Occupational Therapy- improving the hospital to home interface for older people

Winston Churchill Travel Fellowship Report 2011

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Summary

A Winston Churchill Memorial Trust (WCMT) travel award allowed me to undertake a study visit to the University of Southern California to learn about the Lifestyle Redesign® occupational therapy approach and to investigate how it could be applied to the hospital/home interface for older people.

Changing population demographics have led to changes in health and social care policy. There is now emphasis on prevention of illness, reducing hospital admissions and on health and wellbeing. Occupational Therapists (OTs) have skills that can help to achieve this change. Randomised controlled trials using Lifestyle Redesign® demonstrated that preventative occupational therapy can provide sustained, cost effective improvements to older people’s health and wellbeing.

During my visit, I attended classes and research meetings, visited clinical settings and met with many involved professionals (including Dr Florence Clark, Associate Dean and original designer of Lifestyle Redesign®) and clients. I learned about the diverse clinical areas where the approach is now being used successfully, some of these are unfamiliar areas of practice for UK based OTs.

Lifestyle Redesign® works on the theory that transformational change is possible through an expertly facilitated approach that enables individuals to make changes in their daily lives that are health promoting and support wellness and life satisfaction. This allows individuals to live independently for longer and so to require less input from health and social care services.

The different health care system in the US makes direct comparisons difficult, but the diversity of areas where the approach is in use support the theory that Lifestyle Redesign® can be adapted for use at the hospital/home interface for older people. There is potential to use this approach to support the changes in service delivery that are resulting from the current changes in healthcare delivery. There are some challenges to be met in moving to a different way of working, but this approach offers a method of intervention that is person centred and evidence based and therefore aligns well with current Scottish Government policy.

I have identified actions that I am able to undertake to disseminate my learning for the benefit of others. I have also outlined some recommendations so that this information can help to inform the decision-making process and deliver change as part of the service changes that are already underway within my own organisation and more widely.

I have included a personal reflection on the experience of undertaking a WCMT travel award.
Acknowledgements

I am grateful to so many people who have supported, encouraged and helped me during the preparation for this trip and during my time in the United States. Also to those who have been willing to allow me glimpses of their lives and share in their experiences of Lifestyle Redesign® whether as students, University Faculty members, clinicians, patients and clients. Particular thanks are due to:

• **The Winston Churchill Memorial Trust**- for funding my visit and for all their help and support whenever it was needed throughout the process from first application to returning to the UK.

• **My hosts at the University of Southern California Division of Occupational Science and Occupational Therapy**- individuals too numerous to mention made me welcome and assisted me in every possible way to make my time with them a richly rewarding experience and one that taught me more than I could have hoped for.

• **The College of Occupational Therapists Specialist Section- Older People (COTSS-OP)**- colleagues on the National Executive Committee who I have the privilege to work with as co-lead of the Acute Care & Emergency Clinical Forum have been a support and an inspiration. The initial idea for the study visit came about as a result of my involvement with the specialist section.

• **NHS Dumfries & Galloway**- I am grateful to the organization and my managers for having the willingness and imagination to support this study visit. Also to all my colleagues in the occupational therapy service for their support and encouragement- and to the OT staff at Castle Douglas Hospital in particular, they worked very hard to provide cover while I was away.

• **My friends and family**- for always believing in me and encouraging me to expand my horizons, and for keeping in touch while I was away.

• **The clients and patients of OT services on both sides of the Atlantic**- it remains a privilege to be allowed to be part of someone’s life for a short period, at what can often be a difficult or vulnerable time.
Introduction

As an Occupational Therapist (OT) working with older people in hospital and during follow-up after discharge, I was aware of the challenge of changing population demographics for health and social care services.

Lifestyle Redesign®, an innovative approach developed in the USA, has produced convincing evidence that OT can provide sustained, cost effective improvements in the health and wellbeing of older people.

I successfully applied for a Winston Churchill Memorial Trust (WCMT) travel award. This allowed me to visit the US to find out more.

I spent 8 weeks during January and February 2012 at the University of Southern California (USC) in Los Angeles with Dr Florence Clark and the research team in the Division of Occupational Science and Occupational Therapy learning about the approach and investigating how it could be used to improve the hospital/home interface for older people.

Aims of the Visit

- To learn about the Lifestyle Redesign® model first hand and in depth.
- To study and develop my understanding of how the model can be applied in the context of the interface between hospital and home.
- To explore the relevance of this model to my own area of work. Key issues are the translation from an urban, culturally diverse setting to a rural and less diverse region.
- To make links with current policy documents such as Shifting the Balance of Care and Reshaping Services for Older People (Scottish Government) that make clear the need for a new approach to services for older people.
- To identify how occupational therapy services in my own area of work could deliver the most beneficial and cost effective interventions.
- To prepare a discussion document for the development of occupational therapy services for older people in my region based on the learning from my visit.
- To develop my own practice with individual patients based on my learning.

