

What Happens at the Intersection of Policy and Practice?
Examining Role Conflict and Professional Alienation of
Occupational Therapy Professionals in Complex Environments

By
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ABSTRACT

To examine what happens at the intersection of policy and practice, this dissertation utilizes a three-article format to advance public administration scholarship and contribute to health system research about occupational therapy. This work creates bridging links between public administration scholarship in the areas of street-level bureaucracy and policy alienation and the occupational therapy profession. The articles combine to inform the occupational therapy community by providing empirical findings to validate role conflict and professional alienation experiences of practicing occupational therapy professionals when implementing policy in practice.

The Article One thesis asserts that while policy content matters, it is vital to understand the context of policy, and by extension, the context of practice as a response to policy implementation. Drawing on institutional theory, this work offers an historical review of policy-specific critical junctures in occupational history and how policy has influenced occupational therapy practice.

Article Two connects institutional theory, street-level bureaucracy scholarship, and policy alienation research to explain the experience of role conflict related to implementation of productivity standards for occupational therapy professionals.

Article Three utilizes street-level bureaucracy theory and policy alienation scholarship to provide the foundation for introducing “professional alienation” as an extension of policy alienation constructs. The article examines the extent to which occupational therapy professionals feel pressured to alienate core professional values, such as client-centered care, in practice.

Articles Two and Three present the empirical findings from this original research study, which employed online survey methodology to explore the relationship of professional profile characteristics and work context factors with the two dependent variables of interest – role conflict and professional alienation.

T-tests and multiple regression analyses indicate that professional profile characteristics such as professional credential/status and direct treatment provider designation influence role conflict and professional alienation. Work context factors that contribute to role conflict and professional alienation appear related to practice parameters and policy expectations in specific practice environments such as long term care/skilled nursing facilities and pediatric practice settings.

This study lends support for future research including frontline storytelling of occupational therapy professionals, exploration of context differences, and coping strategies of frontline workers.

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THE INSTITUTIONAL CONTEXT OF PRACTICE: REAPING BENEFITS AND UNANTICIPATED CONSEQUENCES OF POLICY

ABSTRACT

Occupational therapy resides in complex institutional environments bound by policy. While policy content matters, it is vital to understand the context of policy and, by extension, the context of practice as a response to policy implementation. Institutional systems (regulatory, normative, cultural-cognitive) and environmental components (institutional logics, actors, and governance structures) shape and are shaped by the interplay with the occupational therapy profession. Central to historical institutionalism, critical junctures signal key points in time that enact decisions, propel action, and establish policy in response to problems or events. Purposive responses often translate into path-dependent processes complete with both desired outcomes and unanticipated consequences. Occupational therapy's response to policy has directed our path toward hospitals, long-term care/skilled nursing facilities, and schools, while also constricting resources available in mental health settings and limiting our reach in community practice. Now, Vision 2025 challenges us to be forward thinking and shape the context of the next century of occupational therapy practice – another critical juncture!

In January 2012, the American Journal of Occupational Therapy (AJOT) debuted the Health Policy Perspectives column as a forum to share information and viewpoints about the impact of policy on occupational therapy. Lending support for the American Occupational Therapy Association (AOTA) 2017 Centennial Vision (AOTA, 2007), timing of the first column was deliberative and created an avenue for policy discussion at a critical time in policy implementation and health care reform. Indeed, “Health Care Reform Implementation and Occupational Therapy” (Braveman & Metzler, 2012) provided an overview of the Patient Protection and Affordable Care Act of 2010 (ACA, Pub. L. 111-148, 2010) and identified opportunities to promote and extend occupational therapy services, along with potential challenges to the profession in response to ACA implementation. Subsequent columns have illuminated health reform policy by presenting examples of related occupational therapy initiatives, elevating discussion about health and well-being for populations, and highlighting occupational therapy contributions to the Triple Aim goals of quality, access, and cost containment (Berwick, Nolan, & Whittington, 2008).

In the past, policy has opened windows of opportunity for occupational therapy; we are positioned to strategically and boldly move forward as we envision the next century for the profession. However, missing from the discussion is a broader consideration of the institutional context of policy – in effect, the context of occupational therapy practice – that empowers or constrains the profession’s influence and/or advancement in complex health and human service environments. We do not have foolproof forecasting abilities that predict the impact of the policy involvement on future occupational therapy practice; rather, we respond to critical junctures and prepare for consequences of our individual and collective actions – whether expected or unanticipated – to pave the way for professional inroads and legitimacy. Historically,

occupational therapy's response to reform-oriented policy has effectively carved out a place for our profession in the medical industry (hospital, long term care/skilled nursing facilities, home health) and within school systems. However, there are other examples of missed opportunities to extend the reach of occupational therapy and subsequent unanticipated consequences that have impacted and continue to impact the profession and occupational therapy professionals. In this paper, the author aims to address this void in the discussion and offer a health policy perspective that recognizes critical junctures and unanticipated consequences associated with policy implementation in occupational therapy. First, I review institutional structures that define the context of practice. Second, I reflect on critical junctures and pivotal policies that have impacted our profession's developmental trajectory. Third, I discuss possible unanticipated consequences for our profession and professionals. Fourth, I consider reform in the current policy climate as a "critical juncture" and a professional call for positioning and action.

The Institutional Context of Occupational Therapy Policy and Practice

As one of the "helping" professions, occupational therapy exists within a crowded and dynamic system of professions bound by institutional concepts and structures that legitimize our work and shape the context of practice (Abbott, 1988). With a specific interest in cultural and political organizational contexts, institutional theory helps explain the complexity of organizations and professions such as occupational therapy. Specifically, institutional theory examines social structures of organizations and institutional processes that become the authoritative standard or accepted assumption about organizational behaviors, relationships and jurisdictions that define and guide the work of an organization or profession (Abbott, 1988; Scott, 2001).

Scott (2001) presents institutions as resilient social structures designed to both support and constrain work of organizations and the people working within those institutions. Three pillars of institutions – regulative systems, normative systems, and cultural-cognitive systems – provide scaffolding to help explain the interdependent yet distinctive elements that influence policy implementation by occupational therapy professionals. To the extent that institutions constrain organizational and individual behavior, regulative systems operate coercively through rules, laws, and sanctions to ensure compliance. The normative system introduces values and norms that guide institutional behavior through social obligation and professional requirements such as certification and accreditation. The cultural-cognitive pillar represents the shared understanding and logic of action that ascribes meaning and legitimacy to the routine and culturally acceptable ways of doing work.

To the extent that organizations and professions require social and/or system legitimacy to survive, all three pillars individually and interdependently shape the context of policy and practice. For occupational therapy, federal government agencies such as Centers for Medicare and Medicaid and state level practice acts and regulatory bodies impose rules and laws that bind our work. Normatively, the National Board for Certification of Occupational Therapy constructs and administers the entry-level practice exam and permits use of occupational therapy practice credentials through continuing competency requirements; the Accreditation for Certification of Occupational Therapy Education defines entry-level practice expectations via entry-level program requirements. Related to the culture-cognitive pillar, professional membership in the American Occupational Therapy Association or state professional associations, local “communities of practice,” and organizational or departmental teams depict the messengers of professional advocacy and professionalism as well as partners that reinforce professional logics

and behaviors. When evaluating opportunities for policy development and implementation, it is important to conduct a wide environmental scan to identify this complex interplay of contextual features that surround our profession and either support or constrain our policy efforts and practice opportunities.

Expanding the discussion of institutions and organizational context, Scott's research examining changes in institutional environments of healthcare organizations introduces additional components of institutional environments: institutional logics, institutional actors, and governance structures (Scott, Ruef, Mendel, & Caronna, 2000). First, *institutional logics* are defined as the "socially constructed, historical patterns of cultural symbols and material practices, assumptions, values and beliefs by which individuals provide meaning to their daily activity" (Thornton, Ocasio, & Lounsbury, 2012, p. 51). Institutional logics constitute the organizing principles – the logic – that guide organizations and people as they strive to legitimate their field contributions and individual work. As guiding principles, institutional logics shape organizational behavior and individual action. Shared philosophies and practices define organizations and professions, therefore institutional logics shape individual and collective identity and organizational or professional commitment.

Next, *institutional actors* are individuals, categorical groups of people, or organizations that serve as carriers of institutional practices and create institutional stability or change through their actions and interactions. Within an institutional environment, actors contribute through their work or "material" and as carriers and shapers of a given logic, philosophy, or belief. That said, institutional environments shape actors while actors also work to incorporate their interests and influence governance structures that dictate practices. Finally, *governance structures*, not

necessarily government, serve as systematized rules and regulatory arrangements employed by designated jurisdictional authority to enforce organizational expectations and institutional policy.

Through Scott's work (2001), we understand that different models of organizational influence and oversight delineate governance structures. Models of note in healthcare environments include the market model, the state model, and the association model, with each holding greater authority and dominance at different points in history. The market model is fueled by the competitive exchange of goods and services for desired resources by organizations working to establish credibility, status, and power. The state model asserts its authority and responsibility for protection through laws, regulations, and sanctions. In the association model, specific interests and "ownership" of expertise that define professional jurisdiction and legitimacy distinguish associations. Using these models, key policy developments or other change in governance structures as points of demarcation, Scott identifies three distinct "institutional eras" of change in healthcare environments as a means to understand the historical context of institutional change. The eras of professional dominance (up through 1965), federal involvement (1966 to 1982), and managerial control and market mechanisms (1983 to present) mirror the association model, the state model, and the market model respectively. Occupational therapy history and evolution mirrors these same "eras." The discussion about institutional pillars and components of institutional environments highlights the interconnectedness among all elements with each influencing the others; the same is true for historical periods or events.

Understanding Critical Junctures in the Development of Our Profession's Path

Occupational therapy history provides a solid foundation for the future, yet history can only foster growth to the extent that we apply past field-level lessons when considering future opportunities and risks that move us forward. Under the guise of historical institutionalism, any

discussion about institutional development or change should give due attention to the historical nature of an institution's journey or path. An historical analysis of organizational development provides context for understanding events and decisions. However history alone is not critical in and of itself; it is most useful to the extent that the temporal processes inform the present and provide an enlightened picture of the future. Historical institutionalism recognizes that historical change is a process that happens over time and that the outgrowth of developmental change often results in formal rules, norms, and policy adopted by institutions. Generally, this type of discovery relates to the concept of "path dependence." As discussed by Pierson (2000), path dependence assumes recognition that patterns of *timing and sequence* are crucial when determining the effects of an event (the proverbial "timing is everything"); the notion of *contingency* or understanding that large consequences can result from small events happening at the right time; *multiple equilibria* as indicated by the idea that in early stages of a path-dependent process there is the possibility of a number of outcomes; and *institutional inertia* where once a given developmental threshold or increasing returns process has been established, what is in place will be resistant to change given that supporting conditions remain present (Hacker, 2002; Pierson, 2000). The degree to which these path-dependent processes intersect with "critical junctures" influences historical dynamics that have lasting consequences for political, economic, and professional development.

In Hacker's (2002) comparative study of public and private benefits within the context of pensions and health care, he argues that actors or organizations do not inherit a "blank slate" that is easily molded in response to changing preferences or power brokers; rather, the institutional choices made previously largely shackle the opportunities for change or alternate paths. In his view, "developmental trajectories are inherently difficult to reverse" (p. 54). The path-

dependence process does not necessarily point to a static or impenetrable path, although there are paths that are more difficult to change than others. It is clear that institutions do often engage in self-reinforcing processes that make a decision to change course or policy either unattractive or costly, specifically in terms of the complex interdependency of many institutional decisions (reimbursement, networks, identities, legitimacy). According to Pierson (2000), “as social actors make commitments based on existing institutions and policies, their cost of exit from established arrangements generally rises dramatically” (p. 259). Again, a path-dependent process does not have to imply an absolute “lock in” or “lock down” of an institutional policy or decision due to committed resources or movement along a self-reinforcing path. Instead, we can use knowledge gained by identifying self-reinforcing processes to understand the barriers and constraints that make a given policy or path so persistent and resistant to change. With this understanding, there is an opportunity to “undermine a self-reinforcing trajectory by weakening or overwhelming the mechanisms that encourage continued movement down that path” (Hacker, 2002, p. 54). This suggests, “change continues, but it is bounded change” (Pierson, 2000, p. 265).

Not all institutions are as susceptible to path-dependent processes as others. Hacker (2002) presents the following as conditions likely to encourage path-dependent processes: (1) policy creates or encourages large organizations with significant start-up expenses; (2) policy benefits affect substantial organized groups or constituencies; (3) policy promotes future-bound commitments that are the foundation for life and organizational decisions by policy beneficiaries; (4) institutions and policy expectations are woven through complex networks, often with notable societal and economic impact; and, (5) the characteristics of the policy context make it difficult to recognize and respond to unintended or consequences (p. 55). As we become a more networked society, these features are increasingly prevalent in all work sectors (public and

private, government and non-government, profit and non-profit), across organizations, within the system of professions, and for occupational therapy.

Related to this discussion of critical junctures and path-dependent processes is the notion of unanticipated consequences in response to social actions, policy decisions, and professional choices that guide behavior and practices. In Merton's classic work (1936), "The Unanticipated Consequences of Purposive Social Action," he conceptualizes that action within organizations is purposive and results in anticipated or unforeseen and unanticipated consequences. In his analysis, he does not assume good or ill intent, nor does he suggest "unanticipated" necessarily correlates with negative or unwelcome outcomes. Indeed, some unanticipated consequences prove fortuitous to given beneficiaries. Further, he purports that "rationality" does not necessarily link with purposive action, nor does it eliminate unanticipated consequences. Decisions are made and actions taken within the context of existing (albeit often incomplete) knowledge with allowance for error in judgment and acknowledging that some actions elude rational action in favor of "immediacy of interest," rules, and established norms (p. 901).

Unanticipated consequences of our profession's responses to institutional policy and organizational directives include: alliances with medical model payment streams that limit our flexibility in thinking and doing; subordinate positions in hierarchical service delivery models; and the experience of role conflict or policy alienation by frontline occupational therapy professionals during policy implementation (Tummers, Bekkers, & Steijn, 2009). Alternatively and positively, policy has secured occupational therapy as a required rehabilitation profession and related service provider in "traditional practice settings" such as hospitals and schools; status and salary ensure an occupational therapy workforce committed to "make a difference"; and

communities of practice provide a supportive climate of colleagues to affirm frontline practice decisions and professional identity.

In policy and practice, we must assume a forward thinking posture, engage in a culture of trust, and strategically position our profession to identify and capitalize on critical junctures. Our willingness to use history as a springboard for our future is sometimes tentative, particularly when we encounter rules, logics, and expectations that are unfamiliar or challenge our professional ethics, core values, and foundation principles. While this author humbly defers to our profession's historical scholars for a thorough discussion of historical events within institutional eras and implications for our profession, the next section offers select attention to the importance of history in institutional development and the impact of an organizational or professional response at critical junctures.

Shaping Our Profession – Implications of Policy on Practice

On March 15, 1917, a diverse group of like-minded professionals connected by a belief in the health and healing properties of engagement in meaningful daily life tasks or occupations founded the profession of occupational therapy. Grounded in humanistic principles, the founders espoused the rewards of moral treatment and humanitarian approaches, recognized the therapeutic effect of satisfying labor on mind and body, and proposed the graded use of arts and crafts in treatment with individuals that were physically or mentally ill. Situated in the Progressive Era and influenced by the settlement house philosophies seeking to solve social and work problems of the industrial age, occupational therapy was closely link to the work of Hull House and the Chicago School of Civics and Philanthropy's mission to "promote through instruction, training[,] investigation and publication, and the efficiency of civic, philanthropic and social work and the improvement of living and working conditions" (Loomis, 1992, p. 34).

With solid footing in the humanistic philosophy and social reform movements of the day, occupational therapy would find itself at odds with the burgeoning scientific medicine ideology coming forth during the same time period as the scientific management movement (Taylor, 1912). Related to the focus on scientific management was the growth of a mechanistic view of society, and subsequently medicine, thereby providing philosophical justification for dismissing individual differences and human qualities. Finally, the expansion of scientific medicine and the emergence of a hierarchical model dominated by doctors solidified the physician as the “superior” in the medical model while relegating nurses and related professions such as occupational therapy to subservient roles within the health care hierarchy (Colman, 1992).

For occupational therapy, the hierarchical arrangement within the medical arena was solidified early through the requirement for a physician’s “prescription” for an occupational therapist to evaluate and treat. In part, this medical marriage contributed to the shift from the profession’s community-based, socially grounded work to a science-focused, institutional frame to address engagement in meaningful activities. Time would tell if and how this shift in philosophy would affect our professional work and legitimacy within the system of professions – the stage was assuredly set for future growth and certain conflict. Critical junctures noted above created the early landscape that would be instrumental in the ongoing development of occupational therapy.

