and it's not therapeutically beneficial. I could have somebody working in standing. Maybe it's not so challenging to this person. I've over adapted this activity and raised the table up so she can lean against it, but I'm getting a little bit closer. Or I have a client playing a video game using the Xbox Connect where he has to move around and duck and step and jump, and now I'm really working on impaired balance. So that is very intentionally therapeutic. And finally, the last construct is about engaged participation. And this has to do with how actively engaged is my client or are they a passive participant in what's happening? The reality is there are some interventions that just are passive. If we think about physical age at modalities or coma stim or scar

massage, those are things that are, the client is passively just receiving those services. It's not ideal and hopefully, you're doing some other things as well where there can be more active engagement, but it's just one more construct that helps us be more occupation-based. So here's a scenario with a therapist giving patient education about infant massage. So our very first passive role, so we're looking at the mom now. She's sitting there while the therapist demonstrates the infant massage. We might have some more coaxed participation.

So here the therapist is really kind of convincing the mom to engage and do some of the therapy. Or at the highest level where a therapist is really, sorry, where our client is really actively engaged, the mom is doing the massage and the therapist is looking on approvingly with those great acting skills. So these are the four constructs that if we put them all together, we're gonna judge each one individually and figure out how occupation-based am I? So I want you to think a little bit about your own practice and consider a therapy session that you do with somebody. So I'm gonna sort of paint a little scenario. Let's say you're working in a skilled nursing facility or inpatient rehab and it's in the morning. You go to the client's room and the first thing you do is transfer them from their bed to the wheelchair, so you're providing some functional mobility training. So that's the first therapeutic interaction you do. Then you go down to the gym and their sitting balance isn't great, so you do some sitting balance exercises. That's another therapeutic interaction. And then because you needed to work on the balance so that you could work on lower body dressing with this person. So as your training them to use a dressing stick or a long-handled shoehorn, you're working on adaptive dressing. That's a third therapeutic interaction. But then you need to provide some education about their hip precautions. So in that one therapy session, you've done four different therapeutic interactions. And so each one of these can sort of be viewed individually and asking these questions about, so we'll just take adaptive dressing. If we ask ourself about that adaptive dressing, is it an actual occupation? Yes, is it meaningful to my client? Well, if they said they wanna be independent in

dressing, then yes, it is. Is it intentionally therapeutic? Well, if their goal is to be able to dress independently and I'm working on dressing, then that's very intentionally therapeutic. And am I engaging my client? So are they the ones doing the dressing? So that would be an example, that one therapeutic interaction, where you're very, very occupation-based, even though something else that you did, maybe the functional mobility, might not be so occupation-based.

So the idea is when we think about the collective of our practice, knowing that sometimes you'll be putting on a hot pack. Sometimes you'll just be doing exercises. But the collective of our therapy is what we're really trying to look at. So when we think about our own practice, there is a spectrum of where we are. Are we down here at the medical model side where we're doing a whole lot of non-occupation, not in an appropriate context, not using the materials of an occupation, really dictated and lead and run by the therapist, some very passive approaches to all the way at the other end where we're being much more occupation-based. Remember what I said at the beginning that down here on the right, this occupation-based, this is the Holy Grail. This is where we really wanna get to eventually, although we may not ever get there. Most of us exist somewhere here in the middle. But the purpose of today is to be conscious about moving you along this spectrum closer to the right. We don't wanna only operate down here to the left, because then a third-party payer would say, "Is that occupational therapy?" It could just be any other discipline. So how do we, how do we get there? How do we make practice even more occupation-centered? There are several things you can do.

If we think about where we wanna end up, we always have to consider where we wanna end up so we can figure out where to start. So Stephen Covey who wrote "The Seven Habits of Highly Effective People", one of his habits was begin with the end in mind. So if the end for me is to be very occupation-centered and work on people's occupations, and help support their occupational engagement, I have to find out what

occupations to work on. I need to figure out who they are as an occupational being and what are their occupational goals. So something as simple as administering an occupational profile on each client when I first meet them and really discovering what occupations are meaningful to them, that's gonna help draw my map to figure out which occupations I need to work on. Something I can do a little bit more globally is identify occupations that are commonly engaged in by the clientele.

So certainly in different areas of the country there will be some different interests. So if I'm located maybe in a retirement community in Palm Beach County, Florida, a lot of people golf. So that's an occupation commonly engaged in by the clientele. So I'm gonna wanna make sure that I have materials in my clinic to simulate golf exercises or golf activities, because I know that will be meaningful to my clients versus skiing if I'm in the mountains of Colorado. Hopefully, we can do that via a video game like a Wii or an Xbox Connect. So you wanna identify what people engage in so you know what to get. And then it can be really helpful to create occupation kits. These two pictures on the left are actually pictures that we took from our clinic makeover, our first clinic makeover study. You can see that this was sort of the laundry kit and we had everything together near everything else. We had the ironing board and the iron, laundry baskets, clothes hangers. This was a little basket of clothes pins, and we had a rope that we strung up so people could hang up laundry. It's much better to have all these things available in one place.