This report is intended as a starting point for discussion within my own service, for OTs and other interested parties. It will discuss the changing face of 21st century health and social care and the how government policy is changing in response to new challenges. The basic concept of the Lifestyle Redesign® approach in OT will be described along with the evidence that it can be a cost effective and sustainable approach. The report summarises the learning experiences that I was involved in during my study visit and discusses the relevance of these to the issue of OT intervention improving the hospital/home interface in the UK. The report concludes with actions and recommendations and a personal reflection on my own development and learning during the visit.
Background

In the 21st century life expectancy in the developed world is greater than it has ever been, but chronic conditions and diseases are increasing (Scottish Government 2009 & 2010), partly as a result of longer lives but also due to lifestyle factors. At the same time, the number of people of working age available to fund and provide care is declining (Scottish Government 2010). Older people are statistically the highest users of health and social care services, increasingly so in ‘older old age’. Health services have traditionally been designed to treat illness, often in hospital, rather than to promote good health. This is expensive and can no longer be sustained.

Government policy is changing to respond to the challenge, Table 1 below gives an overview of some of the most significant Scottish Government policy. There is new emphasis on prevention of illness, promoting health and wellbeing and delivering services closer to home, with reduced use of hospital beds. Older people are statistically the highest users of hospital ‘bed days’. Being in hospital has many detrimental effects for older people. It is timely to look at ways to reduce admissions and length of stay and ensure discharges are successful. Current policy recognises the role that a range of professions and agencies, such as occupational therapy, can play. A new Allied Health Professions (AHP) document (Scottish Government 2012) is out for consultation at present, if adopted, it would see the majority of AHPs, OT included, based in the community instead of hospital in future.

Occupational Therapy

‘A simple definition of occupational therapy is that it helps people engage as independently as possible in the activities (occupations) which enhance their health and wellbeing

Occupational therapists, with the assistance of OT support staff, help people of all ages who have physical, mental or social problems as a result of accident, illness or ageing, to do the things they want to do. These could be daily activities that many of us take for granted, from grocery shopping or brushing your teeth, to more complex activities such as caring for children, succeeding in studies or work, or maintaining a healthy social life.’

(College of Occupational Therapists, UK)
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| **Shifting the Balance of Care (SBC)** | Describes changes to be made at different levels of health & social care. The overall aim is to improve health & wellbeing and improve outcomes by intervening earlier in the course of disease, faster diagnosis and individually tailored care delivered closer to home. | 8 broad complex ‘impact areas are identified. These include:  
- Flexible & responsive care at home with support for carers  
- Integration of health & social care.  
- Reducing avoidable admissions to hospital.  
- Extended scope of services provided by non-medical practitioners outside acute hospital. |
| **Healthcare Quality Strategy for NHS Scotland** | 3 Quality Ambitions:  
- ‘Mutually beneficial partnerships between patients, their families and those delivering healthcare services…’  
- No avoidable injury or harm…  
- The most appropriate treatments, interventions, support and services…’ | Emphasises prevention, delaying and reducing the impact of ill health  
Outcome measures include:  
- Emergency admissions/stays  
- Population living over 75 years  
- Aspects of patient experience and self reporting of general health. |
| **Reshaping Care for Older People** | Considers the wider context of care and services. Aims:  
- To test new ideas to help people who need care to live full and positive lives and be less dependent on formal care.  
- To gather and make use of meaningful feedback.  
- To develop options for future care that are balanced between state and citizen.  
- Continued engagement with key interests. | Emphasis on preventative work e.g. keeping older people safe, confident and able to look after themselves at home.  
- Shift away from hospital based care to local care closer to home.  
- Enabling maximum independence for as long as possible. |
| **From Strength to Strength** | Celebration of the progress AHPs in Scotland have made since the AHP strategy document Building on Success (2002). | Emphasises importance of ‘proactive, anticipatory services, closer to home’.  
- Reducing unnecessary hospital admissions.  
- Keeping older people well and at home as long as possible.  
- Helping regain independence after illness.  
- Interventions moving ‘upstream’, enablement & self-management.  
- Shift from acute to community. |
Randomised controlled trials (RCTs) developed by USC, beginning in the 1990s have provided high quality evidence that preventative occupational therapy can improve health related quality of life and satisfaction for older people. These benefits are sustained over time indicating that preventative OT can help older people remain healthy and independent longer, reducing the need for hospital admissions or care services and improving quality of life.

There have now been a number of publications about these studies, known as Well Elderly 1 & 2. References are included for those who would like to read further (Clark 1993, Clark et al 1996, Clark et al 1997, Clark et al 2001, Clark et al 2011, Jackson 1996, Jackson et al 1998, Hay et al 2002).

One of the criticisms of research in OT has been that it has not had enough RCTs. RCTs are seen as the 'gold standard' for quantitative research and results are therefore taken seriously. Because the Well Elderly studies were RCTs and showed such positive results, they have attracted interest outside the US.