Undoubtedly, significant social, cultural, economic, and political events have the capacity to act as critical junctures for a profession, but equally critical are the responses to events or injustices through legislative actions and progressive policy designed to bring about change. For purposes of this discussion, we adopt the definition of “progressive” as “favoring or advocating progress, change, improvement, or reform, as opposed to wishing to maintain things as they are,

especially in political matters” ([“Progressive,” 2016](#)). In part, policy has shaped the context and practice of occupational therapy by supporting development of occupational therapy personnel, securing payment for occupational therapy services, ensuring access to occupational therapy services, and supporting participation in meaningful engagement in daily life through reduction of barriers. Examples of legislation that have influenced the path of occupational therapy include, but are not limited to, the Vocational Rehabilitation Law of 1918, the Rehabilitation Act of 1954, the Community Mental Health Centers Act of 1963, the Medicare Act of 1965, the Education of the Handicapped Act (PL 94-142) of 1975, the Technology-Related Assistance for Individuals with Disabilities Act of 1988, the American with Disabilities Act of 1990, and the Balanced Budget Act of 1997. Each of these legislative actions instituted policy that had a direct effect on occupational therapy – on the work of the profession, on our jurisdiction, and on competition within the system. In some cases, such as the passage of the Rehabilitation Act of 1954, the Medicare Act of 1965, and PL 94-142, professional jurisdiction was expanded, work shifted, and professional relationships within a given system redefined.

Looking to the 2015 AOTA Workforce Study, we see that 68.7% of survey respondents work in hospitals, long-term care/skilled nursing facilities, and schools – more than two-thirds of all occupational therapy professionals work in settings largely affected by the three legislative acts just mentioned. Conversely, only 2.2% of occupational therapists work in mental health today– significant in light of our professional roots in the moral treatment era and statistics that show 54% of occupational therapists worked in mental health in 1950 (AOTA, 2015; Reed, 1993). Next, let’s consider select policies and their impact on the context and contributions of occupational therapy, along with unanticipated consequences that secure and challenge our profession.

Critical Juncture – Medicare Act of 1965

In the wake of the Great Depression, the Social Security Act of 1935 was initiated with the expressed intent to provide financial assistance in the form of employment insurance and insurance for aged needy individuals. Thirty years and multiple amendments later, Public Law 89-97 established Medicare which ensured “hospital insurance” covering a range of inpatient hospital services and skilled nursing facilities for the elderly and other categorically identified groups while creating opportunities in home health and outpatient rehabilitation for occupational therapy. With policy implementation designed to ensure universal healthcare for the elderly, the healthcare environment was pushed to respond to health service needs of the fastest growing population in the United States and to do so largely within long term care/skilled nursing facilities (LTC/SNF) and home health environments. Questions regarding service context, service delivery models, and payment for facility care, nursing, and therapy service providers left room for policy interpretation, implementation, and ultimately, system abuse. Until 1997, Medicare utilized a retrospective cost-based model structured to cover routine services and related costs but without guidelines or limits for use of related therapy services.

Faced with a booming elderly population and growing concerns about payment fraud and abuse, the Balanced Budget Act of 1997 ushered in a new payment era utilizing a prospective payment system (PPS) that targeted skyrocketing costs for Medicare services. While the Center for Medicare and Medicaid Services (CMS) made payment related policy changes to address the growing costs, the cost saving measures meant deep cuts in Medicare payments to long term and skilled nursing facilities. As a result, there were industry-wide closures of facilities, reduction in staff and related service providers, and reports of reduced quality of care (Konetzka, Yi, Norton, & Kilpatrick, 2004). Central to the PPS was the introduction of the Resource Utilization Group

(RUG) system grounded in time and efficiency studies aimed at cost-containment; this system remains in place today. Although instituted to reduce costs, the most recent 2013 RUG utilization, payment, and charges data has prompted CMS to increase scrutiny on therapy services in skilled nursing facilities to ensure patient need rather than profit margins drive service delivery (AOTA, 2016). This investigation takes place parallel to mounting concerns expressed by occupational therapy professionals about unrealistic productivity standards in long term care/skilled nursing facilities (AOTA, 2014a; 2015b). Currently, the LTC/SNF context stands as the fastest growing and overall highest primary work setting at 25.8%; 55.9% of occupational therapy assistants and 19.2% of occupational therapists report working in the LTC/SNF arena (AOTA, 2015)

Considering these historical markers as critical junctures, we recognize that our profession has embraced opportunities afforded us as rehabilitation therapy service providers through these policies. However, we have also been constrained by reimbursement methods and shaped by the tug of war between competing institutional logics, resulting in unanticipated consequences. As a profession, we enjoy inclusion in core rehabilitative teams in hospitals and skilled nursing facilities and individually find financial reward in competitive compensation. Subsequently, the payment promise of government supported health insurance and private payers have dictated service delivery related to treatment approaches, documentation of therapy, and practice settings. Related, reimbursement and cost containment strategies such as productivity requirements are directing changes in scope of practice, threatening quality of care, and challenging our professional ethics and values (Howard, 1991; Jongbloed & Wendland, 2002). Occupational therapy professionals often find they experience ethical tension and role conflict when caught between their altruistic commitment to support client goals and policy directives to

support organizational profit margins (Foto, 1988). While AOTA has been responsive to membership requests for support and information related to ethical decision making and policy when faced with pressure to compromise quality care, this issue remains a high priority and area of concern for individual frontline practitioners, mid-level managers, volunteer leadership, and AOTA lobbyists and staff.

Critical Juncture – Education for All Handicapped Children Act of 1975

In 1975, the Education for All Handicapped Children Act (Public Law 94-142) changed the context and approach to rehabilitation for children with disabilities by moving the locus of service delivery from institutions and hospitals to school systems. Temporally and philosophically, this educational reform policy was consistent with civil rights legislation and deinstitutionalization practices highlighting rights of all people to experience and enjoy life in the least restricted environments possible. Prior to PL 94-142, services for children with disabilities were often inadequate or provided in institutional environments such as pediatric rehabilitation centers. Specific purposes of PL 94-142 were to guarantee that all children with disabilities receive a free, appropriate public education with required related services, adequate resources for special education needs, and assurances of protection of consumer rights in policy implementation. Mandated by this law and subsequent reauthorizations of the Individuals with Disabilities Education Act of 1997 (IDEA), occupational therapy is identified as a related service provider, thereby opening the door for occupational therapy as a primary therapy serving the pediatric population within school systems. With the shift in pediatric service delivery context, reimbursement, and employment opportunities, occupational therapy professionals followed suit.

In AOTA's most recent Salary and Workforce Survey report (2015), 19 percent of occupational therapy professionals identified schools as their primary work setting. Schools

represent the third highest employer of occupational therapy professionals overall behind long term care/skilled nursing facilities and hospitals. While the demand for occupational therapy personnel in school systems increased, so did the press for occupational services and the special education community to reconcile the medical model logic with ability models and task analysis and environmental medication approaches (Ottenbacher, 1982). Related to these policies, “unanticipated consequences” manifest in challenges experienced by occupational therapists and occupational therapy assistants in their daily work.

On the frontlines of occupational therapy practice in schools, the philosophical integration between occupational therapy and special education ideology or models remains an underlying source of conflict. Many occupational therapy providers struggle in this relationship due to competing agendas (meeting standardized test benchmarks prioritized over student ability and development goals), administrative directives dictating service parameters (direct vs. indirect service; therapy minutes and caseload requirements), and different service expectations regarding process approaches and goals (inclusion or “pull-out” model; therapy focus on task/environment adaptations or remedial approaches). Depending on administrative leadership and organizational/system culture, these conflicting values and disparate expectations can create pressure to deliver occupational therapy services in a way that compromises the core values of the occupational therapist or occupational therapy assistant. Further, these pressures constrict the ability of some occupational therapy professionals to assert professional power by silencing their advocacy voice and limiting the extent to which they demonstrate professional ideals of evidence-based practice and client-centered care when working with children and families. Although the “fit” has been challenging, occupational therapy makes valuable contributions to meaningful life engagement through service for all children in schools and their families.

Critical Juncture – Community Mental Health Act of 1963

During occupational therapy's formative years, occupational therapy in psychiatry was recognized as a professional stronghold through our early presence in acute inpatient units and state hospitals serving individuals with serious and persistent mental illness. In the next fifty years, we would see reduced numbers of occupational therapy professionals working in mental health, changing resource priorities within the profession, and movement in service delivery from hospitals and institutions to community settings (Bonder, 1987). Authoring one of the feature articles in the 50th Anniversary Edition of the American Journal of Occupational Therapy, occupational therapy visionary Wilma West (1967) identified that rapid social and political change were prompting shifts from the traditional medical or illness focus to a philosophy of health, along with changing treatment and cure approaches to prevention strategies. This emerging philosophical shift from illness to health emphasizing the importance of disease prevention and health maintenance also highlighted the necessary shift in service delivery setting from hospitals and institutions to community health, education, and social support contexts. According to West (1967), "our changing responsibility to the community" (p. 312) would require occupational therapy professionals to engage with clients and community/public health partners through emerging roles and a different practice lens. She challenged us to prepare and respond to the changing context of practice dictated by policy change. While this charge from occupational therapy leadership aligned with social, cultural, and political changes of the time, the profession was not positioned to respond at this critical juncture in our history.

The Community Mental Health Act of 1963 legislatively authorized establishment of community mental health centers and jumpstarted the deinstitutionalization movement in mental

health. This mandate prompted mass state hospital closures and large scale movement of patients or “residents” from familiar institutional environments to ill-prepared social service organizations and living communities. This single piece of legislation required significant philosophical, policy, payment, and practice shifts that would affect patients and professionals alike. While other professions responded through focused and timely research, lobbying, and exploration of new practice areas, the occupational therapy response in the face of deinstitutionalization was largely ineffectual. At this critical juncture, we were not prepared; we struggled to envision ourselves outside of familiar practice models and contexts.

Coincidentally, the big shift out of mental health arenas and the growth of occupational therapy practice in physical medicine environments occurred at nearly the same time – while mental health was deinstitutionalizing and physical medicine was gaining steam and maintaining dominance in the healthcare arena. Collectively, our resistance to or lack of readiness for change contributed to a major reduction in the occupational therapy presence, therapeutic contribution, and subsequent influence in the mental health arena. Present day leaders are championing a resurgence in occupational therapy within mental health by building capacity and confidence of occupational therapy professionals to meet needs of children with mental health needs (Bazyk et al., 2015) and working to ensure occupational therapy involvement the developing community mental health initiatives and federal policy (Stoffel, 2013). Further, the profession’s volunteer leadership and AOTA continue to articulate our role and distinct value in mental health in policy discourse and encourage frontline practitioners to insert occupational therapy into all mental health solutions (AOTA, 2013).

Another Critical Juncture – Now!

AOTA's Vision 2025 claims, "Occupational therapy maximizes health, well-being, and quality of life for all people, populations, and communities through effective solutions that facilitate participation in everyday living" (AOTA, 2016a, para. 1). While the intent of any vision is to fix our eyes and efforts forward, occupational therapy's "new" vision represents philosophical ideals asserted by occupational therapy founders in 1917. Over time, the constancy of strategic planning efforts, calls for action for grassroots advocacy, commitment of resources to ensure an occupational therapy seat at the policy table, and questions about the distinct value of our profession's contributions remind us to be vigilant and responsive when standing at critical junctures.

Since its founding, public policy has shaped occupational therapy practice as we have responded to critical junctures and capitalized on windows of opportunity to secure our presence on relevant health and human service policy agendas. Capoccia and Kelemen (2007) state that critical junctures are building blocks for institutional change yet are actually rare events over the course of institutional life. Critical junctures often provide windows of opportunity – the timely merger of problems, proposals, and political streams – that trigger change or institutionalize path-dependent processes in response to historical turning points (Kingdon, 2002). Whether evoking incrementalism, sequenced development, or revolutionary change, critical junctures expand the range of options available as solutions to problems and elevate the impact or consequences of choices made during these key windows of opportunity. As highlighted in AOTA's Health Policy Perspectives column, the Patient Protection and Affordable Care Act of 2010 provided a window for demonstration of occupational therapy's distinct value related to population health outcomes, life participation goals of clients, and meeting the Triple Aim goals

(Berwick, 2008; Patient Protection and Affordable Care Act, 2010). With results of the November 2016 presidential election, there is much speculation about the fate of ACA benefits and opportunities. Likely, we stand at another critical juncture as the new administration vows to repeal and replace this act with legislation that will support a market-based alternative touted to increase efficiency, contain the rising cost of health care, and “empower” consumers to manage their health and healthcare spending. Even though there is uncertainty about future policy directives, occupational therapy can position itself to respond to policy changes and insert our profession on relevant policy agendas as part of the solution.

Considering occupational therapy’s path and the influence of policy on practice, it is important to understand how the profession has responded to critical junctures and determine if our responses have positioned us to serve clients, communities, systems, and the profession. When feeling constrained by institutional environments comprised of regulative, normative, and cultural-cognitive systems, we have opportunities to evaluate the history of decisions and the impact of decisions within and in response to defined systems. Neo-institutionalism suggests that many strategic plans and structural decisions are made without particular concern for efficiency or commitment to an organization’s core principles or mission; rather, they are initiated to accommodate oversight requirements and respond to mounting external pressures (Frumkin & Galaskiewicz, 2004). When planning for change under pressures of institutional isomorphism, we have opportunities to be strategic in our planning and intentional in system interactions. Even though the path we choose might indeed be dependent on past decisions, our present or future path does not have to be locked into only one action or outcome. Hacker (2002) states, “existing policy or institutions are not necessarily a reflection of the current constellation of factors surrounding it, much less a functional response to them” (p. 53). It is vital that occupational

therapy maintains a future focus and actively engage in the development and implementation of policy that benefits the profession and consumers of occupational therapy.

Closing Thought Piece

The following quote provides a challenge for occupational therapy as we seek to remain a viable profession within the systems where we currently have jurisdiction, explore systems where we must boldly assert ourselves, and be active and influential in policy and practice decisions that reflect our historical roots and aspirations for the profession:

At this point I feel compelled to say I believe we are now at a very critical and strategic place in our profession's work. We are compelled to make some rather fundamental and far-reaching decisions with respect to our philosophy, our policies, and our practice; and upon the results of our decision our program will either be expanded and more completely integrated into our social order, or it will be more definitely segregated, specialized, and restricted. (Lee, 1933, p. 84)

At this critical juncture, our profession's future path depends on our decisions.

ROLE CONFLICT ON THE FRONTLINE: WHEN PRACTICE AND POLICY COLLIDE

ABSTRACT

Occupational therapy professionals working in complex health and human service environments often experience role conflict when working within policy parameters such as productivity standards.

Objective: This original research examines the conflict between policy, organizational, professional, and client expectations experienced by occupational therapy professionals related to productivity standards. This study sought to understand role conflict when implementing reimbursement policy, the association between professional profile characteristics and role conflict, and the impact of work context factors including practice settings on the role conflict experience.

Method: Through electronic survey distribution to occupational therapy professionals in one Midwestern state, the researcher examines the relationship of professional profile characteristics and work context factors with role conflict.

Results: T-tests and regression analysis indicate practice credential, work function, employment status, and practice settings influence role conflict related to productivity standards.

Conclusion: From this study, it is apparent that organizational context and frontline worker status contribute to role conflict. Further research and workforce support are warranted.

As a profession, occupational therapy exists within increasingly complex health and human services environments in response to societal change, health care reform, educational mandates, and professional evolution. In these institutional environments, implementation of policy mandates and organizational directives often introduces tension or conflict, which challenges the commitment of individual occupational therapy professionals to engage in authentic practice. When implementing policy, some occupational therapists and occupational therapy assistants share that they feel pressured to compromise professional ethics, overlook quality standards, or abandon core professional principles in support of organizational mission statements or fiscal bottom lines. Faced with multiple logics, such as balancing efficiency-driven or profit-focused business models with the professional logic of care, occupational therapy professionals may experience ethical tension and role conflicts. Anecdotally, some frontline practice stories associate this kind of pressure with the implementation of productivity standards as a guide for workload expectations and reimbursement. Presently, the occupational therapy profession lacks information to understand more fully the nature of this problem and the extent to which frontline occupational therapy professionals are conflicted in their daily work. This article seeks to advance the discussion and scholarship about how occupational therapists and occupational therapy assistants experience conflict at the intersection of policy and practice.

Health policy and systems research is an emerging area of study that “seeks to understand and improve how societies organize themselves in achieving collective health goals, and how different actors interact in the policy and implementation processes to contribute to policy outcomes” (World Health Organization, 2016, para. 1). Occupational therapy does not have a strong track record of health policy and systems research about the impact of policy on practice in health, education, and community systems. In 2011, AOTA and AOTF joined forces to craft

the Occupational Therapy Research Agenda, prioritizing intervention research, translational research, and health services research as part of their shared vision for scholarship. This agenda serves our profession's effort to solidify our occupational science base and establish evidence to prove efficiency and efficacy in occupational therapy services. Yet in occupational therapy research, there is a paucity of studies examining the impact of organizational contexts on practice or the experience of occupational therapy professionals during policy implementation in their daily work. This study aims to contribute to health policy and systems research through interdisciplinary scholarship merging public administration and occupational therapy.

This article examines the literature related to organizational contexts and institutional complexity as a frame for consideration of role conflict during policy implementation by occupational therapy professionals. First, I consider complex health and human service organizations through the lens of societal change and institutional structures. Second, I conceptualize occupational therapy professionals as frontline workers and apply constructs of role conflict to occupational therapy professionals as policy implementers of productivity standards. Third, I outline study methods for addressing the research questions and propositions; results and discussion will follow. The article concludes with discussion about implications for occupational therapy and evolving health policy and systems research through public administration and occupational therapy scholarship.

