Occupational Therapy: Effectiveness & Efficiency

Daniela Sarah Apap

Market forces and quality development have driven the move towards increased effectiveness and efficiency within all industries, including health care. In order to survive as a profession, occupational therapy must keep abreast with these changes and partake in this paradigm shift.

This article examines and appraises the concepts of effectiveness and efficiency as they relate to the occupational therapy process within a client-centred framework. Strategies that can be adopted to increase effectiveness and efficiency within practice are also presented.

From Business Practices to Our Doorstep

Over the last twenty years there have been unparalleled changes within health care with an increasing focus on ensuring that health care services are of high quality, effective in terms of outcomes, and that resources available are deployed in the most efficient and cost-effective way (Lloyd & King, 2002). This move towards increasing effectiveness and efficiency did not occur in a vacuum. It was the result of a wider paradigm shift of the economic and social spheres towards a market mentality (Morrison, 1998).

Of course health is not a commodity to be bought, sold and haggled over as one would a house or an item of clothing; of course our departments are not production lines; of course clients are not passive objects. However, quality development, brought about by the 'quality gurus' from America such as Deming, Juran, Crosby, and Feigenbaum, has resulted in a transformation in all industries including health care (Morrison, 1998).

Market forces within health care promise increased efficiency, increased equality and equity, enhanced standards and quality, increased motivation, as well as increased accountability and

responsiveness (Morrison, 1998). These claims cannot be dismissed easily, especially since they may offer a solution to the many challenges health care is currently experiencing, including population aging resulting in a concomitant increase in the number of people with lifelong disabilities and chronic illnesses, pressures for cost containment, as well as an exponential growth in the types of health care professions along with a misdistribution in the geographical location and in the actual numbers of certain professionals (American Occupational Therapy Association Inc., 1996).

In terms of health care, the influence of market forces were evidenced in a number of reforms and government policies (e.g. United Kingdom: Department of Health 1997, 1998a, 1998b) designed to touch and change every aspect of health care – the total jigsaw (Lloyd & King, 2002). The principle aim of these reforms has been to increase effectiveness and efficiency. This translates into greater clinical accountability for occupational therapists (Roberts & Barber, 2001; Lloyd & King, 2002).

This shift towards greater effectiveness and efficiency has been perceived by rehabilitation professionals as being threatening as they fear that their work may not be understood to the full due to inadequate measurement of outcomes and, hence, be undervalued (Smith et al., 2001). Others have argued that the pressure for effectiveness and efficiency has resulted in feelings of frustration, rather than motivation, amongst professionals since they feel robbed of their freedom of activity and have become confined to implement decisions which have been taken by others (Lloyd & King, 2002).

In the light of the above considerations, this article aims to explore the principles of effectiveness and efficiency and the way these concepts influence the occupational therapy (OT) process.

Terms Defined

Effectiveness refers to outcomes. It considers whether an intervention works in the 'real world' (Smith et al., 2001). With specific reference to OT one may ask "What gains in functional status did a client achieve?" (American OT Association Inc., 1996).

Efficiency, on the other hand, considers the use of resources – e.g. time, space, materials, people, money – employed in order to achieve a particular outcome (Morrison, 1998). An occupational therapist may pose the question "How many resources were utilised in order to gain a specific measurable change in functional status?" (American Occupational Therapy Association Inc., 1996). Increasing efficiency means reducing the expenditure whilst not reducing the intensity and quality of care (Eastaugh, 1993).

In summary, effectiveness refers to attaining goals, whilst efficiency refers to minimising the cost of resources employed to attain these goals. (American Occupational Therapy Association Inc., 1996).

Quality versus Cost – Value for Money?

Stamatis (1996) states that the survival of health care depends on the success of improving quality whilst at the same time reducing costs. The ratio of quality to cost is known as value. Therefore, value is the main principle, which brings together effectiveness, efficiency, and cost. Providing the highest quality service for the lowest price means providing the service with the highest value (American Occupational Therapy Association Inc., 1996). This may seem to be a daunting task to achieve as, in the words of Gaucher and Coffey (1993, p. 90), one may ask "How can you talk about quality when you are cutting costs?"