Two significant UK publications are:

- **NICE 16- 'Occupational Therapy interventions and physical activity interventions to promote the mental wellbeing of older people in primary care and residential care'** - The National Institute for Health & Clinical Excellence (NICE) produces reports on a wide range of clinical activities and makes evidence based recommendations for practice. Well Elderly I is referenced in the costing report for NICE Public Health Guidance 16 (NICE 2008)

- **Lifestyle Matters-** A feasibility study of an 'occupation-based health-promoting intervention' inspired by the Well Elderly study (Mountain et al 2008). It included the development of a manual similar to the Lifestyle Redesign one, intended for the UK (Craig & Mountain 2007). It showed that delivering the programme was feasible and that participants benefited.
Lifestyle Redesign®:

"Is a process of acquiring health promoting habits & routines in daily life" (Clark et al 1997)

‘Is the process of incorporating health-promoting habits & routines into your daily life. OTs look at how you “occupy” your time, and how the daily activities you engage in affect your overall health, wellness and life satisfaction”-USC OT Faculty Practice

Four core beliefs of the OT profession informed the design of Lifestyle Redesign®:

- Occupation is life itself
- Occupation can create new visions of possible selves
- Occupation has a curative effect on physical and mental health and on a sense of life order and routine.
- Occupation has a place in preventive care. (Mandel et al 1999)

Trademarking ‘Lifestyle Redesign®’

By now readers will have noticed the ‘®’ symbol denoting that Lifestyle Redesign® is trademarked. This prevents anyone not fully qualified by USC from carrying out interventions called ‘Lifestyle Redesign’. The trademark was acquired by USC to protect the quality of research being done using this approach, not to prevent use of the methodology. Many OTs have drawn on the concept and this is welcomed, but programmes need to be entitled something different e.g. the Lifestyle Matters programme discussed above.
The Visit

University of Southern California Division of Occupational Science and Occupational Therapy

The University of Southern California (USC) is a privately funded university located across 2 campuses in central Los Angeles. OTs have been educated here since 1942 and many of the profession’s famous names are alumni e.g. Mary Reilly and Gary Kielhofner.

Mission and Vision

‘The mission of the USC Division of Occupational Science and Occupational Therapy is to maximize the potential of people to construct healthy, satisfying and productive lives by generating knowledge of value to society, advancing the profession and educating generations of practitioners, researchers and leaders.

Our Vision

We envision the Division of Occupational Science and Occupational Therapy as a hub of innovation and leadership where we study participation in daily activities defined in the discipline as “occupation” and its relationship to healthy living over the lifespan. We aim to establish occupation as an essential component in health and well-being. We promote this perspective by educating a global community of researchers and practitioners and advancing practice models about occupation that are science-driven and address health and societal needs.’

(Division website at http://ot.usc.edu/)

In addition to the two University owned hospitals, close links are maintained with clinical partners at Rancho Los Amigos National Rehabilitation Centre, Children’s Hospital and others. A global network of contacts including Ghana, Hong Kong & Romania is well established.

There are 3 main ‘arms’ of the Division’s work:

- **Research**- the Division is currently operating with a research ‘portfolio’ of over $8 million. The studies in progress have potentially powerful implications for OT practice and range from community based lifestyle interventions to neuro-imaging following stroke to improve rehabilitation methods. Numerous peer reviewed publications have contributed to the aim of generating ‘rigorous science with clinical relevance’

- **Clinical Practice/Care Services**- clinical OT staff work within the USC Occupational Therapy Faculty Practice and Keck Medical Center at USC Hospital. Lifestyle Redesign® forms the basis for the Faculty Practice programmes. In addition to meeting patient needs, the clinical practitioners are closely involved with the teaching and research ‘arms’.
- **Training/Education** - the entry-level Masters programme has recently been remodeled and includes foundations and essential core studies, practice ‘immersions’ (Paediatrics, Mental Health & Adult Physical Rehabilitation/Geriatrics), academic fieldwork, leadership development and specialty focused elective placements.

During my visit I had the opportunity for involvement in all three areas and was able to gain an appreciation of how closely interwoven they are and how Lifestyle Redesign® is applied in many different situations.

The Health Professions Center, Health Sciences Campus- this was my base.
**My typical weekly schedule:**

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<td>Clinical visits, shadowing OTs in practice, meetings with clinicians and managers. (I also managed to include 2 Public Holidays in my visit- Martin Luther King Day and Presidents Day)</td>
<td>AM: study/office time or one-to-one meetings. PM: Communication Skills for Effective Practice class. Or Well Elderly research meeting. Pressure Ulcer Prevention Study research meeting.</td>
<td>AM: Lifestyle Redesign Class at 'the Center'. PM: study/office time or one off meetings</td>
<td>AM: study/office time or one off meetings Weight Management group at main campus PM:- study/office time or one off meetings</td>
<td>AM: Pressure Ulcer Prevention Study OT intervener meeting. PM: Faculty teaching seminars</td>
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**Lifestyle Redesign Class**

I joined the 2nd year Masters OT students for the first 8 weeks of their 16 week Lifestyle Redesign® class.

From the syllabus:

“The course is designed to enable you to implement innovative Lifestyle Redesign® programs and to develop advanced clinical skills in this area....This course explores the ways in which Lifestyle Redesign® can be employed to meet key public health problems of the 21st century:......The course will both increase your understanding of theory and enable you to develop clinical skills to create and execute lifestyle interventions addressing America’s (and beyond) current health concerns.”