Health and Human Service Organizations as Complex Systems

Health and human service professionals, including occupational therapists and occupational therapy assistants, inhabit complex organizations and work under conditions of societal change, professional expectations, and contextual challenges. At the societal level, professionals feel the impact of sociodemographic changes associated with immigration,

segregation, and population shifts in terms of family structures, lifestyles, religious beliefs, and other characteristics. Additionally, changes in economic conditions, service technology advances, government, political ideology, and institutional focus challenge organizational and individual service provision efforts (Hasenfeld, 2010). Interestingly enough, striking similarities exist between these present day changes and the “significant problems” forecast to affect occupational therapy fifty years ago – education, minimum wage legislation, automation and unemployment, inflation and the balance of payments, population explosion, and Medicare (Davidson, 1967, p. 213). Although external to organizations, past and present changes shape institutional policy, organizational practices, professional legitimacy, and individual behavior.

In response to challenges of organizational complexity, institutional theory suggests that there is potential for growth and conflict at the intersection of stability and change. Scott (2001) asserts that institutions are social structures designed to both support and constrain work of organizations and the people working within institutions. Three pillars of institutions – regulative systems, normative systems, and cultural-cognitive systems – provide scaffolding to explain the interdependent yet distinctive systems that influence policy implementation and the work of professionals. Regulative systems operate coercively through rules, laws, and sanctions to ensure compliance. The normative system introduces social obligation and professional requirements as the values and norms guiding institutional behavior. The cultural-cognitive pillar represents the shared understanding or logic of action that ascribes meaning and legitimacy to the routine and culturally acceptable ways of doing things. Related to occupational therapy, regulatory directives come through our state practice acts and federal health and education service laws. Accreditation standards and certification requirements create normative obligations. Communities of practice, mentors, and lateral peer colleagues represent cultural-cognitive systems.

Parallel to institutional pillars, Scott and colleagues' (2000) research about changing healthcare organizations introduced three additional components of institutional environments to encourage deeper analysis of organizations: governance structures, institutional logics, and institutional actors. Related to regulative systems, governance structures are the systematized rules and arrangements employed by designated jurisdictional authority to enforce organizational expectations and institutional policy. Institutional logics constitute the organizing principles, beliefs, and practices – the logic – that guide organizations and people as they strive to legitimize their field contributions and individual work. Institutional actors are individuals, categorical groups of people, or organizations that serve as carriers of institutional practices and create institutional stability or change. Together, institutional components interact to bring about action that defines institutional environments.

Although distinct, institutional components are interdependent with institutional actors influencing logics, institutional logics drawing in receptive actors, and governance structures codifying real or desired work of actors and logics. Related to occupational therapy, this interdependence is noted between interprofessional and intraprofessional colleagues, multiple practice ideologies, and laws and oversight organizations sharing the same institutional space. Further, tension between stability and change provides fertile ground for conflict at the policy, organizational, professional, and client levels. As presented by Scott, the healthcare environment serves as one example of highly complex health and human service organizations. I examine the impact of these system complexities through the case example of occupational therapy and occupational therapy professionals.

Occupational Therapy Professionals as Frontline Workers

Uniquely positioned on the frontline or “street-level” of complex health and human service organizations, occupational therapy professionals – occupational therapists and occupational therapy assistants – are institutional actors with power to influence the fabric of institutional environments. As frontline workers, occupational therapy professionals live out the intersecting reality of policy and practice in complex health and human service environments – according to Lipsky (1980), occupational therapists and occupational therapy assistants are “street-level bureaucrats.” Institutional logics and organizational contexts defined by governance structure and organizational hierarchy shape the behavior and beliefs of frontline workers, such as occupational therapy professionals. At the same time, individual practice decisions and professional philosophies and technologies demonstrated by organizational members shape organizational procedures and institutional rules.

Field-level work happens on the frontline of practice where institutional actors model their profession, shape their practice, push innovative technologies, influence organizational socialization, and serve clients. In the field, pragmatic “real-life” challenges, professional accountability, and competing values or expectations place frontline workers in a distinct position to influence the lives of people as part of routine work. Frontline professionals might experience friction between professional ideals or values and the needs or goals of clients. Competing values often lead to conflicting identities and roles (Maynard-Moody & Musheno, 2003). Role conflicts and a push to act in a manner inconsistent with one’s core public service ideology or professional values can lead to policy alienation (Tummers, Bekkers, & Steijn, 2009). Even within complex and sometimes conflicting organizational environments, occupational therapy professionals working on the frontline have an opportunity to influence

institutional logics, practice technologies, and professional contexts through policy implementation in their everyday practice.

Role Conflict on the Frontline

From public administration scholarship, Tummers et al. (2009) conceptualized policy alienation to describe the disconnect from policy by public professionals, particularly frontline workers. The three dimensions of policy alienation are: (1) policy powerlessness (strategic, tactical, or operational levels), (2) policy meaninglessness (societal or client levels), and (3) role conflicts that manifest when faced with competing institutional logics, demands, or goals. Three types of role conflict that public professionals might experience during policy implementation include policy-professional, policy-client, and organizational-professional role conflicts (Tummers, Vermeeren, Steijn, & Bekkers, 2012). Policy-professional role conflict occurs when faced with policy demands that are incompatible with one's professional principles or values during policy implementation. Policy-client role conflict emerges when the behavior or response required of the professional by the policy is inconsistent with the role behaviors expected of the professional by the client. Organizational-professional role conflict manifests during policy implementation at the organizational level when organizational demands are incongruent with one's professional principles, values, or behaviors. Policy-professional role conflict and organizational-professional role conflict are related but distinctly different; policy-professional conflict centers on policy content and organizational-professional conflict centers on policy implementation. For this research, occupational therapy is the profession of interest; the role conflict experience of occupational therapy professionals when working to reconcile productivity demands and professional ideals or values in practice is the issue of concern.

Regarding health professionals collectively, several studies have examined role conflict and tension associated with ethical dilemmas, competing institutional logics, limited organizational resources, and dissonance related to their ability to assert professional judgment and misaligned professional-management values or system demands (Gaudine & Thorne, 2012; Maben, Latter, & Clark, 2006; Nowak & Bickley, 2005). Highlighting challenges in reconciliation of disparate logics, Smith and Donovan (2003) explored the everyday practice experience of frontline child welfare caseworkers to gain a better understanding of the impact of institutional expectations and organizational pressures on implementation of best practice. According to study participants, time constraints and dominant, competing institutional logics leverage pressure which limits use of effective intervention approaches such as family-centered care and strengths-based approaches in practice and creates role conflict for caseworkers. Chiarello (2014) examined how pharmacists make decisions and exercise discretion when faced with discrepant logics associated with managed prescription medications in their daily work. While pharmacists' training includes a medical focus on pharmacological intervention with clients, the reality of frontline practice when dispensing prescriptions requires a legal lens as well. Pharmacists recognized the conflicting ideology and exercised discretion when choosing how to respond to competing logics. Growing research in nursing and other health professions are examining the prevalence of moral distress in their workforce, possible ethical tensions as sources of distress, and the impact of context on role conflict in practice (Penny, Ewing, Hamid, Shutt, & Walter, 2014).

As a profession, occupational therapy withstands conflict when advocating for inclusion in federal policy and state law, introducing innovative therapy programs in organizations or community, and engaging in client-centered and occupation-based practice in the workplace. For

occupational therapy professionals, role conflicts can occur when policy dictates payment streams, when vying for positions within hospitals or allocation of scarce resources, when voicing concerns about patient discharge plans, or when driving philosophical change within a department. When conflicted, occupational therapy professionals often experience ethical tensions related to resource and systems issues, upholding ethical principles and values, client safety, working with vulnerable populations, interpersonal conflicts, upholding professional standards, and practice management (Bushby, Chan, Druif, Ho, & Kinsella, 2015).

In her American Occupational Therapy Association's Inaugural Presidential Address, Lamb (2016) acknowledged the pressures of current practice contexts and that some occupational therapy professionals experience these conflicts in their work yet challenged each practitioner to remain authentic in his or her practice. Specifically, productivity pressures abound and test our resolve to embrace and not alienate from our professional principles and values. Issues commonly associated with organizationally imposed productivity standards include pressure to engage in unethical billing practices, underassessment of a client's functional performance to allow/require provision of unnecessary or inappropriate therapy minutes, and working to meet unrealistic productivity standards at the expense of client-centered care or ethical principles (AOTA, 2014b). Admittedly, the stories from the frontline raise concern about the state of distress, tension, or conflict in the occupational therapy workforce and have heightened awareness that we know little about the practitioner experience. Presently, the profession has limited research focused on identifying and understanding the experience of role conflict for occupational therapists and occupational therapy assistants; specifically, those working on the frontline of practice when implementing policy. This research study aims to address this knowledge gap in health policy and systems research related to occupational therapy

by providing a forum to hear from occupational therapy professionals experiencing role conflict associated with implementation of productivity standards in their work context.

Professional Profile Characteristics and Work Context as Factors Influencing Role Conflict

Review of the literature provides insight about the impact of policy content, work contexts, and personality characteristics on policy implementation by public professionals (Tummers, Steijn et al., 2012). However, targeted scholarship examining the experience of frontline occupational therapy professionals working to implement institutional rules and organizational policy is limited. This study seeks to understand role conflict during policy implementation of productivity standards and identify professional profile characteristics and work context factors associated with the experience of role conflict in occupational therapists and occupational therapy assistants.

Using the 2015 AOTA Salary and Workforce Survey structure as a model, I identified professional profile characteristics and work context factors including practice settings as possible factors related to role conflict in practice. Professional profile characteristics describing the occupational therapy professional and professionalism are as follows:

- Professional OT practice credential – The professional practice credential provides information about level of professional training as the occupational therapy assistant (OTA) requires an associate’s degree and the occupational therapist (OT) requires a bachelor’s degree (before 2007) or a post-baccalaureate degree (after 2007) for entry level practice. Academic requirements for the OT include preparation for managerial responsibilities, including policy awareness and legislated supervision of OTAs in practice. Consistent with street-level bureaucracy scholarship, OTAs are prominently

positioned on the frontline of practice while OTs engage in administrative activities and supervisory responsibilities in addition to frontline practice (Lipsky, 1980).

Increased distance from policy makers and uncertainty about policy intent can contribute to role conflict.

- Years of experience in the OT field – Occupational therapy professionals in early years of their career might experience different levels of role conflict in practice than mid-late career professionals. Early career occupational therapy professionals (10 years or less) often experience “transition shock” when leaving the idealistic and supported learning environments of professional programs. Entering the “real world,” many feel inadequately prepared to navigate the policy environment of occupational therapy practice. The possible disconnect between academic preparation and practice realities, such as productivity standards, may create role conflict for some early career professionals (Duchscher, 2009)
- Professional membership status – Current professional association membership at the national or state level supports professionalism. Professional associations determine educational requirements, practice standards, and ethical conduct expectations. Institutional scanning and policy advocacy are critical benefits of professional association membership. Organizationally, they educate and offer support to occupational therapy professionals to address concerns about policy and practice. Due to awareness of professional issues, such as productivity standards and ethical conduct expectations, current professional membership status might contribute to role conflict in practice (Noordegraaf, 2011).

- Employment status – Employment status often determines level of administrative duties, workload expectations, and the nature of organizational politics in one’s work, with full-time workers shouldering more organizational responsibilities. Conversely, part-time workers are often absolved from organizational or administrative obligations but have greater productivity expectations or direct treatment responsibilities. More frequent frontline positioning of part-time workers suggests they will experience greater role conflict than full-time workers.
- Primary work function – Direct service (treatment/intervention) equates with frontline practice; street-level bureaucrats equate with direct service providers. Lipsky defines street level bureaucrats as “public service workers who interact directly with citizens in the course of their jobs, and who have substantial discretion in the execution of their work” (1980, p. 3). In occupational therapy, client needs addressed through direct service might compete with organizational priorities in a way that create role conflict during service delivery in practice. Due to proximity to clients and practice and distance from policy developers, this research expects to find greater role conflict in direct service occupational therapy professionals than indirect service providers more removed from the frontline.

The following set of propositions address the relationships of professional profile characteristics (professional OT practice credential, years of OT experience, professional membership status, employment status, work function) and role conflict.

- Proposition 1.1 (P1.1) – Occupational therapy assistants will experience greater role conflict than occupational therapists when implementing productivity standards.

- Proposition 1.2 (P1.2) – Early career occupational therapy professionals will experience greater role conflict than experienced occupational therapy professionals when implementing productivity standards.
- Proposition 1.3 (P1.3) – Occupational therapy professionals with current professional membership status will experience greater role conflict related to implementation of productivity standards.
- Proposition 1.4 (P1.4) – Occupational therapy professionals working fulltime will experience less role conflict than part-time occupational therapy professionals when working to implement productivity standards.
- Proposition 1.5 (P1.5) – Occupational therapy professionals providing direct treatment to clients will experience greater role conflict related to productivity standards than occupational therapy professionals providing indirect services.

Work context factors describing the work environment and practice settings of occupational therapy professionals are as follows:

- Practice setting location – Urban, suburban, and rural setting locations serve unique populations at hospitals, schools, LTC/SNFs, and other facilities situated in communities needing specific services. Rural settings face unique challenges related to population changes, insurance or uninsured clients, chronic disease management issues, sprawling geography, and shortage of health care professionals. Pressures associated with population health needs, sparse resources, and reimbursement requirements for struggling rural health service organizations and hospitals can lead to pressure and role conflict for occupational therapy professionals.

- Institutional control/ownership – Ownership commonly describes organizations; ownership or control usually relates to funding and institutional authority (Perry & Rainey, 1988). Public funding often equates with government control and public service. Private ownership and funding coincide with market expectations such as efficiency, cost containment, and profitability. These economic markers relate to productivity standards imposed in response to federal policy generated reimbursement parameters. The corporate nature of private organizations suggests there will be greater role conflict for occupational therapy professionals working in that context.
- Practice setting – Institutional components differ across practice setting, thereby establishing supports or constraints that shape practices and expectations. Across settings, practice realities and professional identity challenges place demands that compromise authentic practice. Specifically, many long term care/skilled nursing practice settings institute high productivity requirements to meet target reimbursement levels, which influences practice decisions. By identifying practice settings, this research examines the impact of practice context on the role conflict experience of occupational therapy professionals (Morley, 2009; Townsend, 1996).

The following set of propositions addresses the relationships of work context factors (organization location, organizational control/ownership, practice setting) and role conflict.

- Proposition 2.1 (P2.1) – Occupational therapy professionals working in rural practice locations will experience greater role conflict than those who work in urban or suburban practice locations.

- Proposition 2.2 (P2.2) – Occupational therapy professionals working in privately owned organizations will experience greater role conflict related to implementation of productivity standards than occupational therapy professionals working in publicly controlled organizations.
- Proposition 2.3 (P2.3) – Occupational therapy professionals working in long term care/skilled nursing facilities (LTC/SNF) will experience greater role conflict related to implementation of productivity standards than those working in other practice settings.

The following proposition addresses the extent to which professional profile characteristics and work context serve as factors that can estimate role conflict.

- Proposition 3 (P3) – Professional profile characteristics and work context factors will serve as positive predictors of role conflict when working within productivity standards.

Methodology

Productivity in Occupational Therapy

Productivity standards are a common measure of work efficiency and a driving force in cost-revenue management utilized in business-minded health care and education environments. As generally understood by occupational therapy professionals, productivity relates to workload expectations and is associated with billing practices and reimbursement. As key actors implementing policy such as productivity standards, frontline occupational therapy professionals often experience tension between multiple institutional logics (i.e., efficiency oriented business models, medicine dominated organizational structures, practice laws) and competing professional ideals or values (i.e., client-centered care, evidence-based practice) (Busby et al.,

2015; Townsend, Langille, & Ripley, 2003). Implementation of unreasonable organizational productivity expectations as a response to institutional reimbursement policy may contribute to role conflict and ethical tension experienced by committed occupational therapy professionals (AOTA, 2014a). The experience of occupational therapists and occupational therapy assistants working in these conditions warrants systematic study.

Study Design

This study examines the extent to which professional characteristics and work context factors affect role conflict experienced by frontline workers. To examine the research questions and related propositions, I situated the study in occupational therapy practice and surveyed occupational therapy professionals about working within productivity parameters in occupational therapy practice. The study used a cross-sectional quantitative survey design.

Measurement Development

Informed by field-level practice accounts and literature focused on frontline workers, role conflict, and policy alienation, the researcher constructed an original survey instrument to explore how frontline occupational therapy professionals experience role conflict when implementing productivity-related policy (Tummers et al., 2009; Tummers, Vermeeren et al., 2012). During the 2014 Kansas Occupational Therapy Association Fall Conference, participants were invited to attend a roundtable discussion titled, “Stories from the Front Lines of Your OT Practice: What’s Pressuring You?” During the 90-minute discussion, 10 occupational therapy professionals representing 2 to 25 years of practice experience and seven different practice settings voluntarily shared their concerns and rewards related to occupational therapy practice. Participants reported feeling torn between workplace expectations, conflicting philosophies, and professional values. They expressed their commitment to quality, individualized care yet were

conflicted and sometimes felt pressured to compromise their standards of practice when faced with contextual factors such as multiple logics, standardized protocols, large caseloads, scarce resources, billing and reimbursement pressures, and high productivity standards. This professional discourse reaffirmed issues raised during informal conversations with occupational therapy students and colleagues. Further, information shared by the roundtable participants proved consistent with literature about complex health and human service environments (Hasenfeld, 2010) and frontline workers, such as occupational therapy professionals, experiencing role conflict in practice (Lipsky, 1980; Maynard-Moody & Musheno, 2003).