The term "money makes the world go round" cannot be truer since lack of funding delimits health care and consequently OT service delivery. However, there are lessons to be learnt from America as this delimitation has not only resulted in constraints on practice but also in great opportunities to demonstrate the value of OT and to critically examine forces which shape OT practice (Jongbloed & Wendland, 2002).

The question here is, therefore, not about whether to treat a particular client, but about how to treat in order for the client to achieve most benefit with the least expenditure of resources (Petitti, 1994). Demonstrating the value of OT is, therefore, essential as otherwise the

profession has no scope for existence and will be replaced by alternative services that manage to demonstrate their effectiveness and efficiency. This is not impossible especially since there already are mechanisms and strategies in place to demonstrate the value of interventions. These include clinical audits in the evaluation of services, the adoption of outcome measures and standardised assessments, and the implementation of evidence-based practice to guide intervention (Packham, 1999; Smith et al., 2001; Jongbloed & Wendland, 2002; Corr, 2003).

America's shift towards effectiveness and efficiency, unfortunately, has not come without a price. Reducing costs has resulted in a reduction in the quality of the service provided. The staff/client ratio (caseload management) adopted in order to increase efficiency has influenced the time members of staff spend with clients. Moreover, reimbursement practices dictate which functional outcomes are considered to be valid treatment goals (Jongbloed & Wendland, 2002). This is in direct conflict with client-centred practice where the client's active participation in negotiation of goals is central to assessment, intervention, and evaluation (Sumsion, 2000). Furthermore, the whole OT process is affected in a way which inhibits treating the client holistically since occupational therapists are constrained to work on improving skills that can be easily demonstrated such as feeding and dressing rather than the management of leisure time and psychosocial skills (Jongbloed & Wendland, 2002).

Client-Centred Practice, Effectiveness & Efficiency – the Challenge

American occupational therapists have come a long way to demonstrate that OT can be effective and efficient yet their position can hardly be enviable as they have traded one good thing for another. They have drifted away from their values and philosophies in order to survive in the changing environment by embracing effectiveness and efficiency. Since it seems they have lost touch with their client's needs and seem no longer able to see the client as a whole person, whether they are really and truly practising OT is debatable (Jongbloed & Wendland, 2002).

The current situation in America can only be considered as a starting point in the journey towards incorporating effectiveness and efficiency into practice. Occupational therapists must be wary of adopting an 'out with the old and in with the new' attitude as we may easily lose sight of our aims. It is not about losing principles for others but about striking a balance, finding a symbiotic relationship with these principles derived from the business industry in order to flourish - finding the way of turning the vicious win/lose circle into the virtuous win/win circle. As Chesworth et al. (2002, p. 30) put it "the challenge for occupational therapy is to ensure that they are providing clinical effective interventions whilst at the same time involving clients within their own treatment planning."

Standardised Assessments and Outcome Measures

Standardised assessments have been developed as scientifically sound instruments designed to measure change in the status of a client more precisely, to provide an accurate basis for documentation, and to demonstrate, in turn, the effectiveness of treatment (Managh & Valiant Cook, 1993). They have been described as being the closest thing to date to the reliability of weighing scales or rulers that health care professionals have to measure changes in clients objectively. The clinical judgement of experienced occupational therapists is undoubtedly valid and of great importance, however, it will always be subjective (De Clive-Lowe, 1996; Stearst, 1999).

Standardised assessments cannot be thought of as being 100% reliable because of the very nature of what they are designed to measure. In the 'real world' there are numerous influences acting on clients during an assessment including motivation, medication, and distraction. Yet they are said to provide a fair and unbiased view of the value of treatment (De Clive-Lowe, 1996).