Now I don't need to start running around the clinic to find different things. Inside there are cabinets. We put together several little kits, things like a women's grooming kit and money management and pet care. We had several different kits that we created, and we labeled the little bins. So again, I could just pull out one box. This was the gift wrapping kit, 'cause here this bottom with the green was a gift wrapping kit, and we had rolls of wrapping paper here. So we could grab this one box, bring it to the table and start our work. So I want you to think about where you're going next, and think

about things that you can do to change your practice. So if anybody's willing to share, please feel free to type in into the Q&A box and identify things that you feel like you could do tomorrow or one month from now.

How can you change your practice based on some of the things you've heard? Anyone wanna offer something? Okay, no one's ready to share. All right, so things that you can do to change your practice, really, oh, we have one. "Using actual classwork from the student's "teachers in our sessions." That's a great idea. So you're not choosing an activity just for the sake of it. They have to do that classwork anyway, so why not do something that's really meaningful to them, and it can be productive and helpful to that child. We have another comment. "I would like to offer cooking kits." Cooking kids are great ideas. When we did our clinic makeover, we went to Walmart and bought five shopping carts full of things. We bought cast-iron pans. We work with dietary to always make sure that we had eggs and bread and peanut butter and cheese and butter so we could make grilled cheese. We bought pudding mixes and soup, cans of soup. So it was pretty simple meal prep. You can actually save money by getting some of the food from dietary as well. "I like a rolling pin to roll out putty for cooking." So that's a really interesting one that, so if you're rolling out putty for like it's dough for making cookies, that's actually really simulated. What would take that up to the next level is actual dough. You can even buy the dough that's the refrigerated cookie dough from the grocery store, because that extrasensory feedback from the scent and the vanilla, there's actually been research about that that when you're getting that extra olfactory sense adds a little bit more authenticity to the movements, and it's the right consistency for rolling, so that's a great idea as well.

Someone else says, "Some facilities have washing machines "and patients do their own weekly laundry." It doesn't get more purposeful than that when people need their clean underwear, so having people do their own laundry is fantastic. So a lot of the things that people mentioned are about things, items, materials that you would wanna

bring into the clinic. So that can be really, really helpful. I would say a great way to make that happen is by using your students and really challenging, when you have fieldwork students, challenging your fieldwork students to create an occupation-based kit that's appropriate for the clients in your setting. And so oftentimes actually they have that assignment in their school to do anyway. But you can create an entire repertoire. If it's something really specific to a client, family members are happy to bring in, whether it's somebody's quilting, or their fishing pole or whatever is meaningful to them. You wanna think about what's temporally relevant too.

So here we are coming upon the holidays, and people are really wanting to engage in those meaningful occupations associated with the holidays. So you can have people making decorations, making a certain kind of food, wrapping presents, making ornaments, making you know, I was gonna say, making potato latkes, but we don't want people to burn themselves on the hot oil. So you wanna think about all the things that might be relevant to that person. So having the things is really important. But being really intentional about asking people, what's important to you? You know, we've all have those folks where we do the evaluation and we say, "What's your goal? "What would you like to accomplish?" And what do they always say? "I want to be able to walk." Well, that's great, but what else do you wanna do? And we can really get that, we can really pull that out of folks by doing an occupational profile. Somebody suggested, "Make greeting cards." That's great. Someone else says, "I do home care because it is "the perfect atmosphere for OT "right on their meaningful occupation." Right, so that's actually one of the most ideal settings is in-home care because you have all the materials, you have the space and it is the most realistic context that you possibly could conjure, because you're in the person's home.

So we wanna start off by asking the right questions, having the materials that we need. How about something you can do beyond your personal practice that might affect everybody in your clinic or everybody in your facility? How do you make that change

happen? This is gonna be more about maybe changing documentation systems or changing policies, or maybe adding some very occupation-based assessments into your clinic, like the Canadian Occupational Performance Measure, or even an occupational profile. So when you have that opportunity when your manager says, "Who wants to be on the committee "to revise our occupational therapy evaluation form?" That's your time to volunteer and say, "Pick me, pick me," because then you can introduce those questions. If the question's not on the evaluation form, nobody's asking that question. So we really need to infiltrate the system and make systemic changes. When it comes time, end of the fiscal year, and the question comes out, what equipment do we need? What do we need to buy? You know, when you think about how much Theraputty costs and how much Theraband costs, it's actually a whole lot cheaper to buy some occupation-based materials.

Somebody suggested, "Get OT staff on the same page "when communicating patient info during weekly meetings." That is a great idea to really represent the profession well and accurately. When at rounds, when you're reporting what's going on, your report should be really focused on occupation, and that lets everybody know on the team, you're the go-to person. You're the person that handles and that oversees that occupational engagement. That's a great idea. Okay, I just wanna acknowledge the folks in the pictures. They are actually my students. Most of them served as models, and one was a very excellent photographer. My references are on here that you can actually see. They should be part of the handouts as well. Some of my real favorite readings are in this reference list that present a lot of these really strong philosophical ideas that shape the way that I think. Are there any other questions?

- [Nika] Okay hi, Wendy, this is Nika. Thank you so much for sharing your knowledge and expertise with us. I don't see any questions coming in, just a whole bunch of thank yous, so we appreciate you taking the time and speaking with us today. I hope

everyone have a great rest of the day and you join us again soon on OccupationalTherapy.com. Thank you.

- [Wendy] Thank you.