Drawing on the AOTA Salary and Workforce Survey (AOTA, 2015a) and Tummers, Vermeeren, Steijn, and Bekkers' (2012) work in role conflict during policy implementation, the researcher constructed a web-based survey instrument for use in this study. The AOTA survey provided categories and structure for collecting demographic data about the respondents, including information about their professional profile, the nature of their work, and practice contexts. Tummers, Vermeeren et al. (2012) conceptualized role conflict related to policy implementation and constructed scales to measure the three types of role conflict that frontline workers might experience: policy-professional conflict, organization-professional conflict, and policy-client conflict. Using these validated scales and survey templates, the researcher developed five-point Likert scales (1 = strongly disagree, 2 = disagree, 3 = neither agree or disagree, 4 = agree, 5 = strongly agree) for specific role-conflict survey items. Template items were tailored to reflect the research questions and context in this study, which improves content validity and reliability. For the survey, five single items comprise the scale to measure role conflict between the policy and professional; another five survey items create the scale to measure role conflict between the organization and professional. A single survey item measures

policy-client role conflict. Together, the eleven survey items combine to serve as the full role conflict scale (see Appendix A - Role Conflict Survey Items). To ensure scale reliability, the researcher conducted Cronbach's Alpha analysis based on 0.8 as good reliability (Field, 2009). Each role conflict scale had high reliability with Cronbach's Alpha, with the policy-professional scale at .879, the organization-professional scale at .923, and the full role conflict scale at .933. Additional survey items gathered data about Triple Aim healthcare goals (Berwick, Nolan, & Whittington, 2008), practice preferences, professional training, and organizational expectations for occupational therapy practitioners; however, these items are not included in analysis for this study.

Before finalizing the instrument, the researcher piloted the survey and the survey distribution process by sending the first draft to 10 reviewers for feedback about content clarity and ease of survey completion. Reviewers included students, experienced practitioners, researchers, and academicians representing occupational therapy, recreation therapy, and public administration. Reviewers offered the following suggestions: (1) incorporate language to assure respondents of anonymity, (2) provide information about dissemination of results, (3) include definitions of study constructs (productivity or client-centered care), and (4) attend to wordiness or redundancy in survey items to improve clarity. Additional feedback from reviewers included support for this topic of inquiry and confirmation of manageable survey completion time. The researcher adjusted language in survey introduction, instruction, definitions, and individual items to improve response accuracy, survey completion, and the overall survey experience for respondents.

Procedures

After review of the proposed study protocol and survey, the Human Subjects Committee Lawrence Campus approved the study. Qualtrics Online Survey Software supported electronic distribution of the web-based survey and supporting email communication (Qualtrics. 2016). Applying Dillman's Tailored Design Methods (Dillman, 2000), the study utilized a four-point contact strategy for electronic survey dissemination: (1) introductory contact/pre-notice email for initial recruitment, (2) survey distribution email including cover letter describing the survey, consent parameters, and the survey software link, (3) reminder/thank you email with second distribution of survey software link, and (4) final reminder/thank you email. Additionally, as part of the fourth contact strategy, a targeted recruitment email was sent to occupational therapy professionals with less than three years of OT experience to encourage participation of early career occupational therapists and occupational therapy assistants. Data collection occurred during February 2015.

Participants

The population for this study consisted of all occupational therapists and occupational therapy assistants licensed to practice occupational therapy in Kansas. As of November 2014, public record information compiled by the Kansas State Board of Healing Arts (KSBHA) and provided to the researcher indicated there were 1586 occupational therapists and 673 occupational therapy assistants (N=2259) licensed in Kansas. All licensed occupational therapy professionals who provided an email address to the KSBHA served as the distribution list for the study's online survey; the base sample for this study consisted of 2,173 occupational therapists and occupational therapy assistants. Of the 2,173 emails sent out, 1,238 were opened (57%). Of the email opened, 608 participants opened the embedded survey link and completed the survey

with varying degrees of totality and consent. For analysis, the researcher included all surveys indicating “yes” on consent item with partial to full survey completion (n=546) and surveys leaving the consent item blank but with full survey completion (n=3). Exclusion criteria included opening the survey but not starting it (n=2), indicating “no” on the survey consent item (n=6), leaving the consent item blank but with partial completion in other data fields (n=3), indicating “yes” on consent item but leaving all other items blank (n=14), or only completing the demographic survey items (n=34). Based on these inclusion and exclusion criteria, 549 surveys were used in the analyses for a 25% overall survey response rate.

Possible reasons for non-response include emails not received due to wrong addresses or emails captured by technology security programs, technology comfort (or discomfort) level of the study population, preferences for mail or online study engagement, or did not choose to dedicate time to survey completion. Further, the researcher received follow-up emails from individuals sharing their willingness to complete the survey but questioning if they should do so because of their current work status, living in another state but still licensed in Kansas, or their professional focus was outside of occupational therapy. Also, the researcher received follow-up emails from study participants with appreciation for providing a voice for practitioners through the survey and exploring current professional issues in occupational therapy. Topic relevance and professional meaning are possible reasons for the response rate.

Study Variables

The dependent variable was the level of role conflict experienced by occupational therapist and occupational therapy assistants when implementing policy related to productivity standards. Drawing on role conflict scholarship and scale development by Tummers, Vermeeren et al. (2012), this study tested three specific types of role conflicts and the broader role conflict

construct represented in full by all role conflict scale items. The types of role conflict that manifest during policy implementation include policy-professional role conflict, organizational-professional conflict, and policy-client role conflict.

Using the 2015 AOTA Salary and Workforce Survey structure as a model, I identified professional profile characteristics and work context factors including practice settings for use as independent variables in this study. Professional profile characteristics include professional occupational therapy credential (occupational therapist or occupational therapy assistant), years of experience in the occupational therapy field, professional association membership status, employment status, and primary work function. Work context factors describe the practice environment by setting location, institutional control/ownership, and practice settings. While respondents were able to list more than one practice setting as their place of work, I considered all practice settings independently in study analysis. Practice settings included academia, community, early intervention, outpatient, home health, hospital (non-mental health), long-term care/skilled-nursing facility, mental health, school, and other. As independent variables, these factors allow us to examine the relationship between professional characteristics, work contexts, and practice settings and the experience of role conflict in occupational therapy professionals during policy implementation.

Results

Descriptive Statistics

After consideration of inclusion and exclusion criteria, surveys from 549 respondents comprised the sample data used for analysis in this study. Professional profile characteristics and work context factors including practice settings described the study sample. Regarding professional profile characteristics, the majority of respondents were occupational therapists

(n=432; 79%) with occupational therapy assistants represented as well (n=117; 21%).

Proportionately, this was consistent with the 2015 AOTA Salary and Workforce Survey, which had OT (82%) and OTA (18%) respondents. The sample was an experienced group as indicated by 65% with more than 10 years of occupational therapy experience. Early career occupational therapy professionals with 10 years or less of occupational therapy experience represented the remaining 35 % of respondents. Regarding professional association membership, 31% of respondents were current members of the American Occupational Therapy Association (AOTA); 44% of respondents reported membership in their state's professional association. Professional profile characteristics related to worker identification included employment status and primary work function. This occupational therapy workforce sample was largely comprised of full-time workers, with 69% indicating they worked 32 or more hours weekly; the remaining 31% worked less than 32 hours weekly or do not work in the OT field presently. The vast majority of the study participants (89%) identified their primary work function as providing direct patient care working on the frontline of health and human service provision. The remaining 11% of occupational therapy professionals engaged in indirect service through administration or management, consultation, academia, or other professional activities.

In this study, work context factors described the organizational location, authority/control, and practice settings where occupational therapy professionals worked. Regarding work location, 74% of respondents indicated their primary work location as either urban or suburban setting and 26% identified their primary work setting as rural. Organizational control/ownership at facilities or programs where respondents (n=464) work could be public (64%) or private (36%). Respondents (n=85) were able to indicate if they were “unsure” of the

entity with authority or control over their place of employment, but only respondents indicating public or private ownership were included in the study's analysis.

Practice settings rounded out the professional profile as respondents indicated the work settings where they provided occupational therapy services. Drawing on AOTA's (2015a) designated categories, work settings included academia, community, early intervention, outpatient, hospital, long term care/skilled nursing facility (LTC/SNF), mental health, schools, and other. Although respondents were able to select all work settings where they practice on the survey, I isolated each practice setting category for independent analysis. Further, I collapsed academic, community, mental health, and other into one "other single setting" category. Because respondents were able to select all work settings where they practiced, the survey included an additional category to capture respondents working in multiple settings. Collectively, three settings – LTC/SNF (18%), hospital (16%), and schools (11%) – accounted for 46% of occupational therapy practitioner responses. This survey item indicated that 36% of respondents worked in two or more practice settings.

Role Conflict

Utilizing the study-specific role conflict scale adapted from validated scales and template items generated by role conflict scholarship (Tummers, Vermeeren et al., 2012), I calculated mean scale scores as the role conflict measure for analysis (see Appendix A for Role Conflict Scale Items). Crafted as a five-point Likert scale (1 = strongly disagree to 5 = strongly agree), the higher the mean score on a role conflict scale or specific item, the greater the role conflict experience. The mean score for all respondents on the role conflict scales were as follows: (1) Role Conflict: Organizational-Professional Scale was 2.95 (n=497; SD=.966), (2) Role Conflict:

Policy-Professional Scale was 3.01 (n=492; SD=.861), (3) Role Conflict: Policy-Client survey item was 3.16 (n=492; SD=1.046), and (4) Role Conflict: Full Scale was 2.99 (n=499; SD=.832).

For this study, I used independent samples t-tests to examine the mean differences between professional profile characteristics (professional OT practice credential, years of OT experience, professional membership status employment status, work function) and work context factors (organization location, organizational control/ownership, practice setting) with the experience of role conflict related to implementation of productivity standards in practice. Independent samples t-tests analyzed the difference between two group means with significant findings and determined if the independent variable impacted the dependent variable, thereby suggesting an association between the two variables.

Professional Profile Characteristics (IV) and Role Conflict (DV)

Regarding professional practice credential, statistically significant findings showed that occupational therapy assistants (Mean = 3.25, SD=.9) experienced greater role conflict than occupational therapists (Mean = 2.93, SD=.8), $t(497) = -3.52, p < .00$. Proposition 1.2 suggested that early career occupational therapy professionals (Mean =3.05, SD=.83) experience greater role conflict than occupational therapy professionals with more than 10 year of occupational therapy experience (Mean=2.97, SD=.83); however, the mean difference between the two groups did not prove significant, $t(496) = 1.059, p = .29$. Likewise, t-tests showed no association with national professional association membership status, $t(495) = 0.24, p = .81$, or state professional association membership status, $t(495) = 0.30, p = .76$, and the role conflict experience.

Regarding employment status, t-test results were statistically significant, with part time occupational therapy professionals experiencing greater role conflict than respondents with full time employment, (Mean=3.13, SD=.8 and Mean=2.93, SD=.84, respectively; $t(497) = -2.44, p =$

.015). On average, occupational therapy professionals identifying with direct patient/client work functions (Mean = 3.03, SD = .82) experienced greater role conflict than respondents with indirect work functions (Mean = 2.66, SD = .90), $t(491) = 3.21$, $p = .001$, which is significant (see Table 2.1).

Work Context Factors and Practice Settings (IV) and Role Conflict (DV)

Independent samples t-tests evaluated study questions related to the impact of work context factors on role conflict; the analysis did not find relationships between organizational location or organizational ownership/control and role conflict. Contextual factors of organizational location, $t(491) = .375$, $p = .71$, and organizational ownership/control, $t(420) = .99$, $p = .32$, with professional alienation did not prove statistically significant. Next, analysis of distinct practice settings used t-tests to evaluate if the practice setting itself impacted role conflict when working with productivity standards. Test results specific to hospital, school, and home health practice settings were not statistically significant, suggesting little difference in role conflict when comparing occupational therapy professionals working solely in these settings to respondents that did not. Analysis of role conflict for occupational therapy professionals working in early intervention, outpatient, and “other single setting” proved statistically significant. Findings revealed that occupational therapy professionals working exclusively in these settings experienced less role conflict than occupational therapy professionals not working in these settings. Addressing Proposition 2.5.A., statistically significant findings showed that occupational therapy professionals working in long term care/skilled nursing facilities experienced greater role conflict than those not working in the LTC/SNF practice setting, with mean scores of 3.41 and 2.91 respectively, $t(497) = 5.25$, $p = .00$ (see Table 2.2).

Table 2.1

Summary of Professional Profile Characteristics Means Association with Full Role Conflict Scale

Characteristics	M	SD	df	t-test	Sig
OT Professional Practice Credential			497	-3.52	.00**
OT	2.93	0.8			
OTA	3.25	0.9			
Years of OT Experience			496	1.06	0.29
10 years or less	3.05	0.83			
11 years or more	2.97	0.83			
Professional Association Membership (AOTA)			495	0.24	0.81
Yes	3.01	0.81			
No	2.99	0.84			
Professional Association Membership (state)			495	0.30	0.76
Yes	3.01	0.85			
No	2.99	0.81			
Employment Status			497	-2.44	.015*
Full Time	2.93	0.84			
Part Time	3.13	0.8			
Primary Work Function			491	3.21	.001**
Direct	3.03	0.82			
Indirect	2.66	0.89			

Notes. * $p < .05$. ** $p < .01$. M = Mean. SD = Standard Deviation. Df = Degrees of freedom. Role Conflict Scale (adapted from Tummers, Vermeeren et al., 2012) crafted as five-point Likert scale (1 = strongly disagree to 5 = strongly agree). Score interpretation = the higher the mean score on the full role conflict scale or specific scale item, the greater the role conflict experienced.

Professional Profile and Work Context as Predictors of Role Conflict

To complete analyses for this study, multiple linear regression analysis was used to address Proposition 3 and answer the question about how professional profile characteristics and work context factors predict role conflict. I selected this approach because I was interested in explaining the variance in: 1) role conflict (continuous variable) related to professional profile characteristics; and 2) role conflict (continuous variable) related to work context factors. The researcher conducted the following procedures to ensure the models met the necessary

Table 2.2

Summary of Work Context Factors and Practice Settings Means Associated with Full Role Conflict Scale

	M	SD	Df	t-test	Sig
LTC/SNF Only			497	5.25	.00**
Yes	3.41	0.78			
No	2.91	0.82			
Hospital Only			497	-0.03	0.98
Yes	2.99	0.83			
No	2.99	0.83			
School Only			497	-0.43	0.67
Yes	2.95	0.68			
No	3	0.85			
Home Health Only			497	-0.45	0.65
Yes	2.93	0.91			
No	3	0.83			
Early Intervention Only			497	-3.19	.002**
Yes	2.3	0.99			
No	3.01	0.82			
Outpatient Only			497	-2.66	.008**
Yes	2.49	0.45			
No	3.01	0.84			
Other Single Setting			497	-2.71	.007**
Yes	2.54	0.85			
No	3.02	0.83			
Multiple Settings			497	-0.41	0.68
Yes		2.97	0.81		
No		3.01	0.85		
Organization Location			491	0.38	0.71
Rural	3.02	0.92			
Suburban/Urban	2.98	0.81			
Organizational Control/Ownership			420	0.99	0.32
Public	2.92	0.8			
Private	3	0.86			

Notes. * $p < .05$. ** $p < .01$. M = Mean. SD = Standard Deviation. Df = Degrees of freedom. Role Conflict Scale (adapted from Tummers, Vermeeren et al., 2012) crafted as five-point Likert scale (1 = strongly disagree to 5 = strongly agree).

Score interpretation = the higher the mean score on the full role conflict scale or specific scale item, the greater the role conflict experienced.

assumptions: tested for independence of residuals, multicollinearity (VIF values are close to 1 and not greater than 10), outliers to discard (Cook's distance maximum, criterion <1), and graphs or PP plots to determine linearity, normality and heteroscedasticity.

Having met assumptions for linear regression modeling, the multiple regression analysis was conducted to identify predictors of role conflict. The analysis included relevant professional profile characteristics (professional practice credential, employment status, primary work function) and work context factors (long term care/skilled nursing facility, early intervention, and outpatient practice settings). Overall, the regression analysis proved to be a statistically significant model (R Square = .12, adjusted R Square = .11, $F(6,486) = 10.82$, $p < .001$). Results of the multiple regression analysis reinforced significant professional profile findings by identifying the professional practice credential, employment status, and primary work function as likely predictors of role conflict. Further, they retained their predictive power when incorporated in the full regression equation. Regarding role conflict and work context, the results of the multiple regression analysis including long term care/skilled nursing, early intervention and outpatient practice settings indicated a predictive link between these practice contexts and role conflict. This predictive quality remained when included in the full regression equation (see Table 2.3).