Another strategy proposed to increase efficiency and effectiveness is the single assessment process (Cohen, 2003). By using a shared assessment method each health care profession, whilst maintaining its standardised assessment, will contribute to a large assessment framework. This should result in less

time wastage for all, since duplication will be avoided, and savings with respect to salaries as general information in the assessment process could be collected by unqualified/less qualified staff. It may also be seen as being more of a person-centred approach since a client will not have to answer the same question over and over again (Cohen, 2003).

Unless outcomes are systematically measured, one cannot know whether interventions are effective and efficient (Jongbloed & Wendland, 2002). Measuring outcomes appropriately may help in improving clinical practice through an improved monitoring, evaluation and planning of a service (Smith et al., 2001).

Townsend et al. (1997) encourage occupational therapists to document outcomes using language congruent with OT's core concepts. This means that outcomes should be described in terms of occupation, occupational performance, and client-centred practice rather than self-care, productivity, and leisure, as it is believed that this will provide "a valid information base for demonstrating OT's effectiveness, efficiency and cost-benefits" (Townsend et al., 1997, p.142).

When investing in a standardised assessment it is important to select one that can also be used as an outcome measure. Standardised assessments cost money, however, the high costs incurred in the short-term in order to buy the instrument and, possibly, to train staff in its use, will lead to greater efficiency and proven effectiveness in the long term and, thus, result in greater savings in terms of time and cost (Smith et al., 2001). In making the right choice, there are several points to take into account. The most basic points to consider are:

- suitability for target population (in terms of age, diagnosis, and time taken to administer),
- suitability for the particular setting (e.g. inpatient/community-based)
- reliability and validity,
- whether it meets practical needs for efficiency (e.g. time to administer, need of specific training prior to use, ease of administration and scoring, how easily results can be communicated, and sensitivity to changes in client status)

- limitations (e.g. in terms of normative sampling and validation) and
- client-centeredness (De Clive-Lowe, 1996; Unsworth, 2000; Roberts, 2005).

Another question that needs to be tackled when selecting a standardised assessment or an outcome measure is whether to choose a multi-professional tool (one that can be used by different professions) or a uni-professional tool (one that is specific to, for e.g., OT). On one hand a multi-professional tool can be seen as efficient especially in terms of time and money, however, it is unable to distinguish between the effectiveness specifically resulting from different services. Thus, in a sense a multi-professional tool would fail to demonstrate the unique contribution of OT, and, therefore, would hardly do any favours in supporting the need for OT and would not contribute to OT's evidence base. By using a uni-professional tool, occupational therapists would be able to attribute the outcomes to the therapy being provided and, therefore, therapy effectiveness can be shown more specifically (Unsworth, 2000; Edmans, 2001; Roberts, 2005).

The Canadian Occupational Performance Measure (COPM; Law et al., 1991) has been put forward, as a possible link between effectiveness, efficiency, and client-centred practice (Chesworth et al., 2002). This individualised measure can be used both as an assessment as well as an outcome measure (Townsend et al., 1997). However, it must be emphasised that, to date, there is no single tool which targets all the needs in OT and the COPM cannot be used in all situations, and, furthermore, it should be used in conjunction with other measures (Chesworth et al., 2002).

Clinical Reasoning and Intervention

The current health care environment also requires effective and efficient clinical reasoning (Neistadt, 1996). The efficiency and effectiveness of a therapist's clinical reasoning increases proportionally with experience. Mattingly and Fleming (1994) state that experienced practitioners are described as being efficient in their clinical reasoning because they "'get it right' in very few tries" (Mattingly & Fleming, 1994, p. 15)

In order to dampen the effects of the decreased efficiency and effectiveness of clinical reasoning in novice practitioners, Fortune and Ryan (1996) have proposed a caseload management system in which, following initial assessment, cases are graded according to the amount of clinical reasoning skills required. In this system simple cases are given the value of 1 whilst complex cases are graded at 3. This ensures that caseloads are varied in such a manner so as to find the best mix to match the background and experience of practitioners, maximise efficiency and effectiveness, and promote continuing professional development and experiential learning at an adequate and practical level. It is proposed that this system will not only provide greater efficiency in terms of time but also in the use of expertise. Although it seems to be feasible and useful at face value, it is important to note that no formal evaluation of such a system had been conducted at the time this article was published and conclusions are based on informal feedback received (Fortune and Ryan, 1996).