The class is held in the beautiful Victorian Center for Occupation and Lifestyle Redesign house close to the main USC campus. Charlie Chaplin once lived here!
Although Lifestyle Redesign® ‘was first conceptualized as an intervention to address America’s increasing aging population… [it] has implications for all lifestyle related health concerns.’

We studied the development of Lifestyle Redesign® at USC and the first Well Elderly Study (WE1), the RCT that provided evidence of the effectiveness of the intervention, it’s cost effectiveness and the potential of OT as a preventive intervention (Clark et al 1997). The ‘manual’ produced during that study (Mandel et al 1999) remains the starting point for learning about the methodology. The scientific background to Lifestyle Redesign® has it’s roots in both occupational therapy and occupational science disciplines. We investigated the public health concerns of the US (similar to the UK with an increase in chronic conditions, many obesity or age related), factors that make for successful ageing and some of the many areas where OTs use Lifestyle Redesign® successfully.
A theme that became increasingly apparent during my visit was the scale of the problem of poor diet and obesity and the subsequent impact on health. We were introduced to a fascinating book (Kessler 2009) that offers an explanation for the proliferation of ‘conditioned hypereating’ and how it can be controlled that aligns well with Lifestyle Redesign®.

Lifestyle Redesign® programmes include processes of:
- Didactic and (where groups are involved) peer exchange
- Occupational self analysis
- Provision of information
- Direct experience
- Personal exploration
- Goal setting

It is important that any OT carrying out this intervention should have some experience of it themselves. The class divided into pairs and worked together throughout the semester using a template designed for college students to guide them through a didactic process to examine their own occupational choices and to address any issues.

Some of the key concepts of Lifestyle Redesign® are that:
- Experience in occupation leads to change, but not necessarily linear change.
- It is possible for people to develop skills in occupational self analysis
- When people understand the importance of occupation, they have a ‘tool kit’ to redesign their lives.
Communication Skills for Effective Practice Class

I joined the 1st Year Masters students for Dr Fazio’s class held in the Center for Health Professions (CHP) at the Health Professions Campus (HPC). I was with the class for Modules 1 & 2:

- **Communicating in the Workplace**: basic communication; revisiting the communication skills of the ‘therapeutic self’ and the effective health care provider. Communicating in organisations as employee and employer. Understanding the impact of ethnicity and culture on communication.

- **Building on basic communication skills to encourage goal setting and progress in our clients, our colleagues and our supervisees. Understanding change, whether self-selected or imposed.**

Change theory and motivational interviewing are introduced (Prochaska et al 1994, Rosengren 2009) and the students practice skills in the design and implementation of therapeutic groups (Schwartzberg et al 2008). A thorough knowledge of change theory is essential for any OT working with clients on lifestyle change issues. The OT must be able to recognize the stage an individual is at in order to offer the right support and to identify what intervention is appropriate at that point. Motivational interviewing skills are closely aligned with coaching techniques and are important in working with individuals or groups. Group work can form all or part of a Lifestyle Redesign® programme.

I found this class very beneficial as it allowed me to review my skills and knowledge in the context of considering ways that this approach could be utilized within my practice and the service I work in. It was also a great opportunity to network with many of the students and to learn from each other.

This class and the Lifestyle Redesign® class linked well and gave me an insight into the development of knowledge and skills that students achieve between the first and second years of their Masters course.

Clinical Practice Visits

*Keck Medical Center of USC*

As a hospital based OT, I was keen to find out more about the work of OTs in similar settings here. I had to complete my mandatory Health Insurance Portability & Accountability Act (HIPAA) training (this covers confidentiality issues plus added content due to the billing system in the US) before I could go into patient areas. As a
UK registered OT I could observe sessions with the US OTs but I am not registered to practice in the US.

The on-site Keck Medical Center at USC is a tertiary centre i.e. a specialist, rather than a general hospital. It carries out procedures such as organ transplantation and treats highly complex patients. The 7-day OT service covers in and out patients. USC bought the hospital 3 years ago and the OT service now has close links with the Division.

Outside Keck Medical Center of USC

Spending a couple of days shadowing OT clinicians Lyndsay Price & Stacey Morikawa allowed me to observe and discuss practice first hand. Lyndsay is a permanent member of the OT team. Her caseload for our day was busy and varied and included a first evaluation with an older gentleman who had been admitted acutely with a stroke and a review of functional status with a younger woman post-transplant. Two of the patients did not speak English (not uncommon in Los Angeles) but Lyndsay was able to continue in Spanish!

Stacey works at the hospital part time during her 1-year doctorate programme residency. Her project is to develop an OT programme for patients being admitted for bone marrow transplantation. Patients are admitted about a week prior to transplant for preparatory work. Post procedure, they remain in protective isolation for 22 days. Stacey is developing an programme to help patients to cope with the emotional, physical and occupational demands of this situation in order that their final outcome will be improved, that they are ready to leave hospital on schedule and are prepared to resume their usual occupations post discharge. We saw a patient in the first week
of protective isolation who was struggling with the isolation and boredom. The session explored the patient’s usual occupations with a view to identifying some that could be adapted for the limited environment.