Discussion

Occupational therapy professionals working in complex health and human service environments often experience role conflict when working within parameters set by policy. In this study, I sought to understand role conflict when implementing policy such as productivity standards, the association between professional profile characteristics and role conflict, and the impact of work context factors, including practice settings, on the role conflict experience. The

Table 2.3

Multiple Regression Analysis of Professional Profile Characteristics and Work Context Factors with Role Conflict

Model	Unstandardized B	Standard Error B	Standardized B	t	Sig.
Professional OT Practice Credential	-.405	.090	-.090	-2.038	.042
Employment Status	-.185	.077	-.103	-2.390	.017
Primary Work Function LTC	.292	.112	.112	2.601	.010
Early Intervention	-.184	.097	.182	4.117	<.001
Outpatient	.399	.223	-.148	-3.454	.001
	-.770	.191	-.091	-2.122	.034

Notes. Dependent Variable: Role Conflict Full Scale (11 items)
(R Square=.12, adjusted R Square=.11, F(6,486)=10.82, p<.001)

results suggested congruence between policy-organization-professional levels influence the type of role conflict experiences during policy implementation, occupational therapy professionals experience role conflict differently, and some work context factors impact role conflict in practice.

Role Conflict

Productivity standards are an example of organizational policy implementation in response to higher order institutional policy development. Specifically, the Center for Medicare and Medicaid Services (CMS) establishes the policy parameters for reimbursement of medical and rehabilitation services while organizational systems and agencies establish performance requirements and productivity standards required to meet their own profit margin goals. In practice contexts outside the CMS jurisdiction, administrators are accountable to related regulators and payment oversight guidelines that influence organizational policy, performance, or productivity expectations, and ultimately direct work of professionals in practice.

The distance between policy makers, policy implementers, and policy outcomes creates space for cognitive dissonance and role conflict in the hearts and minds of health and human service workers. In this study, respondents experienced greatest role conflict when faced with productivity related policy that required incongruent client behaviors and expectations to meet policy requirements or was inconsistent with goals of clients/patients ($M = 3.16$; $SD = 1.046$). This policy-client role conflict represents the commitment to the client-centered philosophy of the occupational therapy profession (Townsend et al., 2003). The citizen-agent narrative from street-level bureaucracy theory resonates with this finding as well (Maynard-Moody & Musheno, 2000). Further, study participants experienced policy-professional role conflict ($M = 3.01$; $SD=.861$) slightly more than organizational-professional role conflict ($M = 2.95$; $SD=.966$). Policy-professional role conflict represents the difficulty in reconciling disparate policy content and professional values or ethics, while organizational-professional role conflict captures the conflict that might occur during policy implementation due to competing professional values. When considering policy about productivity standards, it is important to remember that productivity requirements are the organizational policy response to reimbursement policy established at higher institutional levels. The difference between the two is often lost when engaged in frontline practice, yet the true frontline pressure can be generated when rehabilitation professionals must submit charges for services in accordance with organizational productivity and treatment directives related to external policy (Gray, 2014). This is particularly true in skilled nursing facility environments, where therapy utilization and contact minutes translate to payment and are under increased scrutiny by CMS (AOTA, 2016).

Occupational therapy professionals commit to work within the AOTA Code of Ethics (2015b), which binds them by rules and truth. Overall, study respondents appeared divided in

their feelings about role conflict and productivity standards, which is understandable in light of business principles such as efficiency and cost-effectiveness that underlie most successful business models. When considering the mean score for each of these role conflict measures, I found they were close to midpoint on the scale. The Likert scale measures variation in levels of agreement or disagreement with survey statements, with midscale providing a non-commit zone for respondents. I saw distribution across all three sentiments (agree, disagree, neither), highlighting that not all occupational therapy professionals experience role conflict related to productivity standards. Many occupational therapy professionals recognize the business ideology within health care and human service organizations aims to support the health of the organizations where they work. Yet respondents still experienced role conflict when required to meet unreasonable expectations of doing “more with less” or feeling pressured to compromise their standards of care and professional ethics and values. Results suggested that occupational therapy professionals were more at odds with policy makers related to reimbursement practices than with their organizations and managers as policy implementers, extending grace and believing managers are doing their best in spite of externally imposed top-down policy.

Professional Profile Characteristics and Role Conflict

According to Lipsky (1980), frontline workers are the ultimate “policy makers” as they implement policy in their daily work, yet little is known about the “implementers” and how professional characteristics influence the role conflict experience associated with policy implementation. Related to profile characteristics of occupational therapy professionals, I proposed that occupational therapy assistants would experience greater role conflict than occupational therapists, early career occupational therapy professionals would experience greater role conflict than their more experienced occupational therapy colleagues, and professional

membership status would not affect role conflict related to productivity. Study findings supported the proposition that occupational therapy assistants experienced greater role conflict than occupational therapists. In support of this finding, occupational therapy assistants typically work on the frontline in direct treatment rather than in more indirect treatment roles and that required professional supervisory relationships insert additional layers between policy making and policy implementation, which can create tension or conflict. Further, the primary work setting for OTAs is long term care/skilled nursing facilities guided by CMS reimbursement policy and the resulting productivity standards instituted organizationally (AOTA, 2015a). As is discussed in the next section, practice context impacts role conflict.

Regarding years of experience and role conflict, the results were not statistically significant, indicating that the role conflict is experienced by occupational therapy professionals across the span of their careers. This finding refutes my proposition that early career professionals might feel greater conflict due to recent academic connections with professional idealism. I found that occupational therapy professionals can experience policy evoked role conflict at any time in their career – in this case, role conflict evoked by productivity standards.

As proposed, professional membership status did not influence role conflict associated with productivity standards. This finding warrants discussion on two points. First, the AOTA Code of Ethics (2015b) sets the aspirational professional conduct bar for all occupational therapy professionals (not just AOTA members), and by extension helps frame organizational and institutional behavioral expectations. Second, AOTA responds to numerous inquiries and provides resources to support occupational therapy professionals experiencing role conflict and moral distress when faced with any practice issue, including productivity-specific ethical questions. Clearly, AOTA serves the occupational therapy profession as a guide and resource for

occupational therapy professionals faced with competing values or unethical practices, yet the decisions made on the frontlines of practice are often individual, and the professional role conflict experience is always personal.

Professional profile characteristics associated with worker identification, such as employment status and work function, can impact personal practice decisions related to professional work. Findings revealed that these profile characteristics of employment status and work function impacted role conflict for occupational therapy professionals. Looking at worker identification factors, respondents who self-identified as direct service providers and part-time workers experienced more role conflict. Specifically, study results supported the proposition that occupational therapy professionals aligning with direct patient/client work functions experienced greater role conflict than respondents with indirect work functions. Frontline workers directly involved with client interaction or patient treatment are required to carry out organizational or departmental protocols designed to meet institutional policy objectives, even when they are incongruent with their professional values. Consistent with street-level bureaucracy scholarship, this conflict is more acute during direct service than indirect service where management, academic, and consultative work provides opportunities for greater professional discretion and distance from disparate institutional logics (Lipsky, 1980). Findings regarding employment status showed that part time occupational therapy professionals experienced greater role conflict than respondents with full time employment, thereby supporting the proposition. One explanation for this finding is that there are higher productivity standards for PRN (as needed) workers, thereby demanding more direct patient contact in condensed time periods. Additionally, it is possible that part-time workers might be balancing competing demands and logics of more

than one employer or practice setting. In this case, work demands might impact role conflict for frontline occupational therapy professionals.

Work Context Factors and Role Conflict

Work context serves as the institutional frame and social structure in which professions secure legitimacy and jurisdiction while professionals seek to establish identity and authority through their work (Abbott, 1988). Within these “inhabited institutions,” occupational therapy professionals encounter enabling and constraining social and organizational forces that can create role conflict for indirect and direct service providers (Hallett & Venstreca, 2006). Similar to the professional profile discussion, this study sought to identify work context factors associated with role conflict during policy implementation. The findings revealed that work context features including organizational ownership, and practice settings impact role conflict for occupational therapy professionals.

When considering work context features, the study found that work location did not have a significant impact on role conflict related to implementation of productivity related policy while organizational ownership or control is associated with role conflict. Further, the analysis examined the relationship between urban/suburban and rural organization locations and role conflict; the analysis did not support the proposition that occupational therapy professionals working in rural practice settings would experience greater conflict than those working in urban/suburban work contexts. This finding suggested that the potential for role conflict in occupational therapy practice was not geographically bound; rather, role conflict related to the demands of universal institutional policy and the implementation protocols institutionalized by organizations wherever they were located. In other words, reimbursement requirements imposed by CMS prompt organizations to develop profitable business plans, which include productivity

standards to optimize payment for services regardless of work location. Recognizing this reality, occupational therapy professionals make decisions about where they work and the type of organization or agency in which they work, effectively expressing willingness to work in a given location and ascribe to a defined business philosophy.

Closely related to the discussion of profitable business planning was the impact of organizational ownership on role conflict. This study sought to understand the impact of public or private organizational ownership or control on the role conflict experience related to productivity requirements. This proposition expected that occupational therapy professionals working in privately owned and managed organizations would experience greater role conflict than those working in a publicly controlled work environment related to role conflict. The researcher grounded this assertion in extensive public administration and organizational theory scholarship focused on private and public distinction in organizations. Relevant for this study is the administrative practice of employing productivity standards to manage costs, increase efficiency, and secure profits, which many believe aligns with private authority (Perry & Rainey, 1988). While comparison of the means indicated a slightly higher score for private over public organizational authority/control, the t-test statistic proved not significant, suggesting there was not a clear distinction between private and public organizations as a factor influencing role conflict. It is of note that 14% (n=77) of respondents did not know whether they worked for a private or public institution/organization. This finding suggested that many occupational therapy professionals need additional education about the context of practice and governance structures that impact service provision and payment.

Practice Settings and Role Conflict

As health and human service providers, occupational therapy professionals work in complex environments governed by different regulations and rules, infused with multiple institutional logics, and inhabited by many organizational and individual actors motivated by mission statement and professional values. In this crowded space, role conflict can easily develop. Based on the analysis, some practice settings did impact role conflict when working with productivity standards. Although not specifically presented as a proposition, an exploratory examination of findings specific to hospital, school, and home health practice settings did not find statistically significant results, suggesting little difference in role conflict when comparing occupational therapy professionals who worked solely in these settings to respondents who did not. Analysis of role conflict for occupational therapy professionals working in early intervention, outpatient, and “other single setting” proved statistically significant but indicated less role conflict experienced by occupational therapy professionals working only in these settings. In cases where there was not a statistically significant relationship or where there was an inverse relationship, the work contexts had different reimbursement structures, practice models and methods, inter- and intra-professional relationships, and access to resources. Every practice setting outlines performance expectations for their workers, and profitability targets are set in organizations that comprise these work environments. Typically, these settings are structurally and operationally different from settings that are largely dependent on CMS reimbursement policy for payment and ultimately, profit. In work contexts where productivity standards dictate daily work schedules and shape worker-client/patient interactions, I found greater role conflict. Specifically addressing Proposition 2.5, statistical findings were significant and demonstrated that occupational therapy professionals working in long term care/skilled nursing facilities

experienced greater role conflict than those not working in the LTC/SNF practice setting. This finding confirmed anecdotal accounts by occupational therapists and occupational therapy assistants with work experience in this practice setting: the demands of this work context often conflict with professional ethics and philosophical principles of occupational therapy. Interestingly enough, the LTC/SNF practice setting employs more occupational therapy professionals than other settings; 56% of occupational therapy assistants identified the LTC/SNF work context as their primary work setting (AOTA, 2015a).

The researcher views this information as a cause for concern and a call for action. Concerns abound regarding the number of occupational therapy professionals who experience role conflict when providing occupational therapy services in this work context. Conflict associated with incompatible professional and organizational expectations has behavioral implications such as engaging in work that supports or sabotages the institutional mission and psychological effects such as job dissatisfaction, workforce burnout, or an early exit from the profession (Brehm & Gates, 1999; Edwards & Durette, 2010). This setting is rich in opportunities for occupational therapy professionals to serve as change agents and provide the example of authentic practice grounded in meaningful daily life activities, guided by ethical principles, and centered around wants and needs of the clients we serve (Gray, 2014; Lamb, 2016; Stoffel, 2015).

Study Limitations

Even with thoughtful planning, every study has limitations; this study is no different. Regarding study methodology, Dillman, Smyth, and Christian (2009) identify four types of survey errors that limit the successful use of surveys: coverage, sampling, nonresponse, and measurement errors. In this study, the researcher greatly reduces coverage error through the close

approximation of the sampling frame to the population. However, the sampling frame was comprised of occupational therapy professionals in the population who provided email addresses to the KSBHA registry, which introduces the possibility of error due to exclusion of non-email registrants. An electronic survey distribution was selected to address coverage bias, yet I did not have email addresses for all members (n=86; 3.8%) of the study population and failed to offer an alternate format for study completion. According to the Pew Research Center (2015), 89% of the United States adult population uses the internet, suggesting that internet surveys exclude almost 10% of a given population from participation due to lack of access. This survey sample frame includes 96% of all licensed occupational therapy professionals in Kansas, thereby reducing coverage and sampling errors, yet it remains a limitation.

Regarding study sample, even though the study has a large sample (n = 549), I must acknowledge that the survey respondents were accessed from one state's public registry, which might limit the range or diversity of responses and thereby limit generalizability to other populations. The recruitment email shared the name of the researcher to ensure transparency, yet this could have unintentionally influenced the willingness of potential study subjects to participate in the study. Regarding response bias, the tendency to provide socially desirable responses can skew results, particularly when exploring provocative issues such as feeling conflicted about implementation of organizational policy. The response rate suggests respondents were eager to provide information about current practice issues but cannot ensure there is equitable representation of views.

Implications for Occupational Therapy

Occupational therapy exists in complex health and human service environments. As frontline health and human service professionals, occupational therapists and occupational

therapy assistants are acutely aware of the contextual complexities and challenges to professionalism in occupational therapy practice. As the AOTA and AOTF Occupational Therapy Research Agenda supports Intervention Research, Translational Research, and Health Services Research (AOTA/AOTF, 2011), I ask that consideration be given to support health policy and systems research relevant to occupational therapy as well. Studies focused on the experience of occupational therapy professionals during policy implementation are limited, which leaves a gap in knowledge and understanding when practice and policy collide on the frontline of practice. This study seeks to bridge that research gap while championing the important work of frontline occupational therapists and occupational therapy assistants. Reflecting on this study's findings, the researcher challenges others to do the following:

- Research – Expand the AOTA/AOTF Occupational Therapy Research Agenda to include health policy and systems research and research that seeks to understand systems issues and the subsequent human capital expense of practice in complex contexts.
- Policy – Secure our occupational therapy presence at high-level policy making tables. Equally important is asserting our voice when planning to implement policy in organizations on the frontline of practice.
- Practice – Encourage coping rather than conflict, seek out resources and support colleagues when working in contexts that challenge our professional ethics or compromise our commitment to practicing authentic occupational therapy practice.
- Academia – Prepare occupational therapy professionals to understand policy and interface with policy environments that may or may not be consistent with professional ideals.

As our profession reaches out to underserved populations, seeks inclusion in overlooked practice settings, or works to remain relevant in current practice contexts, we experience role conflict.

Occupational therapy and the occupational therapy workforce will be well served by conducting health policy and systems research that will continue to examine and subsequently understand and support frontline occupational therapy at the intersection of policy and practice.

CHAMPIONING AUTHENTIC OCCUPATIONAL THERAPY PRACTICE:
ALIENATION OR EMPOWERMENT

ABSTRACT

When championing occupational therapy's distinct value, occupational therapists and occupational therapy assistants can meet resistance from systems, colleagues, and clients, leaving these professionals feeling alienated from core principles and authentic practice. This original research examines professional alienation in occupational therapy professionals as they work to influence inclusion of client-centered care in institutional policy, organization processes, and practice environments. Targeting occupational therapy professionals in one Midwestern state, the researcher conducted an electronic survey to examine the relationship of professional profile characteristics and work context factors with professional alienation during implementation of client-centered practices. With some variation by practice credential, experience, work function, and setting, findings indicate occupational therapy professionals experience less professional alienation and greater empowerment when committed to professional principles and values. Occupational therapy is a profession comprised of empowered professionals.

As occupational therapy prepares to celebrate its 100th year, leaders and stakeholders of the profession reflect on AOTA's Centennial Vision 2017, which reads, "We envision that occupational therapy is a powerful, widely recognized, science-driven, and evidence-based profession with a globally connected and diverse workforce meeting society's occupational needs" (AOTA, 2007, p. 613). Within the occupational therapy community, "powerful" generated passionate discourse about perceptions of power, operationalizing power, and the necessity to boldly articulate and demonstrate our distinct value in order to remain a relevant and influential profession. Abbott (1988) describes professional power as "the ability to retain jurisdiction when system forces imply that a profession ought to have lost it" (p. 136). For all professions, academic work, clinical reasoning, and social/cultural authority define jurisdictional claims while dominance dictates power (Abbott, 1988). Research examining professional power reports that professions are able to assert their power within organizations or systems to the extent that key stakeholders recognize and legitimize the profession's principles and practices (Garrow & Hasenfeld, 2016).