With regards to intervention, efforts to decrease costs have resulted in clients being discharged as soon as possible and in treatment moving into the community (changing location). This decrease in the number of times therapists see their clients has, in turn, resulted in a greater sense of responsibility in questioning practice and in carrying out efficient evaluations. Limited funds have also resulted in increased delegation of tasks to OT assistants i.e. increased skill mix (Jongbloed & Wendland, 2002).

One of the ways of guaranteeing effectiveness and quality in health care services put forward by the government within the United Kingdom (Department of Health 1997, 1998a, 1998b), is evidence-based practice (Roberts & Barber, 2001) - an approach that involves acquiring and making use of the most recent research into the effectiveness of health care interventions in order to inform the decision making process (Bannigan, 1997). It does not only ensure that OT intervention is effective but also increases efficiency since resources are not wasted on less effective interventions (Bannigan, 1997).

Another pathway towards ensuring best practice is through continuing professional development and life long learning. This is because they provide the chance to reflect on current practice and to research effective interventions (Roberts, 2002).

Simple strategies that may be adopted in OT intervention in order to increase efficiency include orderliness and neatness to ensure that resources are stored in places to which there is easy access. Cleaning and checking the condition of equipment and resources should be done by everyone on a regular basis (Morrison, 1998). Regular maintenance makes equipment last longer, thus, saving resources and, also, provides enough time for re-ordering of equipment should this be needed.

Evaluation...not just about outcome measures

Evaluation is an essential aspect of an intervention or a service. Its purposes are manifold and include assessing effectiveness of an intervention or service, establishing whether the outcomes can be really attributed to the service or whether they have been the product of other external factors, and also as a basis for making recommendations for change (Corr, 2003). The use of outcome measures has already been considered, however, outcome measures are not the only tool available for evaluating OT.

Clinical audits are another tool and need not be considered as a tool which is best left in the hands of specialists (Packham, 1999). Clinical audit has been described by Packham (1999, p. 278) as "one of the dynamic factors that drive clinical effectiveness and the allocation of resources, and assists in meeting the perceived needs of the client".

As part of their role in ensuring best practice, in 1998, the COT's in the UK launched a 'Clinical Audit Information Pack' (Edmans, 2001). The purpose of this guide was to portray the clinical audit as being something which was not only possible for ordinary occupational therapists but also desirable (Edmans, 2001).

Any knowledge gained from evaluating OT services and intervention should be published in order to substantiate the currently scant evidence base of OT.

Contributing to the evidence base of OT should be viewed as an obligation towards the profession and most of all towards our clients.

Conclusion

Whether or not OT should become aligned with market forces and the principles of effectiveness and efficiency is a non-question, because: 1) market forces are already in place due to funding arrangements; 2) clients' current market mentality and expectations of for example information, accountability, efficiency, and 'standards' are here to stay as they are rooted in a broader current of economic and social change (Ball, 1994). Despite being subject of trenchant criticism, due to the fact that the principles of effectiveness and efficiency have been wrongly perceived as a threat to health care professionals, this assignment has argued that they are principles without which our service may in fact be of a threat to our clients.

In OT terms, the impact of effectiveness and efficiency is evident in every step of the process. These principles have brought about an increasing emphasis on standardised assessments, outcome measures, evidence based practice, continuing professional development, and clinical audits, as well as a conscious effort to prove the value of OT. So let us leave aside prejudices, suspicions and the distrust that we may have of changes in management practices and let us not let OT become the graveyard of creativity, flexibility, adaptability, and problem-solving capabilities.

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Daniela Sara Apap, B.Sc (Hons) Occupational Therapy, is currently reading an M.Sc in O.T. at the University of Plymouth, UK.