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Is the use of life history and narrative in clinical practice reimbursable? Is it occupational therapy?

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THE ISSUE IS

Is the Use of Life History and Narrative in Clinical Practice Reimbursable? Is It Occupational Therapy?

Narrative and life history methods in occupational therapy offer practitioners an opportunity to understand what might otherwise remain an unspoken and informal part of therapeutic interaction. In contrast to the formal information about a patient's medical and psychosocial condition, therapists often gain insight into the patient's inner life (e.g., family background, favorite music, holiday and birthday traditions) through the spontaneous conversations that arise during treatment. This informal information is important to occupational therapists because it fills in the details about the patients they are working with and how the illness experience is affecting, and will ultimately affect, the patients' lives. Informally collected data invariably find their way into treatment interventions, informing the selection of treatment goals, activities, and outcomes.

The use of factors such as age, roles, values, culture, and interests to guide therapy has been a consistent theme in occupational therapy theories and frames of references (Miller & Walker, 1993) and has been demonstrated as a strategy therapists use to form ideas during the treatment process (Clark, 1993; Crepeau, 1991; Mattingly & Fleming, 1994; Peloquin, 1990). The use of case stories in the occupational therapy literature illustrate the central role of patients' stories in therapists' clinical reasoning (Clark, 1993; Crepeau, 1991; Mattingly & Fleming, 1994). The following is a description of such reasoning:

Since functional performance requires intention, physical action, and social meaning it is not surprising that people who concern themselves with enabling

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function have to address problems of the person's sense of self, sense of future, physical body, meaning, and social and cultural contexts in which actions are taken and meanings are made. Since these areas of inquiry are typically guided by different types of thinking, it is necessary that therapists become facile in thinking about different aspects of humans using various styles of reasoning. Thus, putting it all together for the whole person to function as a new self in the future is guided by complex and multiple forms of clinical reasoning. (Fleming, 1993, pp. 879-880)

Narrative and life history methods provide a language to define how therapists interact with patients, come to understand the complexity of the thera-

peutic issues at hand, and decide to deal with those issues in therapy. Terms such as life world, illness experience, and the patient's story are examples of this language. By putting these ideas into words, therapists are able to frame the problems they are seeing in clinical encounters and begin to generate treatment interventions to address them. The language of these methods also gives therapists a way to share their ideas about what is going on with a particular patient as they informally interact with their occupational therapy colleagues. In addition to influencing successful treatment outcomes in occupational therapy, life history and narrative methods also provide a way for therapists to discuss specific patient-centered issues with the family, members of the treatment team, and other professionals.

The Occupational Therapy Process

At each juncture of the occupational therapy process, narrative and life history data can provide the therapist with foundational information. The data can guide insight and fuel decisions regarding issues of evaluation, goal setting and treatment planning, and discharge.

Evaluation

In considering occupational therapy's inherent commitment to occupation, Clark and Larson (1993) strongly endorsed evaluation methods that allow the therapist to come to know the patient:

...of utmost concern to therapists would be evoking personal narratives from their patients that reveal the meaning the patient derives from particular occupa-

tions, how they chunk or enfold their occupations, and how their occupational patterns flowing through the stream of time fit into a framework of how they understand their lives... Therapists would also need to see illness and catastrophic injury not as isolated circumstances, but rather as a discontinuity within a framework of a total life (p. 55).

Occupational therapists use formal and informal assessments as their primary modes of inquiry: "Who is this person?" For example, formal assessments, such as the Occupational Performance History Interview (Kielhofner, Henry, & Walens, 1989), or informal assessments, such as the unstructured interview (Florey & Michelman, 1982), yield information about the patient, including his or her roles and skills, cultural and personal values, sense and use of time, personal responsibilities, and perceptions of self. Pursuing topics in conversation, such as how patients spend their time, what they think they are good at, how they cope with everyday stressors, and what they hope to accomplish in the next year, can be highly useful in uncovering themes of meaning within the patient's life history. With this type of information, therapists can identify the problems facing the patient and develop plans that will shape future treatment.

Goal Setting and Treatment Planning

In a discussion of the philosophical base of occupational therapy, Yerxa (1979) presented an analysis of Eleanor Clarke Slagle lectures "to identify the values contained within them" (p. 27). Focusing on values regarding patient-therapist interaction and the profession, Yerxa highlighted the role of the patient's perspective in the construction of therapeutic goals:

Occupational therapy's use of 'meaningful' and 'purposeful' activity places value upon the patient's view of meaning... the meaning of the activity, its choice, and satisfaction in it are determined by the individual patient's needs, interests and motivations. (p. 27)

In a later work, Yerxa (1980) considered the fit between the health care "climate" (p. 529) of the future and occupational therapy's "early mission of

caring" (p. 529), stressing the importance of "a 'mutual cooperation' model of therapist-patient relationship, in which the patient and therapist enter into a partnership" (p. 532). Implementation of such values requires that the therapist come to know the patient and the unique concerns that are most important to that patient.