For occupational therapy, the ability to assert professional power is dependent on each occupational therapy professional embracing and demonstrating core professional work, ideals and values in practice to validate our contributions and secure endorsement of dominant system authorities. Occupational therapy professionals might work in externally or hierarchically controlled practice environments that do not share the same professional values or support inclusion of occupational therapy's philosophical ideals. For example, client-centered care is central to occupational therapy's focus on enabling meaningful participation in everyday life, yet occupational therapy professionals often feel tension when "working against the grain" in a "celebrated yet subordinated" position within medical, educational, or community practice

contexts (Townsend, Langille, & Ripley, 2003). Tension introduced by philosophical differences, incompatible system expectations, or contextual constraints can compromise professional commitment and leave professionals feeling professionally alienated from their work (Mortenson & Dyck, 2006; Tummers, 2012b). Certainly, occupational therapy professionals must understand the environments in which they work and the impact of context on service provision consistent with professional values and core principles. Further, occupational therapy must also understand the experience of service providers working in complex health and human service environments and the extent to which practice complexities influence the capacity of occupational therapy professionals to demonstrate authentic occupational therapy practice in their daily work. Their experience warrants focused study.

The Power of Occupational Therapy

Championing AOTA's 2017 Centennial Vision included advocating for the profession and each occupational therapy professional to embrace their power with confidence and strengthen our position within professional systems and policy arenas (Clark, 2010). Setting the tone for her AOTA presidential term, Lamb (2016) used her Inaugural Presidential Address to espouse the "power of authenticity" in daily practice while challenging occupational therapy professionals to harness our power, embrace occupational therapy's core values, and seize opportunities to demonstrate the distinct value of occupational therapy in our work and in our words (AOTA, 2015b). Therefore, the call for authenticity requires us to engage in occupational therapy practice that is occupation-based, client-centered, contextually relevant, grounded in evidence, and demonstrative of value to individuals, populations, organizations, and systems. Occupational therapy professionals often work in practice environments where they feel pressured to alter practice approaches or compromise professional values in ways that limit

occupational therapy effectiveness and quality outcomes. When challenged, we must embrace rather than alienate “the power of authenticity” to ensure best practice and strengthen our position as a profession within organizations and systems.

This article examines the experience of professional alienation or professional empowerment by occupational therapy professionals working to influence implementation of client-centered care in their practice. Having introduced the concept of power and authentic occupational therapy, I discuss client-centered care as a core philosophy and value in occupational therapy practice. Next, I present the concept of policy alienation as foundational to the construct of professional alienation. Then I outline study methods used to examine how professional characteristics and practice contexts influence professional alienation when implementing client-centered practice; results and discussion will follow. Finally, I propose implications for providing authentic occupational therapy and our profession’s response to the Centennial Vision 2017 charge to be “powerful” in our work.

Client-Centered Care on the Frontline

Grounded in early foundation principles of occupational therapy, the Canadian Association of Occupational Therapists (CAOT) infused client-centered care into the professional lexicon by providing the following widely used definition of client-centered practice:

collaborative approaches aimed at enabling occupation with clients who may be individuals, groups, agencies, governments, corporations, or others. Occupational therapists demonstrate respect for clients, involve clients in decision making, advocate with and for clients in meeting clients’ needs, and otherwise recognize clients’ experience and knowledge. (Canadian Association of Occupational Therapists, 1997, p. 49)

In her pioneering work, Law (1998) solidified the foundational and practical knowledge base for client-centered occupational therapy. To improve the conceptual understanding of a client-

centered approach, Sumsion and Law (2006) examined 15 years of scholarship to identify distinctive elements of client-centered practice such as the influence and locus of power in therapeutic relationships, information sharing through listening and communicating, active professional-client partnership in service delivery, client choice and empowerment, and the message of hope.

While knowledge informs practice, knowledge does not always open an easy path for implementing professional ideals such as client-centered care in everyday work. Professionals aspire to emulate best practice approaches, yet they must navigate implementation challenges at system, therapist, and client levels (Wilkins, Pollock, Rochon, & Law, 2001). At the system level, client-centered care requires a philosophical commitment by the organization and administrative support for implementation that addresses real or perceived time and resource constraints, limits policy and process barriers that derail efforts to establish professional-client relationships, and lends support for innovative work groups and professionals dedicated to “living the philosophy” (p. 75). At the therapist level, occupational therapy professionals working to incorporate client-centered care into their practice can be limited by their own understanding of client-centered practice, resistance to change in service delivery, or difficulty sharing authority or power in a therapeutic partnership. At the client level, it can be challenging for the occupational therapy professional to identify exactly who the client is and to recognize the client’s need for support so they can actively collaborate with their care providers. Further, some professionals struggle to use a client-centered approach with all clients because of differences in habilitation or rehabilitation potential, perhaps inserting bias when assessing client value or worth and preparing for service delivery. to Even when committed to professional values and occupational therapy’s core tenets such as client-centered care, occupational therapy

professionals continue to find implementation difficult. When implementing client-centered practice, the extent to which professionals feel adequately prepared, informed, and supported can minimize challenges attributed to the system or context, the professional, or the client.

Philosophically, occupational therapy is synonymous with client-centered practice, yet it is not the only profession that values client-centered care, nor are we the only frontline professionals to enter therapeutic or service relationships based on direct client contact. Michael Lipsky's (1980) introduction of street-level bureaucracy theory opened discussion about the individuals that work directly with clients on the frontline of health and human service. From his work, "street-level bureaucrats" such as police officers, teachers, case workers, and counselors are identified by their frontline status, their immediate and intimate responsibility for citizen interaction, and the execution of discretion to meet requirements of their job (Lipsky, 1980, pp. 3, 27). While not writing policy, frontline workers actualize policy through pragmatic decision making during service delivery (Maynard-Moody & Musheno, 2003, p. 11).

Applied to occupational therapy professionals, we identify the work of frontline occupational therapists and occupational therapy assistants by their direct service with clients, therapeutic use of self, professional reasoning and decision making, practices guided by professional values and philosophies, and the implementation of organizational rules or policies and departmental protocols. Every day, frontline public servants work within institutional parameters and practices to interpret and implement policy while working to meet client needs. In effect, Lipsky suggests that street-level bureaucrats actually define public policy through their work with clients. Frontline public service workers are in close physical and emotional proximity to their clients; it is expected they will be responsive to the service needs of clients while still

adhering to top-down directives in typically “rule saturated, if not rule bound,” practice contexts (Maynard-Moody & Musheno, 2003, p. 10).

Drawing from public administration scholarship, Maynard-Moody and Musheno (2003) capture stories from frontline public service workers to understand their decision making orientation and related tension through identification as a “state-agent” or a “citizen-agent.” The state-agent narrative represents the more dominant understanding of street level or frontline work regarding hierarchy, accountability, rule following, resource distribution, and pragmatic work within bureaucratic controls. Alternatively, citizen/client-agents recognize the importance of rules and guidelines while also noting their inherent limitations and restrictions, thus supporting a focus on client needs through pragmatic improvisation and practical service responses (Maynard-Moody & Musheno, 2012). The human contact associated with frontline work suggests policy serves clients, and that clients are central to interactions, interventions, and outcomes; presumptions are not always true. In these important exchanges “at the boundary between citizens and the state,” frontline workers are influential in extending the authority of both and shaping the practices and subsequent policies that define health and human services (Maynard-Moody & Musheno, 2000). Occupational therapy professionals know that boundary well. With this in mind, are occupational therapy professionals empowered to seize the opportunities to shape institutional policy, influence organizational practices, and demonstrate or articulate professional principles and values such as client-centered care – or do we feel professionally alienated?

Policy Alienation of Health and Human Service Professionals

Immersed in changing and increasingly complex health and human service organizations, public service workers often experience external pressure and internal tension during policy

implementation. In any context, organizational complexity can be influenced by the presence of multiple institutional logics, particularly when faced with competing logics and incongruent values. Thornton and Ocasio (1999) define institutional logics as “socially constructed, historical patterns of material practices, assumptions, values, beliefs, and rules” that guide organizational activity (p. 804). The extent to which logics are compatible and viewed as central to organizational functioning can serve as an indicator of more or less conflict within an organization, and by extension, varying degrees of tension experienced by individuals working in the organization (Besharov & Smith, 2014). Even when conflicted, frontline workers continue to make decisions about how to interpret policy and deliver services, yet do so while feeling more or less alienated from policy intentions and target outcomes. For frontline workers such as occupational therapy professionals, multiple logics such as business models driven by productivity standards and reimbursement parameters often conflict with professional values and practice ideals such as client-centered care. Admittedly, solid business models and professional models can and do coexist to support organizational success, but professionals can feel powerless when implementing policy or question the meaning of policy in their work – experiencing policy alienation. In the same way, occupational therapy professionals working to balance multiple and/or conflicting institutional logics and organizational demands may experience ethical tension in practice, particularly when pressured to compromise professional values or ideals such as client-centered care. We do not know the extent to which occupational therapy professionals, particularly frontline practitioners, feel alienated from professional values and ideals or feel powerless in their ability to engage in authentic practice when working in complex environments. These unanswered questions prompt research to examine the concept of professional alienation introduced in this study.

Conceptually introduced by Tummers, Bekkers, and Steijn (2009), policy alienation is defined as a “general cognitive state of psychological disconnection from the policy program being implemented by a public professional who interacts directly with clients on a regular basis.” Specific to policy alienation, two dimensions delineate the experience of public professionals when implementing policy in their work: powerlessness and meaninglessness (Tummers, 2012b). Policy powerlessness relates to the extent to which individuals believe they have power to influence policy development. Professionals may experience powerlessness at varying levels – strategic powerlessness, tactical powerlessness, and operational powerlessness. To delineate, strategic powerlessness refers to the “perceived influence of professionals on decisions concerning the content of a policy, as is captured in rules and regulations” (Tummers, 2012b, p. 518). Tactical powerlessness is defined as the “perceived influence of professionals over decisions concerning the way a policy is executed within their own organization” (p. 518). Operational powerlessness captures the “perceived influence of professionals during actual policy implementation” (p. 518). Shifting to the concept of meaninglessness, policy meaninglessness refers to the degree that professionals understand and believe there is a relationship between the policy and desired goals. Whether at the client level or societal level, meaninglessness examines policy relevance by the extent to which the policy adds value when working to meet big picture goals that serve individuals and the common good.

Professional Alienation – Extending a Policy Alienation Framework

In policy alienation scholarship, studies focus on the disconnection from policy in practice and the experience of frontline workers when implementing policy (Tummers, 2012a). Guided by this work, I shift attention to the commitment of professionals to exemplify core professional values and philosophical concepts that are central to their work regardless of policy.

As an extension of the policy alienation framework, this original research introduces *professional alienation* as a general cognitive state of psychological disconnection from a profession's core philosophical ideals and/or values as a means of responding to policy/organizational demands and/or managing tension or role conflict. Through this professional alienation lens, powerlessness relates to the extent to which professionals believe they can influence inclusion of professional ideals or values at strategic, tactical, or operational levels within their organizations. Likewise, meaninglessness refers to the degree to which professionals believe that inclusion of professional ideals or values in practice makes an impact on clients or society. While organizations view policy as the structural glue for their mission and resources, the philosophical foundations, work technologies, professional boundaries, and core values that shape professional identities, secure jurisdiction within systems, and legitimize their contributions bind professions (Abbott, 1988). As a profession, occupational therapy positions itself in complex health and human service environments, which can challenge or empower occupational therapy professionals to assert their commitment to demonstrate authentic occupational therapy practice. To examine the construct of professional alienation, I model work by Tummers to understand the degree to which occupational therapy professionals experience powerlessness or meaninglessness when working to incorporate client-centered care into their practice (Tummers, 2012a; Tummers, Steijn et al., 2012). Refer to Appendix B - "Policy Alienation Concepts Applied to Professional Alienation in Occupational Therapy Professionals Implementing Client-Centered Care in Practice" for construct overview.

Professional Profile Characteristics and Work Context as Factors Influencing Professional Alienation

With the stage set, this research brings together conceptual preparation with study propositions to examine professional alienation on occupational therapy professionals. Specifically, this study seeks to understand the professional alienation experience of occupational therapy professionals related to incorporation of client-centered care in occupational therapy practice. Further, this study identifies professional profile characteristics and work context factors associated with the experience of professional alienation in occupational therapists and occupational therapy assistants.

Using the 2015 AOTA Salary and Workforce Survey structure as a model, I identified professional profile characteristics and work context factors, including practice settings as possible factors related to professional alienation in practice. Professional profile characteristics describing the occupational therapy professional and professionalism are as follows:

- Professional OT practice credential – Regardless of practice credential, client-centered care is a core professional value infused in academic and clinical preparation of all occupational therapists and occupational therapy assistants. Perceived constraints related to supervision, time requirements, limited resources, and challenges of implementing client-centered care might influence professional alienation for all occupational therapy professionals. For occupational therapy assistants, implementing treatment plans and practice directives from occupational therapy supervisors in direct service to clients can introduce additional constraints and create a sense of powerlessness in practice (Wilkins, Pollock, Rochon, & Law, 2001).

- Years of experience in the OT field – The evolution of professional preparation along with recent health care reform activities such as the “Triple Aim” have fueled a renewed commitment to client-centered care (Berwick, Nolan, & Whittington, 2008). Early career occupational therapy professionals are equipped to demonstrate client-centered care in practice but might lack confidence in their professional identity to go “against the grain” if stifled by the practice context. When not feeling supported by professional peers or if not seeing practice examples that reflect client-centered care, professionals might distance themselves from this core value. This is especially true for early career professionals seeking to legitimize their position among professional or organizational colleagues (Krusen, 2011).
- Professional membership status – For the occupational therapy profession, the American Occupational Therapy Association establishes ethical conduct expectations, entry-level educational requirements, and practice standards which identify client-centered care as central to our professional work. State level professional associations and practice communities provide support for professional development and professional socialization. While current professional membership status often equates with professionalism, so does the demonstration of client-centered care as authentic occupational therapy practice. Professional association membership provides education and support that shapes professionals and has potential to limit professional alienation (Noordegraaf, 2011).
- Employment status – Full-time or part-time employment status define working hours of an occupational therapy professional, but might also reveal work pressures associated with practice responsibilities that challenge implementation of client-

centered care. For example, part-time workers might be assigned higher productivity markers because of reduced administrative or departmental responsibilities. When assigned greater productivity expectations or other performance requirements, they might feel pressure to compromise client-centered care in order to meet the mark. Frontline positioning ensures high volume client interaction, which many part-time occupational therapy professionals prefer, but it can also create a press for reimbursement over client-centeredness.

- Primary work function – In the course of direct service provision of occupational therapy, client-centered care focused on client goals might compete with organizational priorities. This tug between client priorities and individualized care or organizational demands and protocols can create tension for the occupational therapy professional working to satisfy all requirements. Because of proximity to clients and the reality of frontline practice dilemmas, it is likely there will be more professional alienation in direct service occupational therapy professionals than in indirect service providers with greater distance from frontline practices (Lipsky, 1980).

The following propositions address the relationships of professional profile characteristics (professional OT practice credential, years of OT experience, professional membership status, employment status, work function) and professional alienation.

- Proposition 1.1 (P1.1) – Occupational therapy assistants will experience more professional alienation than occupational therapists when implementing client-centered care.

- Proposition 1.2 (P1.2) – Early career occupational therapy professionals will experience more professional alienation than experienced occupational therapy professionals when implementing client-centered care.
- Proposition 1.3 (P1.3) – Occupational therapy professionals with current professional association membership status will experience less professional alienation when implementing client-centered care than occupational therapy professionals with inactive membership status.
- Proposition 1.4 (P1.4) – Occupational therapy professionals with part-time employment status will experience greater professional alienation related to implementation of client-centered care than full-time working occupational therapy professionals.
- Proposition 1.5 (P1.5) – Occupational therapy professionals providing direct treatment to clients will experience more professional alienation than occupational therapy professionals providing indirect services.

Work context factors describing the work environment and practice settings of occupational therapy professionals are as follows:

- Practice setting location – Urban, suburban, and rural setting locations serve unique populations at hospitals, schools, LTC/SNFs, and other facilities situated in communities needing specific services. In rural settings, unique challenges related to an aging population and shortage of health care professionals place high demands for personal contact and extended relationships with clients. Dedicated to communities and clients, occupational therapy professionals working in rural settings will strongly align with rather than alienate from client needs in their practice.

- Institutional control/ownership – When describing organizations, ownership usually relates to funding and institutional authority (Perry & Rainey, 1988). Public ownership suggests governmental involvement and public service while private ownership seems more aligned with corporate values such as profit, efficiency, and cost containment. Occupational therapy professionals prioritize people in their work, which is not always valued or supported in market models. The business focus of private organizations might prompt professional alienation related to client-centered care by occupational therapy professionals more than the public service orientation of public organizations.
- Practice setting – For many occupational therapy professionals, the practice settings where they work can create ethical tension related to implementing client-centered care. Sometimes, the tension is due to the challenge of reconciling system level objectives or policies with client-focused needs and goals. In other settings, the organization’s philosophy and the professional values of the therapist or therapy assistant are incongruent. Specific to client-centered care, a lack of support in the workplace or general lack of understanding about client-centered care can leave occupational therapy professionals to distance themselves from this professional value (Bushby, Chan, Druif, Ho, & Kinsella, 2015). Occupational therapy research on this topic related to specific practice settings is limited, thereby prompting exploration of this contextual factor.

The following set of propositions address the relationships of work context factors (organization location, organizational control/ownership, practice setting) and professional alienation.

- Proposition 2.1 (P2.1) – Occupational therapy professionals working in rural practice locations will experience less professional alienation than professionals working in urban/suburban practice locations.
- Proposition 2.2 (P2.2) – Occupational therapy professionals working in private organizations will experience greater professional alienation related to implementation of client-centered care than occupational therapy professionals working in public organizations.
- Proposition 2.3 (P2.3) – Occupational therapy professionals’ experience with professional alienation related to implementation of client-centered care will be associated with variation in practice settings.