Stacey’s project makes explicit use of Lifestyle Redesign®. Lyndsay’s more acute remit makes use of it in implicit ways e.g. in utilizing patient ‘narrative’ or story telling techniques that are used to shape treatment programmes.

A trial of using the approach for patients with Ventricular Assist Devices (VADs) was carried out (unpublished) and presented at the American OT Association conference. It indicated potential for use in this setting and identified some of the challenges.

**Rancho Los Amigos National Rehabilitation Center**

Rancho is not part of USC but a separate entity with it’s own research and clinical programmes located on the other side of the city. The in-patient wing in the modern Jaquelin Perry Institute has about 150 beds. The out-patient service for Occupational Therapy, Physiotherapy & Speech & Language Therapy sees about 150 patients per day. About 40 OTs are employed. There is close collaboration between the USC OT Division and Rancho. Lifestyle Redesign® has been a major part of the development of this link.

I spent an afternoon with Michelle Berro, Clinical Manager, Outpatient Therapy Services and Michal Atkins, OT Clinical Manager, who is currently leading the introduction of 4 new Lifestyle Redesign® programmes. Michal used the approach
successfully for a contract from the Veteran’s Association (VA) for patients with chronic pain. The 4 areas now to be developed are:

- Traumatic Brain Injury
- Spinal Cord Injury
- Stroke
- Neurology

I joined some of the OTs with a Lifestyle Redesign® group developed by Alison Chu for people who have had a stroke and want to make lifestyle changes to reduce the chance of a further stroke. The group meets weekly at Rancho and covers a range of topics. The group had been discussing healthy eating the previous week. I joined them the day they were going out to look at food labels and menu planning in a real life situation. As most group participants are on low incomes, the local 99 Cent store was chosen for the visit. The aim was to investigate food labels for items they often use and find possible alternatives, also to plan and buy for a healthy meal to cook together—within a strict budget. In this real life situation; issues and queries arose that might not have done without the prompts elicited by being surrounded by food choices and marketing. People naturally shared experiences. These ‘storytelling’ opportunities were captured by the OTs who facilitated group discussion and exploration of choices.
Gerontology

I met with Tina Yang, an OT who works in Gerontology (older people) to talk about her experience of using Lifestyle Redesign® with older and 'less well' individuals. She carried out a Lifestyle Redesign® programme for residents in an assisted living facility.

The people she worked with were typically fairly physically able, but many had a degree of cognitive impairment. Tina explained that some cognitive impairment does not mean that Lifestyle Redesign® cannot be a useful technique as the 'here & now' aspect of taking part in the sessions can be of benefit. The programme encouraged active and positive engagement in personally meaningful occupations instead of the more passive activities, like watching TV, that were on offer. Some constraints are inevitable in any form of institutional setting e.g. pre-set meal times. The programme included 2 field trips, one to the local library and one to a museum, both opened up new horizons for residents, both in terms of finding places some would be able to revisit and of making autonomous choices.

We talked about the potential for Lifestyle Redesign® to be used in any area of OT practice. Tina, as others have done, stressed the importance of occupational storytelling and occupational story making in the transformative process.

Weight Management Group

I joined the first 8 weeks of a 16 week Lifestyle Redesign® Weight Management Group that ran for an hour every Thursday lunchtime at the main campus. The 8 participants all worked nearby and were attending for various reasons from wanting to be more active and healthy to preparing for bariatric surgery. The first week, Dr Chantelle Rice, the OT facilitating the group introduced the programme, explaining what the terms ‘occupation’, ‘Occupational Therapy’ and ‘Lifestyle Redesign®’ mean and how they apply in the context of weight management. Everyone was weighed using a body composition scale (assesses additional factors such as fat mass %) and group members set long-term goals i.e. what they hoped to achieve by coming to the group. Some basic information about diet, food choices, the importance of drinking plenty of water etc. was discussed. The session ended with everyone setting a short-term goal, to aim for that week. The topics for the weekly sessions included nutrition labels, physical activity, lifestyle balance and emotional eating. There was a ‘weigh-in’ at the start of each session (but weights were not generally discussed). Sessions ended with individual goal setting for the week ahead.
Throughout the process I was able to see individuals engage in the various aspects of the Lifestyle Redesign® process; didactic exchange took place in the group setting, occupational self analysis took place in the sessions and outwith, facilitated by Chantelle, group members experimented with real life new experiences and set goals for themselves that were achievable. An important part of the process was the provision of accurate, up to date information and dispelling of ‘myths’. The process of weekly goal setting allowed graded ‘risk taking’ as individuals experimented with new occupational routines and were supported by the group in their successes (or lack of) at each meeting. At the end of 8 weeks, everyone had lost weight (including me!), all were making good progress towards their long-term goals and all were very positive about the process. Everyone had very different goals and strategies within the overall aim of losing weight. All were developing more active lifestyles and healthier eating habits.

Chantelle kept the tone light hearted and supportive but was clearly very skilled in evaluating individuals’ readiness for change and progress within the group and using
a motivational but realistic approach. Group members were very supportive of each other.