Because of reduced lengths of hospital stays, a therapist may ask, "How can I use the narrative method when I have so little time?" We believe that these circumstances only magnify the urgency to know the person in order to more efficiently prioritize goals, reevaluate goals during treatment, and lay the foundations for discharge planning. In today's inpatient settings, it is common for occupational therapists to see patients as little as one time before they are transferred to the next setting or level of care. In many instances, the first occupational therapist to see the patient is faced with making decisions that will determine the type and frequency of occupational therapy services to be delivered at each succeeding health care juncture (e.g., home health care, outpatient services, community-based care). Similarly, in a school setting, the therapist may have only one session in which to evaluate a child before moving into a consultative role with the teacher to implement the occupational therapy treatment plan. This system of *triaging* occupational therapy services has only recently emerged as a role and responsibility for therapists (Burke & Cassidy, 1991). The use of narrative and life history methods to come to know and understand a patient's goals facilitates the coordination and delivery of care that can be given in health care's fast-paced climate.

Treatment

Narrative and life history methods are useful to both therapists and patients during treatment. While implementing treatment procedures, such as dressing and grooming training or fabricating a splint, a therapist can talk with the patient to determine the pattern of the patient's life before the injury or illness

and how the patient foresees the impact of the illness or injury on his or her future life. When the therapist works with a person with a new disability, narrative and life history methods serve as opportunities to address occupational therapy-related concerns. For example, during a splint fitting, the patient may talk about how awkward visiting hours with relatives are. The therapist may take this opportunity to provide input on behaviors the patient might use to reduce some of the emotional discomfort and isolation that is felt during family visits, for example, using whatever ice-breaking strategies he or she used before the disability when the interaction becomes awkward. Additionally, when a patient is performing activities that have been adapted to promote success, the therapist may take the opportunity to ask the patient to reflect on where else in his or her routines these current modifications or adaptations may prove useful. Thus, the patient is encouraged to reflect on his or her life roles, routines, and responsibilities and to evaluate the effectiveness of an adaptation in promoting his or her own meaningful occupation.

Discharge

Guided by the patient's goals for resuming occupational roles, narrative and life history methods can help therapists plan for realistic and innovative patterns of continuing care and discharge. In health care, the increased emphasis on managed care, competition, and accountability as well as shrinking resources (e.g., time, personnel, money) are forcing us to look at what we do and how our services influence functional outcomes (occupational performance). Beyond checklists, observations, and traditional evaluations, assessments that provide a personalized view of patients within the context of their lives (e.g., family members, available resources, strengths, needs) will also provide the most effective mechanism for framing evaluation findings and the most realistic baselines and goals.

A Refocusing on Occupational Therapy Concerns

Among the key questions that will be

voiced by our colleagues after reading last month's issue of the *American Journal of Occupational Therapy* (AJOT, 50[4]) devoted to the topic of narrative and life history in clinical practice are: (a) Is it really occupational therapy? and (b) Is it reimbursable? Given shrinking hospital and rehabilitation stays, is there enough time to use these methods? How will these approaches help treatment?

Is It Really Occupational Therapy?

Perhaps one of the most frequent reasons for dismissing the use of narrative and life history approaches is that occupational therapists see these methods as separate and different from those they use regularly in their work, something that must be added to their role as occupational therapists rather than being a natural part of their role. For example, occupational therapists specializing in physical disabilities may be more concerned with the patient's actual physical deficits than with his or her personally defined deficits and needs. These therapists' visions of the patient's problems may exclude the need to consider the patient's story, believing that it will keep the therapist from the work that must be done (as dictated by the specific physical deficits that are present with physical disability). Similarly, occupational therapy students and new therapists may also see narrative and life history approaches as burdensome, particularly if they have limited opportunities to develop the necessary patient interaction and psychosocial treatment skills.

The therapists in each of these examples have lost sight of their professional education and training and are delivering a fragmented therapy where only physical aspects of care are addressed. These therapists have forgotten that they are able to create treatment environments that are uniquely constructed to meet a complex array of patient needs. In addition, they are neglecting the importance of enlisting the patient's motivation in the therapy process. To evoke motivation, the therapist must turn to information gathered with narrative and life history methods

to ensure that the patient will be an active participant in his or her recovery. From our observation, when therapists seek to deliver patient-centered therapy, their concern with narrative and life history methods is much more evident.

Is It Reimbursable?