The following proposition addresses the extent to which professional profile characteristics and work context serve as factors that can estimate professional alienation.

- Proposition 3 – Professional profile characteristics will serve as positive predictors of professional alienation when implementing client-centered care, while work context factors will not.

Methodology

Study Design

The aim of this study is to examine the extent to which professional characteristics and work context factors influence commitment to professional values and/or philosophically consistent practices when working in complex health and human service environments. To examine the research questions and related propositions, the researcher surveyed occupational therapy professionals about feelings of professional alienation when working to implement client-centered care in their practice. Specifically, I looked at perceived powerlessness or

empowerment to influence national policy making, organizational planning, and practice implementation along with the extent to which occupational therapy professionals believe in the power and meaningfulness of client-centered care. The study used a cross-sectional quantitative online survey design.

Measurement Development

For this study, the researcher constructed an original survey instrument to explore how frontline occupational therapy professionals experience professional alienation when working to incorporate client-centered care into their practice. To understand core concepts, I facilitated a roundtable discussion titled “Stories from the Front Lines of Your OT Practice: What’s Pressuring You?” at the 2014 Kansas Occupational Therapy Association Fall Conference. For 90 minutes, 10 occupational therapy professionals representing 2 to 25 years of practice experience and representing seven different practice settings voluntarily shared their experiences and concerns related to occupational therapy practice. When asked how client-centered care happens in their practice, participants reported feeling pressured by workplace expectations and conflicting philosophies that differed from their professional values and practice ideals. All participants talked about the client or patient being the reason they wanted to be an occupational therapist in the first place – “to help people” or “to make a difference in a person’s life” – while also identifying factors that limited their effectiveness as a client-centered occupational therapy professional. Several participants talked about feeling pressured for time, bound by reimbursement or productivity requirements, and uncertainty regarding how to document (for reimbursement) the people-connecting and emotional labor parts of their work. One participant commented, “We don’t want to do drive-through therapy” driven by protocol and policy requirements that displaces the client from the focus of therapy. Another person shared that her

work contexts (homes and schools, rather than medical environments) allowed her to have greater job satisfaction due to the difference in regulations, autonomy in her schedule/work, and the opportunity to work closely with the client/family in the context of their daily life activities. Further, information shared during the roundtable discussion proved consistent with literature about complex health and human service environments (Hasenfeld, 2010; Scott, 2001), street-level bureaucrats or frontline workers (Lipsky, 1980; Maynard-Moody & Musheno, 2003), and the experience of professional alienation in practice (Tummers et al., 2009; Tummers, 2012b).

Drawing on the AOTA Salary and Workforce Survey (2015a) and Tummers (2012b) policy alienation work, the researcher constructed a web-based survey instrument for use in this study. The AOTA survey provided categories and structure for collecting demographic data about the respondents, including their professional profile, work context, and practice settings. Tummers, Bekkers, and Steijn (2009) conceptualized policy alienation with application to public professionals; Tummers (2012b) constructed scales to measure the dimensions of policy alienation of public professionals. Adapting validated scales and survey templates provided by Tummers (2012a, 2012b), this researcher developed five-point Likert scales for study-specific professional alienation survey items. Template items were tailored to reflect the research questions and context in this study, which improves content validity and reliability. Nineteen survey items combined to serve as the full professional alienation scale. For the survey, four single items comprised the strategic powerlessness scale, six survey items created the tactical powerlessness scale, five single items comprised the operational scale, and four single items created the scale to measure client meaninglessness (see Appendix C for Professional Alienation Survey Items). To ensure scale reliability, the researcher conducted Cronbach's Alpha analysis based on 0.8 as good reliability (Field, 2009). All professional alienation scales had acceptable to

high reliability with Cronbach's Alpha, with the tactical powerlessness scale at .736, the operational powerlessness scale at .765, the client meaningfulness scale at .892, and the full professional alienation scale at .849. For the strategic powerlessness scale, the reliability statistic was .610, which is lower but in the acceptable range. Although deleting the professional association item from the scale would improve the reliability score, the item remained due to client-centered care being a professionally directed philosophy and value. Based on feedback from pilot survey respondents, the researcher developed alternate survey items to assess social meaningfulness; they were not included in this professional alienation scale. Additional survey items gathered data about practice preferences, professional training, organizational expectations for occupational therapy practitioners, and role conflict; these items were not included in analysis for this study.

Before finalizing the instrument, the researcher piloted the survey and the survey distribution plan by sending the first draft to 10 reviewers for feedback about content clarity and ease of survey completion. Reviewers included students, experienced practitioners, researchers, and academicians representing occupational therapy, recreation therapy, and public administration. Reviewers suggested the survey should include language to assure respondents of anonymity, offer information about dissemination of results, provide definitions of study constructs (client-centered care; productivity), and reduce wordiness or redundancy in survey items. Additional feedback included support for this topic of inquiry and confirmation of manageable survey completion time (< 15 minutes). The researcher adjusted language in the survey introduction, instructions, and individual items to improve response accuracy, survey completion, and the overall survey experience for respondents.

Procedures

After review of the proposed study protocol and survey, the Human Subjects Committee Lawrence Campus approved the study. Qualtrics Online Survey Software supported electronic distribution of the web-based survey and supporting email communication ([Qualtrics, 2016](#)). Applying Dillman's Tailored Design Methods (Dillman, 2000), the study utilized a four-point contact strategy for electronic survey dissemination: (1) introductory contact/pre-notice email for initial recruitment, (2) survey distribution email including cover letter describing the survey, consent parameters, and the survey software link, (3) reminder/thank you email with second distribution of survey software link, and (4) final reminder/thank you email. Additionally, as part of the fourth contact strategy, I sent a targeted recruitment email to occupational therapy professionals with less than three years of OT experience to encourage participation of early career occupational therapists and occupational therapy assistants. Data collection occurred during February 2015.

Participants

The population for this study consisted of all occupational therapists (OT/OTR) and occupational therapy assistants (OTA/COTA) licensed to practice occupational therapy in the state of Kansas. As of November 2014, public record compiled by the Kansas State Board of Healing Arts (KSBHA) and supplied to the researcher indicated 1,586 occupational therapists and 673 occupational therapy assistants (N=2259) were licensed in Kansas. All OTs and OTAs who provided an email address to the KSBHA served as the distribution list for the study's online survey. The base sample for this study consisted of 2,173 occupational therapy professionals licensed to practice occupational therapy through the Kansas State Board of Healing Arts. Of the 2,173 emails sent out, 1,238 were opened (57%). Of the email opened, 608

participants opened the embedded survey link and completed the survey with varying degrees of totality and consent. For analysis, the researcher included all surveys indicating “yes” on consent item with partial to full survey completion (n=546) and surveys leaving the consent item blank but with full survey completion (n=3). Exclusion criteria included opening the survey but not starting it (n=2), indicating “no” on the survey consent item (n=6), leaving the consent item blank but with partial completion in other data fields (n=3), indicating “yes” on consent item but leaving all other items blank (n=14) or only completing the demographic survey items (n=34). Based on these inclusion and exclusion criteria, 549 surveys were used for analysis, which is a 25% overall survey response rate.

Possible reasons for non-response include emails not received due to wrong addresses or emails captured by technology security programs, technology comfort (or discomfort) level of the study population, preferences for mail or online study engagement, or did not choose to dedicate time to survey completion. Further, the researcher received follow-up emails from individuals sharing their willingness to complete the survey but questioning if they should do so because of their current work status, living in another state but still licensed in Kansas, or their professional focus was outside of occupational therapy. Conversely, the researcher received follow-up emails from study participants with appreciation for providing a voice for practitioners through the survey and exploring current professional issues in occupational therapy. Topic relevance and professional meaning are possible reasons for the favorable response rate.

Study Variables

For this study, the dependent variable was the degree of professional alienation expressed by occupational therapists and occupational therapy assistants when implementing client-centered care in practice. Drawing on policy alienation work and scale development by Tummers

et al. (2009), this study used multiple scale items to examine levels of professional powerlessness, professional meaningfulness, and the broader construct of professional alienation represented by the full professional alienation scale. The types of professional powerlessness that might present when working to incorporate client-centered care included strategic, tactical, and operational powerlessness. Professional meaningfulness, specifically client meaningfulness, illuminated the occupational therapy professionals' views about the benefit of implementing client-centered care to meet the needs of clients.

Modeled after the most recent AOTA Salary and Workforce Survey (2015a), professional profile characteristics and work context factors including practice settings described occupational therapy workers and practice contexts for consideration as independent variables. *Professional profile characteristics* were the demographic features that described the occupational therapy professional including professional occupational therapy credential (OT/OTR or OTA/COTA), years of experience in the occupational therapy field, professional association membership status, along with worker identification by employment status and primary work function. *Work context factors* described the practice environment including geographic location and institutional control/ownership. Additionally, respondents selected practice settings where they provided occupational therapy services including: academia, community, early intervention, outpatient, home health, hospital (non-mental health), long-term care/skilled-nursing facility, mental health, school, and other. As independent variables, these factors allowed the examination of the relationship between professional characteristics, work contexts, and practice settings and the construct of professional alienation expressed when engaging in client-centered occupational therapy practice.

Results

Descriptive Statistics

After consideration of inclusion and exclusion criteria, surveys from 549 respondents comprised the sample data used for analysis in this study. Professional characteristics, work context factors, and practice settings described the study sample.

Regarding professional characteristics, the majority of respondents were occupational therapists (n=432; 79%) with occupational therapy assistants represented as well (n=117; 21%). Proportionately, this was consistent with the 2015 AOTA Salary and Workforce Survey, which had OT (82%) and OTA (18%) respondents. The sample was an experienced group, as indicated by 35% with 11-20 years of experience and 30% with 21 or more OT practice years. Early career occupational therapy professionals represented the remaining 35% of respondents: 22% in practice for 3-10 years and 14% of OT and OTA professionals with less than three years of experience. Regarding professional association membership, 31% of respondents were current members of the American Occupational Therapy Association; 44% of respondents reported membership in their state's professional association.

In this study, work context factors described the practice environment and how occupational therapy professionals defined the nature of their work. This sample of the occupational therapy workforce was largely comprised of full-time workers, with 69% indicating they worked 32 or more hours weekly; the remaining 31% worked less than 32 hours weekly or did not work in the OT field presently. The vast majority of the study participants (89%) identified their primary work function as providing direct patient care working on the frontline of health and human service provision. The remaining 11% of occupational therapy professionals engaged in indirect service through administration or management, consultation, academia, or

other professional activities. Regarding work location, occupational therapy professionals working in urban and suburban work contexts comprised 74% of the sample (33% and 42% of respondents, respectively) while 26% identified their primary work setting as a rural area. Organizational control/ownership at facilities or programs where respondents work was largely public (64%) with the remaining 36% identifying their organizations as privately owned and operated.

Practice settings rounded out the professional profile, as respondents indicated the work settings where they provided occupational therapy services. Drawing on AOTA's (2015a) designated categories, work settings included academia, community, early intervention, outpatient, hospital, long term care/skilled nursing facility (LTC/SNF), mental health, schools, and other. Collectively, three settings – LTC/SNF (18%), hospital (16%), and schools (11%) – accounted for 45% of occupational therapy professionals in the study sample. Although respondents were able to select all work settings where they practiced on the survey, I isolated each practice setting category for independent analysis. Further, I collapsed academic, community, mental health and other into one “other single setting” category. The survey category that captured multiple settings indicated 36% of respondents worked in two or more practice settings.

Professional Alienation and Client-Centered Care

For analysis of professional alienation when incorporating client-centered care in practice, I used the Full Professional Alienation Scale comprised of all 19 items measuring constructs of powerlessness and client meaninglessness. Utilizing the study-specific professional alienation scale adapted from validated scales and template items generated by policy alienation scholarship (Tummers, 2012a), I calculated mean scale scores as the professional alienation

measure for analysis. Crafted as a five-point Likert scale (1 = strongly disagree to 5 = strongly agree), the mean score for all respondents on the Full Professional Alienation Scale was 2.25 (n=548; SD=.485). Mean scores closer to one suggested respondents experienced less professional alienation while averages closer to five indicated a greater professional alienation experience. Professional alienation sub-dimension scales indicated the following means: (1) Strategic Powerlessness Scale was 2.42 (n=548; SD=.653), (2) Tactical Powerlessness Scale was 2.40 (n=528; SD=.554), (3) Operational Powerlessness Scale was 2.24 (n=518; SD= .692), and (4) Client Meaninglessness Scale was 1.80 (n=489; SD=.613).

The fifth professional alienation sub-dimension of societal meaningfulness was not incorporated into the full professional alienation scale because the survey used an alternate format that was inconsistent with template scale structures provided by Tummers (2012a). Using a five-point Likert scale scoring frame (1 = strongly disagree to 5 = strongly agree), I crafted separate survey items to capture social meaningfulness specific to the target goals of health care reform's Triple Aim – improved population health, cost-containment, and satisfactory therapy experience – when working to implement the professional ideal of client-centered care (Berwick et al., 2008). Specific questions and key summary statistics included: (1) client-centered care leads to reduced health care costs (Mean=3.54; n=506; SD=.801), (2) client-centered care leads to an improved therapy experience for patients/clients (Mean=4.20; n=506; SD=.701), and (3) client-centered care leads to improved health across specified populations (Mean=3.96; n=504; SD=.752).

For this study, I created dummy variables for each of the professional/worker profile characteristics (professional OT practice credential, years of OT experience, professional membership status, employment status, work function) and work context factors (organizational

location, organizational control/ownership, practice setting) and examined the mean difference on the manifestation of professional alienation. I used independent samples t-tests to test if the between two group means were statistically meaningful.

Professional Profile Characteristics (IV) and Professional Alienation (DV)

Regarding professional practice credential (P1.1), the independent samples t-test was statistically significant, finding that occupational therapy assistants manifested greater professional alienation than occupational therapists (Mean=2.43, SD=.53 and Mean=2.2, SD=.46 respectively, $t(546) = 4.61, p < .00$). Proposition 1.2 expected to find greater professional alienation in early career professionals than mid/late career professionals. While the difference between early career and experienced occupational therapy professionals did prove significant, $t(545) = 3.34, p = .01$, results showed that on average, more experienced professionals (Mean=2.3, SD=.46) demonstrated more professional alienation than early career professionals (Mean=2.16, SD=.49), which is opposite of what was proposed. T-tests showed no association with national professional association membership status, $t(544) = 1.47, p = .14$, or state professional association membership status, $t(544) = 1.31, p = .19$, and the manifestation of professional alienation. Regarding employment status, difference in professional alienation between part time workers (Mean=2.31, SD=.49) and full time workers (Mean=2.23, SD=.48) was not statistically significant, $t(546) = 1.82, p = .07$. On average, occupational therapy professionals identifying with direct patient/client work functions (Mean=2.26, SD = .48) experienced greater professional alienation than respondents with indirect work functions (Mean=2.13, SD = .52), $t(538) = -1.97, p = .049$ (see Table 3.1).

Table 3.1

Summary of Professional Profile Characteristics Association with Full Professional Alienation Scale

Characteristics	M	SD	df	t-test	Sig
OT Professional Practice Credential			546	4.61	0.00**
OT	2.2	0.46			
OTA	2.43	0.53			
Years of OT Experience			545	3.34	0.01*
10 years or less	2.16	0.49			
11 years or more	2.3	0.46			
Professional Association Membership (AOTA)			544	1.47	0.14
Yes	2.21	0.45			
No	2.27	0.50			
Professional Association Membership (state)			544	1.31	0.19
Yes	2.22	0.47			
No	2.28	0.49			
Employment Status			546	1.82	0.07
Full Time	2.23	0.48			
Part Time	2.31	0.49			
Primary Work Function			538	-1.97	.049*
Direct	2.26	0.48			
Indirect	2.13	0.52			

Notes. Results statistically significant at * $p < .05$, ** $p < .01$; M = Mean. SD = Standard Deviation. Df = Degrees of freedom.

Professional Alienation Scale (adapted from Tummers, 2012a, 2012b) crafted as five-point Likert scale (1 = strongly disagree to 5 = strongly agree).

Score interpretation = the higher the mean score on the full professional alienation scale or specific scale item, the greater the professional alienation experience; the lower the mean score, the less professional alienation.

Work Context Factors and Practice Settings (IV) and Professional Alienation (DV)

Independent samples t-tests were conducted to examine the mean differences between work contexts, including practice settings and professional alienation. Contextual factors of organizational location, $t(538) = 1.62$, $p = .11$, and organizational ownership/control, $t(461) = .30$, $p = .77$, with professional alienation did not prove statistically significant. Next, I evaluated distinct practice settings using independent samples t-tests to determine if the practice setting itself influenced professional alienation associated with incorporation of client-centered care. Test results specific to long term care/skilled nursing facility, hospital, home health, outpatient practice settings were not statistically significant, suggesting there is little difference in professional alienation when comparing occupational therapy professionals working solely in these settings to respondents that do not. Analysis of professional alienation for occupational therapy professionals working in the early intervention practice setting proved statistically significant but directionally indicative of less professional alienation manifested by occupational therapy professionals working in this setting than other occupational therapy professionals. In contrast, statistically significant findings showed that occupational therapy professionals working in school settings (Mean=2.4, SD=.48) experienced greater professional alienation than those not working in school settings (Mean=2.23, SD=.49), $t(546) = -2.64$, $p = .01$. T-tests conducted to analyze professional alienation in occupational therapy professionals working in multiple practice settings did not yield statistically significant results, suggesting little difference between those working in multiple settings and those working in only one practice setting. Refer to Table 3.2 for additional data.