Pressure Ulcer Prevention Study (PUPS)

Lifestyle Redesign® has been shown to be a successful approach to improve management of chronic conditions, in this case pressure ulcer prevention for community living individuals with spinal cord injury (Clark et al 2006, Jackson et al 2010). The methodology developed in the Well Elderly studies was adapted for this client group.

There were very different challenges to be met. In Los Angeles one of the most common causes of spinal cord injury is gun-shot wounds associated with gang violence. Many of the clients had sustained their injuries in their late teens or early twenties. Some remain actively involved or on the fringes of gang involvement. Many are living 'marginalised' lives with issues due to poverty, homelessness or prison terms, often needing to become the immediate focus for the OTs. There were a number of discussions about the issues of drug and alcohol use (‘medical’ marijuana is easily available in California) and of ‘arrested development’ in clients who became disabled and dependent- often on their mother- at a young age.

The current study cohort were reaching the end of several months of intervention during my visit and the next studies are in the planning stages.
I was able to attend both the researchers’ meeting and the OT Interveners’ meeting every week. The interveners are blind to the study methods. The interveners aim to deliver all the aspects of the programme on an individual basis, there is no group element to this intervention. They are flexible in dealing with the issues that individuals have in managing their pressure areas within the context of their lifestyle. OTs have had to deal with situations where much needed equipment was not realistic e.g. a pressure relieving mattress is not an option for someone living on the street; equipment was stolen resulting in a quadriplegic young man having to stay in bed all day or be taken out in a manual wheelchair unsuitable for his safety or skin integrity. The meetings were updates and also problem solving sessions for the OTs. One summed up her approach with clients “if it’s valuable to you, then it’s valuable to me”.

Well Elderly studies

The data sets from the original studies continue to be evaluated and grant proposals are in development for further large-scale trails.
I was able to attend some of the research team’s meetings during my visit. The numerous papers regarding these studies are referred to above and references included. A possible future study will test the methodology with people in the public health system, receiving preventative occupational therapy intervention at ages 50-
60s and being followed up long term to assess the benefits into old age.

**Discussions with Dr Clark**

My office base at USC was in Dr Clark’s ‘suite’ of offices so I was able to see close at hand just how busy and varied her daily routine and that of her immediate team can be. In addition to the ongoing research programmes, as Associate Dean of the Division and as current President of AOTA, she has many commitments and travelling to meetings and conferences takes her away at times. I was very grateful to Dr Clark for her generosity with her time and her interest in my visit.

We discussed my aims and ways that Lifestyle Redesign® could be applied with older people at the hospital/home interface. Dr Clark talked about the concept of ‘life management’ that all of us are engaged in at some level. At it’s best, it can be the process that allows us to flourish as human beings. We talked about chronic disease management. This can be very beneficial to individuals but still places the focus on the disease. Lifestyle Redesign®, if used as a way to ‘life manage’, is a broader concept and considers a person’s whole life (echoing the words of the Pressure Ulcer Prevention Study OT intervener who said “If it’s valuable to you, then it’s valuable to me”).

We explored what this might mean in the context of the hospital/home interface for
older people. There are issues of allowing a process of flourishing to continue as old age advances and perhaps physical or cognitive deficits make tasks more difficult. It is still important to address individual’s needs to realise their potential and have their wishes respected. Routines and long established habits are particularly significant for older people. We spoke about the importance of working with these routines, and providing opportunities for new experiences within them. Dr Clark emphasized the importance of maintaining dignity for older people, who may need someone to ‘walk with’ them through this process of change to enable them to experience quality of life as they adjust to change, some of which may be imposed rather than chosen.

We spoke about the issue of nutrition as I found it played a larger part in many of the interventions I observed that I had expected. Dr Clark explained that it often features as it is such an important issue for any individual, if nutrition is poor, then potential cannot be fully realised. In some interventions, such as Weight Management, of course it is a major and explicit part of the intervention, in others, it is often an important part of an overall programme.

Dr Clark is a strong advocate for the profession in the arena of ‘life management’ and preventative programmes as the issues involved in enabling individuals to make lifestyle changes are complex and multi factorial. Despite the fact that programmes may have a clear timetable or planned sessions, there is a high level of skill involved in using a range of methods to ensure that an overall programme is individually tailored to each participant and that their changing needs as it evolves are met.

Future research studies working in the US public health system over longer periods of time are in the planning stages and will be fascinating to follow as the evidence base for OT develops.

Other Activities

I was able to attend various other meetings, talks and presentations as part of the Division’s ongoing work and there were so many contacts and ‘spin offs’ of being on site for an extended period of time. These included:

- A visiting academic’s presentation on **Sensory Integration and Autism**, another of the major research themes at USC.
- Discussing **electronic records** with Kathy Gross, Chief of Occupational Therapy at USC University Hospital and being able to put her and a colleague working on the shared MIDIS electronic record at home in contact with each other, a useful liaison for the future we hope.
I was invited to speak and be one of a panel for the student organized annual International Forum, a very interesting and enjoyable evening.