In discussing the use of therapeutic strategies, why do the treatment methods and modalities used to achieve goals become the focus of concern? In our experience, what is reimbursable is actual patient progress toward occupational performance outcomes, not specific discrete behaviors such as increased strength and range of motion. Without providing a real-life context (an understanding of how a discrete behavior fits into the life roles of the patient), progress is meaningless to a reimbursing. For example, documenting that a man is able to lift 20 lb on Monday, April 12, and 25 lb on Monday, April 19, is not demonstrating significant progress. What matters is that the context (the patient's job) requires that he is able to lift 25 lb repeatedly and that because of occupational therapy treatment, he is now ready to fulfill his job duties.

A woman who has a lower extremity amputation secondary to arteriosclerotic cardiovascular disease (ASCVD) is standing in therapy for 20 min. The patient has minimal responsibilities at home and participates in occupations such as doing crossword puzzles, watching game shows, and socializing with family members and neighbors. She has not been ambulatory for 5 years because of her ASCVD condition and history of poor cardiovascular response to standing activities. Before her current treatment, the only standing she did was to perform transfers (e.g., moving from chair to bed). Within the context of her life, we can see that the patient never stood for more than 5 min at a time. But this patient's occupational therapist has not addressed her occupational history. The therapist has developed a treatment regimen based on her knowledge of the condition being treated; thus, she is continuing to work on improving the patient's

standing tolerance as her occupational therapy program. To most insurers, this therapy is not reimbursable without a documented link to what the patient will be able to, or is able to do, in real-life settings as a result of therapeutic intervention. Again, what is missing in this patient's program is an understanding of the context (the occupational performance) for the therapy and the objective and measurable outcome.

Is There Enough Time?

If narrative and life history methods are going to be thought of as in addition to routine therapy services, then no, there is not enough time during treatment to add another demand. As it is, some therapists are finding themselves barely able to evaluate, treat, and plan for discharge within the narrow specifications of today's health care system.

If therapists are willing to reconceptualize their practices and consider these methods as a natural part of therapy, then yes, there is time. Our point here is that occupational therapists can create opportunities for patients to provide important details about their lives as they were before their accident or injury, the birth of their ill child, or the onset of their debilitating illness and as they hope to be when they complete therapy. By weaving this type of talking and thinking with the doing part of therapy, occupational therapists are able to concentrate their own attention on questions about the disease or disability from the vantage point of functional problems and how the effects of those difficulties can be reduced. This kind of complex multidimensional reasoning (i.e., considering questions of who patients are and what their lives will be now that they have a certain disease or injury) is not only commonplace but also essential to the occupational therapy process. The use of narrative and life history method is not a matter of it taking more or less time, it is a matter of being the essence of practice.

How Will It Help Treatment?

As suggested previously, narrative and life history methods are not done in

addition to therapy. They are part of therapy—the lenses that are used to elicit information about a patient to establish appropriate and realistic goals, facilitate the collaborative relationship between the therapist and patient, and keep the therapy focused on outcomes that are important and meaningful to the patient, caregivers, and family members. Therapeutic methods that help us design the most effective and efficient care seem to be particularly appropriate given the demands for high-quality, affordable, and cost-effective occupational therapy within the current climate of limited time, limited resources, shortages of therapists, and defensive posturing. The current movement in the health care environment of the 1990s is forcing us to get back to the heart of occupational therapy. It is time for us to give up the extraneous activities that others on the treatment team can do more inexpensively and begin to understand where our expertise is most effectively and affordably used. For example, in self-care training where occupational therapists evaluate, establish, and monitor the appropriate dressing techniques and methods for training (teaching the new technique, modifying the environment, fabricating a new piece of equipment), aides and assistants provide the actual routine tasks needed to establish and reinforce the skills.

Summary

Narrative and life history methods are deeply embedded in the occupational therapy process. The recent interest in and attention to these methods provide an opportunity for therapists to examine their routine practices and beliefs and consider some of the areas of patient practices that may have eroded over time. If we are to call ourselves occupational therapists, then our commitment

to persons and the value that they place on activities and occupations must remain foremost in our minds. The strategies endorsed in last month's special issue of *AJOT* appear to be closely aligned to our goal of helping persons reach their valued occupational performance.

Postscript

In the months since this article was completed, changes in the delivery of occupational therapy services have been further influenced by managed care practice, which has resulted in continued curtailment of patient services, including shortened lengths of hospital stays and limited therapy sessions. In response to these practice restraints, occupational therapists have experienced greater pressure to prioritize their therapeutic interventions. The use of methods such as narrative and life history are in greater jeopardy of being omitted as therapists question the relationship of these methods to the functional outcomes that are stressed by third-party reimbursers.

It is our belief that authentic occupational therapy requires the use of narrative and life history methods as part of occupational therapy practice. The challenge for our profession is to fit these methods into the lexicon of functional and physically measurable change. Hence, each therapist must accept the responsibility for ensuring that methods such as narrative and life history are preserved regardless of the environments they find themselves in and that the data gathered from using these methods are talked about and documented in useful, outcomes-driven, consumer-oriented packages. ▲

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