Table 3.2

Summary of Work Context Factors and Practice Settings Associated with Full Professional Alienation Scale

	M	SD	df	t-test	Sig
LTC/SNF Only			546	-1.39	0.17
Yes	2.31	0.53			
No	2.24	0.47			
Hospital Only			546	1.38	0.17
Yes	2.19	0.43			
No	2.26	0.49			
School Only			546	-2.64	0.01*
Yes	2.4	0.48			
No	2.23	0.49			
Home Health Only			546	-0.01	0.99
Yes	2.25	0.48			
No	2.25	0.49			
Early Intervention Only			546	2.17	.03*
Yes	1.98	0.39			
No	2.26	0.49			
Outpatient Only			546	1.08	0.28
Yes	2.14	0.36			
No	2.26	0.49			
Other Single Setting			546	1.36	0.17
Yes	2.12	0.45			
No	2.26	0.49			
Multiple Settings			546	0.74	0.46
Yes	2.23	0.49			
No	2.26	0.48			
Organizational Location			538	1.62	0.11
Rural	2.3	0.50			
Suburban/Urban	2.22	0.48			
Organizational Control/Ownership			461	0.30	0.77
Public	2.24	0.47			
Private	2.26	0.52			

Notes. Results statistically significant at * $p < .05$, ** $p < .01$; M = Mean. SD = Standard Deviation. Df = Degrees of freedom.

Professional Alienation Scale (adapted from Tummers, 2012b) crafted as five-point Likert scale (1 = strongly disagree to 5 = strongly agree).

Score interpretation = the higher the mean score on the full professional alienation scale or specific scale item, the greater the professional alienation experienced; the lower the mean score, the less professional alienation.

Professional Profile and Work Context as Predictors of Professional Alienation

To complete analyses for this study, multiple linear regression analysis was used to address Proposition 3 and answer the question about how professional profile characteristics and work context factors predict professional alienation. This approach helped explain the variance in: 1) professional alienation (continuous variable) related to professional profile characteristics; and 2) professional alienation (continuous variable) related to work context factors. The researcher conducted the following procedures to ensure the models met the necessary assumptions: tested for independence of residuals, multicollinearity (VIF values are close to 1 and not greater than 10), outliers to discard (Cook's distance maximum, criterion <1), and graphs or PP plots to determine linearity, normality and heteroscedasticity.

Having met assumptions for linear regression modeling, I conducted two multiple regression analyses to identify predictors of professional alienation. One analysis included relevant professional profile characteristics (professional practice credential, years of occupational therapy practice experience, primary work function) while the second analysis incorporated relevant work context factors (early intervention practice setting, and school practice setting). I then followed with analysis including all five variables. The regression analysis with the professional profile characteristics proved to be a statistically significant model (R Square = .08, adjusted R Square = .07, $F(3, 535) = 14.84$, $p < .00$). The regression equation with the work context factors was significant (R Square = .02, adjusted R Square = .02, $F(3, 545) = 5.565$, $p < .004$). The full regression model including all possible predictor variables was significant as well (R Square = .10, adjusted R Square = .09, $F(5, 533) = 11.778$, $p < .00$). Results of the multiple regression analysis reinforced significant professional profile findings by identifying the professional practice credential, years of occupational therapy experience, and

primary work function as likely predictors of professional alienation. Further, they retained their predictive power when incorporated in the full regression equation. Although relationships between professional alienation and work context factors were few, the results of the multiple regression analysis including early intervention and school-based practice settings indicated a predictive link between these practice contexts and professional alienation. When included in the full regression equation, statistics showed the school setting retained its predictive quality while the early intervention setting did not (see Table 3.3).

Table 3.3

Multiple Regression Analysis: Predicting Professional Alienation from Professional Profile Characteristics and Work Context Factors

Model	Unstandardized B	Standard Error B	Standardized B	t	Sig.
Professional OT Practice Credential	-.26	.05	-.22	-5.22	<.001
Years of OT Experience	-.19	.04	-.19	-4.45	<.001
Primary Work Function Schools	.14	.06	.09	2.22	.03
Early Intervention	.19	.06	.12	2.96	.003
	-.25	.13	-.08	-1.97	.05

Notes. Dependent Variable: Professional Alienation Full Scale (19 items)
(R Square = .10, adjusted R Square = .09, F(5, 533) = 11.778, p < .001)

Discussion

In this article, I have attempted to build a bridging link between occupational therapy literature describing the power of client-centered care and authentic occupational therapy practice with public administration scholarship in the areas of street-level bureaucracy and policy alienation. By connecting these two areas, I have applied the construct of policy alienation discussed in public administration scholarship to current concerns within the occupational

therapy profession about the extent to which practicing professionals feel empowered to incorporate professional values and ideals in practice. The primary aim of this research was to examine the construct of professional alienation, including dimensions of powerlessness and client meaningfulness, when applied to occupational therapy professionals implementing client-centered care. Here, I discuss the findings of the professional alienation scales along with analysis of professional profile characteristics and work context factors in relation to professional alienation.

Professional Alienation or Professional Empowerment

Based on findings from the full professional alienation scale ($M=2.25$; $n=548$; $SD=.485$) as well as each professional alienation sub-dimensions, occupational therapists and occupational therapy assistants believed they could influence the inclusion of professional ideals or values, such as client-centered care, in their practice. Looking at findings from the professional alienation sub-dimension scales, study participants indicated a greater sense of empowerment when operationalizing professional principles or values in their own practice (operational powerlessness) than when working to institutionalize professional practices in their organizations (tactical powerlessness) or in policy (strategic powerlessness). Occupational therapy professionals believed they could influence decisions about the inclusion of client-centered care in rules and regulations, organizational implementation of policy, and personal demonstration in practice. This is good news.

Turning to the client meaningfulness dimension, the scale suggested that the majority of occupational therapy professionals agreed or strongly agreed there was distinct value added for their own clients when they exercise client-centered care – our work is meaningful and it matters to the people we serve. Further, most study respondents agreed or strongly agreed that client-

centered care leads to an improved therapy experience and improved health for clients/patients. Occupational therapy professionals were not as certain about the impact of client-centered care on the reduction of health care costs, as indicated by the high number of “agree or strongly agree” responses (n=259) and “neither agree or disagree” responses (n=220). While it is encouraging to see many respondents connect client-centered care with cost savings, occupational therapy lacks evidence to support this claim. This finding suggested we need to communicate our distinct value related to reducing health care costs more effectively with both internal and external audiences to ensure commitment to inclusion of occupational therapy in service delivery models. When we demonstrate and articulate our distinct value through improved client experiences, improved health or quality of life outcomes, and cost effectiveness, occupational therapy will be powerful.

Professional Profile Characteristics and Professional Alienation

As discussed, occupational therapy is largely an empowered profession, yet there are variations in our experiences and perceptions as occupational therapy professionals. Specifically, findings showed that occupational therapy professionals engaged primarily in direct treatment experienced more professional alienation than those serving the profession more indirectly. Direct treatment providers are frontline occupational therapy professionals. On the frontline, it is expected that occupational therapy professionals will carry out managerial directives regardless of congruence with their profession ideals or values, implement policy decisions with scarce or restricted resources, and therapeutically serve clients/patients with a range of abilities and needs. This finding was consistent with the citizen/client-agent narrative from street-level bureaucracy scholarship in that direct service providers often feel alienated from their work. Also, results showed that the occupational therapy assistants believed they were less influential than

occupational therapists when working to establish policy, organizational change, or a practice culture that included client-centered care. Again, occupational therapy assistants are present in greater numbers in direct frontline practice but also work under the supervision of an occupational therapist – an additional level of authority away from policy making that directs policy implementation and might constrain individual practice behaviors. While years of professional experience as an occupational therapy professional proved statistically significant, findings were not as proposed – early career professionals (10 years or less in practice) experienced slightly less professional alienation than experienced professionals (greater than 10 years in practice). Literature about transition shock for early career professionals (from protected preparation environment to real world practice contexts) served as support for the proposition, but these findings suggested that transition shock does not dull youthful enthusiasm and recent academic training that espouses client-centeredness in practice (Duchscher, 2008). The finding that the post 10-year professional group experienced greater professional alienation in their work suggested other factors, such as burnout or access to communities of practice support, might warrant future investigation. Overall, I found commitment to influencing practice through client-centered care is alive and well across the span of most occupational therapy careers. Finally, I did not find a relationship between professional association membership and professional alienation – an interesting result, considering client-centered care is an occupational therapy principle or value directed by the profession.

Work Context Factors and Professional Alienation

When considering client-centered care, practice context is often identified as a barrier to implementation of best practice approaches or a reason for not incorporating core foundation principles in practice. Understanding that context may shape how we do or do not practice, I was

interested in the association between work context factors and the perceived influence of the professional to incorporate client-centered care into their work. In this study, findings for organizational control/authority (P2.2) were not statistically significant, but high mean scores suggested that occupational therapy professionals working in public and private organizations were rooted in client-centered care and empowered by rather than alienated from professional values. Setting location (P2.1) did not yield significant statistical findings, but the difference in mean scores was notable, as it suggested that occupational therapy professionals in rural settings experienced greater professional alienation than their urban/suburban counterparts. Earlier discussion suggested that close client-professional relationships might ensure client-centeredness; however, system constraints and scarce time and resources could require the occupational therapy professional to make difficult decisions between client needs and organizational goals.

Proposition 2.3 provided the frame to explore the frequent claim that “context matters,” but the stated expectation in the proposition was purposely ambiguous. This study found that occupational therapy professionals did experience professional alienation related to implementation of client-centered care in some but not all practice settings. Specifically, the results showed statistically significant differences in professional alienation in only two work contexts: the early intervention practice setting and the school setting. Respondents working in early intervention settings reported less professional alienation when compared to those not working in that setting; participants working in school contexts reported greater professional alienation when compared to others. These findings showed that occupational therapy professionals working in early intervention programs or agencies believed they could influence inclusion of client-centered care in their practice, while occupational therapy professionals in

school-based practice settings felt less empowered to incorporate client-centered care in their work. This finding was interesting in light of the shared pediatric population focus between these two very different practice environments, with each setting offering unique supports and constraints to practice. In this case, context does matter. While reporting about data-specific statistical findings and differences is necessary, we must not lose sight of the good news – the bigger story of professional empowerment instead of professional alienation in occupational therapy.

Study Limitations

Careful study preparation aims to anticipate limitations, yet limitations remain. First, the study incorporated a large representative sample of one state’s occupational therapy professional population; however this restricted group might limit the generalizability of study findings to other occupational therapy samples. Additionally, the focus on occupational therapy professionals might limit application when wanting to replicate this study design or extend study findings to other professions or workers. Regarding survey distribution, coverage bias associated with utilization of email with no alternate delivery method introduces the question about representativeness.

Implications for Occupational Therapy – Professional Empowerment

Occupational therapy scholarship seeks to establish our science and evidence base for assessment and intervention and translate findings to demonstrate our value; yet we also need research that illuminates the impact of systems or policy on occupational therapy professionals, our clients, and ultimately, our profession. As a profession, we must assert our power through active involvement in policy making at institutional roundtables and in policy implementation on the frontlines of practice working with clients. As a profession, we must embrace rather than be

alienated from our professional values or core principles such as client-centered care in support of authentic occupational therapy practice.

Moving forward from occupational therapy's centennial celebration, each occupational therapist and occupational therapy assistant must embrace his or her professional power – in educational programs, practice environments, research endeavors, and the policy front. When preparing occupational therapy students for professional practice, we need to arm them with advocacy strategies, knowledge about systems, and real-world practice exposure to allow them to test the transition waters and garner strength for meeting challenges to professional principles and values. Occupational therapy professionals, especially occupational therapy assistants and all frontline direct service professionals, need this support as well.

In summary, this original research introduced the construct of *professional alienation* as a general cognitive state of psychological disconnection from a profession's core philosophical ideals and/or values as a means of responding to policy/organizational demands and/or managing tension or role conflict. While the study sought to discover how occupational therapists and occupational therapy assistants experience professional alienation when incorporating client-centered care in their practice, this was not the prominent finding. Rather, this study offers an encouraging story of professional empowerment when facing challenges to incorporation of core professional values and ideals. Based on findings from this study, occupational therapy is a powerful – not powerless – profession; occupational therapists and occupational therapy assistants are powerful – not powerless – professionals. Occupational therapy has embraced its professional power and can confidently look ahead to our 2025 Vision, which states, “Occupational therapy maximizes health, well-being, and quality of life for all people,

populations, and communities through effective solutions that facilitate participation in everyday living” (AOTA, 2016, para. 1). Can you see it?

APPENDIX A

ROLE CONFLICT SCALE ITEMS

Organization/Professional Role Conflict (Scale)

- Looking from my professional values, I embrace the way my organization implements productivity standards.
- The way my organization works with productivity standards conflicts with my professional autonomy.
- I have the feeling that I sometimes have to choose between my professional values and the way my organization implements productivity standards.
- Exactly following my organization's rules regarding productivity standards is incompatible with my professional values.
- The way my organization handles productivity standards clashes with my values as an OT professional.

Policy/Professional Role Conflict (Scale)

- Looking from my professional values, I embrace productivity standards.
- Productivity standards negatively affect my professional autonomy.
- I have the feeling that I sometimes have to choose between my professional values and the rules set by productivity standards.
- In working within productivity standards, I violate my professional ethics.
- Working with productivity standards conflicts with my values as an occupational therapy professional.

Policy/Client Role Conflict (Single Item)

- Working with productivity standards clashes with the wishes of many of my clients/patients.

APPENDIX B

POLICY ALIENATION CONCEPTS APPLIED TO PROFESSIONAL ALIENATION
 IN OCCUPATIONAL THERAPY PROFESSIONALS IMPLEMENTING
 CLIENT-CENTERED CARE

	Policy Alienation (Tummers, 2012b)	Professional Alienation – General	Professional Alienation – Occupational Therapy Professionals
Strategic Powerlessness	“perceived influence of professionals on decisions concerning the content of a policy, as is captured in rules and regulations”	perceived influence of professionals on decisions concerning the inclusion of professional principles or values in policy, as is captured in rules and regulation	perceived influence of occupational therapy professionals on decisions concerning inclusion of client-centered care, as is captured in rules and regulation
Tactical Powerlessness	“perceived influence of professionals over decisions concerning the way a policy is executed within their own organization”	perceived influence of professionals over decisions concerning the way professional principles or values are executed within their own organization	perceived influence of occupational therapy professionals over decisions concerning the way client-centered care is executed within their own organization
Operational Powerlessness	“perceived influence of professionals during actual policy implementation”	perceived influence of professionals to exercise professional principles or values	perceived influence of occupational therapy professionals to exercise client-centered care
Client Meaninglessness	“perception of the value added for their own clients by professionals implementing the policy”	perception of the value added for their own clients by professionals exercising professional principles or values	perception of the distinct value added for their own clients by occupational therapy professionals exercising client-centered care
Societal Meaninglessness	“perception of professionals concerning the added value of the policy to socially relevant goals”	perception of professionals concerning the added value of their professional principles or values to socially relevant goals	perception of occupational therapy professionals concerning the distinct value of client-centered care to socially relevant goals

APPENDIX C

PROFESSIONAL ALIENATION SCALE

(Adapted from Tummers, 2012a and 2012b)

Template words are italicized. Reverse coding indicated by (R).

Professional Alienation – Strategic Powerlessness (scale)

- *OT professionals* have too little power to influence *implementation of client-centered care in policy*.
- We *OT professionals* were completely powerless during the introduction of *client-centered care in policy*.
- *OT professionals* could not at all influence the development of *client-centered care* at the national level.
- *OT professionals*, through their professional associations, actively helped to think through the design of *client-centered care* in policy. (R)

Professional Alienation – Tactical Powerlessness (scale)

- *OT professionals* can decide how to implement *client-centered care*. (R)
- *OT professionals*, through working groups or meetings, take part in decision over the execution of *client-centered care*. (R)
- The management of my organization should involve the *OT professionals* far more in the execution of *client-centered care*.
- *OT professionals* were not listened to about the introduction of *client-centered care* in my organization.
- *OT professionals* can take part in discussions regarding the implementation of *client-centered care*. (R)

- I and my fellow *OT colleagues* are completely powerless in the implementation of *client-centered care*.

Professional Alienation – Operational Powerlessness (scale)

- I have freedom to decide how to provide *client-centered care*. (R)
- When working with *client-centered care*, I can align my practice decision with the patient/client's needs. (R)
- Tight procedures and policies restrict my ability to implement *client-centered care* where I work.
- While working with *client-centered care*, I cannot sufficiently tailor it to the needs of my patients/clients.
- While working with *client-centered care*, I can make my own judgments. (R)

Professional Alienation – Client Meaninglessness (scale)

- With *client-centered care* I can better solve the problems of my patients/clients. (R)
- *Client-centered care* is contributing to the health and well-being of my patients/clients. (R)
- Because of *client-centered care*, I can help patients/clients more efficiently than before. (R)
- *Client-centered care* is ultimately favorable for my clients. (R)

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