Blogging

An unexpected benefit of the travel award has been that it introduced me to the world of blogging. I had never 'blogged' before and had no idea how to, so I started my blog a few months before I left to get to know how it worked and have continued to develop it as I go along. Throughout the process I have learned new skills, made connections and been able to share what I was doing during my study visit. I worked hard at improving my blog and now have links to various others and have included features that help people to find it.

While I was in Los Angeles, most days I had between 20-30 people viewing it from all over the world, with most ‘views’ in the US & UK. I discovered other blogs about OT and I continue to blog about my experiences as I look at how my learning can be implemented. I have signed up for the Blogging From A-Z Challenge in April 2012 and will use this as a further reflection on my experiences at USC.

I experienced so much during my time at USC. In the interests of brevity, this report can only provide an overview of my experiences. I invite readers to look at the posts on my blog that cover my experiences in much more detail.

My blog can be found at:

http://otebby.blogspot.com/
Discussion

During my study visit I learned how the Lifestyle Redesign® model is being applied to many different areas of work and varied client groups with a diverse range of needs. Although the approach is not directly in use with the client group I was interested in i.e. older people at the hospital/home interface, it’s diverse applicability supports the supposition that it has potential to benefit both services and clients.

Health care services are provided differently in the US. There is no equivalent to the NHS so provision of rehabilitation and support around hospital discharge may depend on the terms of an insurance policy. There are public healthcare funds available for older people and those on welfare, but these are not directly comparable to UK services. Some of the areas of work I learned about, such as weight management or pressure ulcer prevention, are settings that are not usual for OTs in the UK. Using the Lifestyle Redesign® model places the focus on the person not the condition and utilises OTs knowledge of occupational performance to effect change that is health promoting. The pressure ulcer prevention study is very much within the parameters of long term condition management. Another reason that services develop differently in the US is that OT clinics and services actively work to develop new programmes and market them to bring in income, whereas in the UK we are working to deliver the best results with the least use of resources and cost to the public purse. At first sight these strategies appear at odds with each other, but good results are good results. An example I saw in the hospital setting was the need to reduce length of stay, also a familiar theme in the UK. Here we are concerned about length of stay due to cost to the public purse and the need to free up hospital beds, as well as hopefully better outcomes for patients. In the US, insurance companies pay for a set number of hospital days for a particular procedure, if the patient requires longer, then the hospital begins to lose money. The need is the same, the pressure comes from a different source.

From my experiences, it was clear that the approach could have great benefits for older people at the hospital/home interface. This can be a time at which the balance tips between someone being able to manage independently at home, even despite significant physical or cognitive deficits, and this fragile balance being disturbed to the extent that an individual becomes dependent on services or enters a cycle of repeated hospital admissions due to ‘not coping’. One of the challenges of working as an OT in a hospital setting where there is urgency for discharge, is that the focus is on the very basic activities of daily living required to get someone out of hospital, possibly including provision of equipment and recommending support services. There is limited time to explore coping strategies that an individual has already developed or to look at ways that valued activities could be maintained. To ensure safety, recommendations may be made that limit an individual’s activities or are not acceptable to them (Atwall et al 2008, Atwall et al 2012). This can result in an older
individual’s occupations being restricted in the interests of safety, without exploration of alternative activities or ways of doing things that could support independence, open up new horizons or allow valued activities to be maintained. The importance of being able to engage in personally valued activities and achieve a sense of self-efficacy is central to well-being, well-being is now recognized as central to lasting good health, and good health results in reduced use of health and social care services. This is an issue that needs to be addressed in order to gain the best outcomes for older people, for OT clinicians in terms of job satisfaction and for organizations in terms of best value for money and quality of services.

There are challenges to be met by OTs, by organizations and services within them in changing the way services are delivered, especially for services at the 'sharp end' or acute setting. Decisions need to be made about where and how OTs can deliver best value. There are also issues of skills and managing changes in practice. For example, some of the programmes I observed used therapeutic group work. To be a successful and therapeutic intervention, groups require their facilitator to have a high level of skill. All OTs learn these skills in their training, but in the UK, groups are most commonly used in mental health settings. Physical or hospital based OTs develop a different set of very specialist skills and may feel they would need to update skills in this area if they wished to develop groups as part of a programme.

OT interventions based on the Lifestyle Redesign® model have potential to be considered at any level. At a national and policy level, there is potential to explicitly recognize the role that OT can play in prevention and the health and wellbeing agenda. At organizational level, decisions could be made about the future direction of OT services in delivering the public health and prevention aspects of the organizations work. At organizational and service level, there is scope to re-evaluate the role and remit of OT services at this point in time and to incorporate the concept and practice of this approach. This could be targeted to specific areas or patient groups initially. At an individual level, it is possible for OTs to introduce some of the thinking and rationale to their interventions with clients and patients. It is a model of practice that ensures a person centred approach and maintains a clear focus on occupation.

Despite current financial constraints, changing policy has generated some ‘change fund’ monies in recognition of the need for short term additional resources to establish new ways of working (Scottish Government 2009), so this is an opportune time to bring new ideas to the fore. OT has a lot to offer to this new healthcare agenda. Lifestyle Redesign® inspired interventions have the advantage of having a well researched evidence base in some clinical areas and proving successful in a diverse range of practice areas. The approach is person centred and promotes health and wellbeing and is therefore clearly in line with the current policy direction in health care.

I am aware that many OTs are working in preventative roles already in the UK, so my comments are general and made with my own hospital based role and current
service developments in mind, but I am sure many will recognize the issues I describe.

**Conclusion**

It is clear that healthcare services are undergoing a significant change in response to changing population demographics and patterns of health and illness in the 21st Century. This change will certainly include a shift in the focus of many services from hospital settings to the community. Services for older people are at the centre of changes, as this age group is one of the most significant users of healthcare services. The current use of existing services, often involving hospital admissions, is expensive and can be detrimental to older people themselves.

There is recognition of the important role that professions such as OT can play in supporting these changes. OT is well established in the recovery or rehabilitation role where they are a familiar part of the multi-disciplinary team. It may be less apparent to those outside the profession that OTs have the training, knowledge base and skills to deliver programmes and interventions in innovative ways, including in preventative work.

The Well Elderly studies have been widely recognized. They set the scene by demonstrating that a preventative OT programme helped older people to remain healthy and independent for longer, thus reducing health care costs. They demonstrated the skill level required to deliver this complex intervention effectively, de-bunking the cliché that ‘keeping busy keeps you healthy’ (Mandel et al 1999). Lastly, the studies make a clear case for the role of OT in preventative healthcare, a vital component of the new policy direction.

During my visit my experiences allowed me to gain insight into the wider range of areas where this approach could be used. More specifically it gave me the opportunity to understand the approach in enough detail to provide the foundations for development of the approach to improve services and outcomes for older people at the hospital/home interface.
Actions and Recommendations

Actions

I will undertake to do the following:

International level

Publicise and encourage discussion about use of the approach for this client group in the OT profession and beyond. This will be achieved by:

- Continuing to post on my blog, including participating in the Blogging From A-Z Challenge 2012 during April. I will use this forum to further reflect on my experiences during the study visit and discuss ongoing developments.
- World Congress on Active Ageing 2012 – I will be presenting a poster at the congress in August 2012.

National level

Publicise and encourage discussion about use of the approach for this client group in the OT profession and beyond. This will be achieved by:

- Participating in the AHP National Delivery Plan consultation process.
- Disseminating information as widely as possible e.g. via the media (press release submitted), WCMT website (this report will be accessible via the website), COTSS-OP newsletter.

Local organisational and OT service level

I will disseminate information and encourage discussion about the potential demonstrated by my experiences. This will be achieved by:

- Presentations and feedback sessions both formal and informal
- Publication of news release in organisational staff newsletter (submitted)
- Utilise knowledge and skills to support service change

Individual/ Team Level

I will continue to develop my own practice to incorporate relevant aspects of this approach as far as current service design permits. I will share information with team members and encourage discussion as the process of service integration and continues.
Recommendations

Strategic Level

- That senior managers and policy makers should recognise and capitalise on the potential role of OTs in supporting the current policy shift towards preventative interventions and in the health and wellbeing agenda.

Organisational Level

- That the information from this report should be used to inform the debate around use of change fund monies, recognising the potential of this approach to support delivery of strategic and operational aims and objectives.

Service Level

That small-scale tests of change in line with organisational strategic direction should be considered. Examples of potential initial projects might be:

- Developing a targeted intervention for a population of older people with high readmission rates identified in liaison with Health Intelligence Dept.
- Developing current OT community rehabilitation and/or ‘follow up’ services for older people at the hospital/home interface to ensure a more ‘intentional’, evidence based and person centred approach.
- A structured approach to staff training, programme design and outcome measures would be essential components of any trial project.
A Personal Reflection

A Winston Churchill Memorial Trust Travel Award is much more than an opportunity to visit another workplace and learn about a new approach or technique. It is also a once-in-a-lifetime opportunity to grow and develop within one’s profession and as a person and to make connections across the world, that contribute to a deeper learning, understanding and development on both sides. I did not feel this report would be complete without a short personal reflection.

This study visit exceeded all my expectations. I learned so much and was made so welcome by everyone at USC. I had the chance to experience Los Angeles in a way that a short visit or holiday can never allow. I found it much more varied, beautiful and interesting than I had anticipated. I made friends and professional contacts that I feel confident will be long-lasting.

My reading, experience and learning about Lifestyle Redesign® has made me go back to my ‘roots’ as an occupational therapist, in terms of thinking anew about occupation and what it means to the people I work with, but also in considering it’s meaning in my own life and career in the light of 20 years experience. I believe this type of approach has a great deal of potential as healthcare moves into the 21st century. I have been privileged to have the opportunity to experience it in such depth.

Altogether the experience has been one I would recommend highly to anyone considering a travel award. I feel that I am now at the beginning of a new process of putting my learning into practice and I will continue to feel the benefits of the whole experience for a long time to come.
References


Scottish Government (2011) From Strength to Strength. Celebrating 10 Years of the Allied Health Professions in Scotland. UK.