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Abstract

Purpose: The Kawa (river in Japanese) model uses the metaphor of a river to view one's life from a metaphysical perspective, with consideration given to the interaction between social and physical environments, life circumstances, assets, and liabilities. Preliminary research suggests that the Kawa model may be an effective tool for interprofessional collaboration, but studies employing the model with diverse groups of healthcare professionals have not been undertaken. The purpose of this pilot study was to determine if the Kawa model could serve as an effective collaboration tool for a diverse healthcare team within a skilled nursing facility.

Method: A pilot study using survey methodology was conducted with an interprofessional team (N=10) involving rehabilitation, nursing, administration, social work, and activities personnel. Education on the Kawa model and its components was provided to the team, followed by their participation in an interactive activity involving application of the model to a case study. An author-generated survey was administered before and after the study to elicit views about the Kawa model's potential use as a team collaboration tool.

Results: All 10/10 participants agreed or strongly agreed the Kawa model provides a common language for interprofessional collaboration, and 9/10 felt it would be an effective tool to increase collaboration in their facility.

Conclusions: Healthcare professionals from a variety of fields must collaborate effectively for quality client care. Using a tool, such as the Kawa model, may provide a common ground for interprofessional discussions when making decisions about a client's care. Recommendations include replication of this study with larger, more diverse healthcare teams, incorporation of an actual client and his or her family in the team, and comparison of other collaborative practices with those employing the Kawa model.

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ABSTRACT

Purpose: The Kawa (a river in Japanese) model uses the metaphor of a river to view one's life from a metaphysical perspective with consideration given to the interaction between social and physical environments, life circumstances, assets, and liabilities. In preliminary research, there is a suggestion that the Kawa model may be an effective tool for interprofessional collaboration, but researchers employing the model with diverse groups of health care professionals have not performed any studies on the subject. The purpose of this pilot study was to determine if the Kawa model could serve as an effective collaboration tool for a diverse health care team within a skilled nursing facility. **Method:** A pilot study using survey methodology was conducted with an interprofessional team ($N = 10$) involving rehabilitation, nursing, administration, social work, and activities personnel. Education about the Kawa model and its components was provided to the team, followed by their participation in an interactive activity involving application of the model to a case study. An author-generated survey was administered before and after the study to elicit views about the Kawa model's potential use as a team collaboration tool. **Results:** All 10 participants agreed or strongly agreed the Kawa model provided a common language for interprofessional collaboration, and 9 out of 10 felt it would be an effective tool to increase collaboration in their facility. **Conclusions:** Health care professionals from a variety of fields must collaborate effectively for quality client care. Using a tool, such as the Kawa model, may provide a common ground for interprofessional discussions when making decisions about a client's care. Recommendations include replication of this study with larger, more diverse health care teams; incorporation of an actual client and his or her family in the team; and comparison of other collaborative practices with those employing the Kawa model.

Keywords: Kawa model, interprofessional collaboration, interprofessional team interdisciplinary, team, quality of care, occupational therapy

BACKGROUND/LITERATURE REVIEW

The World Health Organization defines interprofessional collaboration as individuals representing a variety of health care disciplines working together “with patients, their families, carers, and communities to deliver the highest quality of care across settings.”¹ Core competencies for effective interprofessional collaboration established by the Interprofessional Education Collaborative (IPEC) include mutual respect and shared values, recognition of one’s professional role and the roles of other professionals, effective communication skills, and the ability to exemplify behaviors of a team player.² The benefits of collaborative care for clients include an enhanced continuum of care, increased quality of care, and higher satisfaction with the care provided.^{3,4} For health care professionals, collaborative care improves communication among professionals and increases efficiency, perceived quality of care, and job satisfaction.⁵⁻⁷

Researchers further highlight the negative impact of interpersonal conflict, job stress, and lack of collaboration in health care as well as strategies to attenuate these damaging elements. A survey of 141 nurses showed that intrapersonal and intragroup conflict among nursing staff decreased job satisfaction.⁸ Similarly, another researcher confirmed the demotivating influence of conflict in the workplace but supported the theory of “empowering leadership” to effectively motivate and engage team members.⁹ In their study of negative relationships, de Jong et al linked adverse attitudes, judgments, and behaviors to decreased team cohesion and performance.¹⁰ In addition, they identified increased team collaboration and interaction as strategies to guard against counterproductive behaviors, such as withholding important information from other team members or attempting to sabotage the team. Turnover among health care professionals is also a concern, which has been positively correlated with conflict in the workplace and poor collaboration among teams.¹¹ Finally, focus group discussions with occupational therapists in New Zealand showed that working with supportive team members, being a part of a collaborative multidisciplinary team, and having adequate supervision all contributed to higher perceived job satisfaction, whereas poor communication, decreased respect, and role confusion were associated with dissatisfaction.¹²

The focus of much of the research available and summarized here is about exploring the impact of interprofessional collaboration or lack thereof. Limited high quality studies have been undertaken to determine effective tools, models, or techniques to improve collaboration and patient outcomes.¹³ Only two studies in the literature search had potential models or tools for operationalizing interprofessional collaboration.^{14,15} The Menefee model depicts a process centralized around the patient and involves consistent, brief, daily participation by all interdisciplinary team members; the patient is asked to voice his or her goal each day, and the team focuses on care transitions both during and after the patient’s stay in the facility. Menefee also emphasized the need to move beyond communication into true collaboration.¹⁴ While this model presents a general process for collaboration, The Continuum of Interprofessional Collaborative Practice in Health and Social Care has a range of five types of collaboration, increasing in intensity as the complexity of the client increases.¹⁵ Along this continuum, the client and family also hold a central position, but the professionals must reflect on the complexity of the client’s situation, the purpose and level of the collaboration, and the integration of discipline-specific knowledge to best meet the client’s needs. The dynamic nature of collaboration and the establishment of mutual goals by those involved is also accentuated in this continuum.

Interprofessional education is a core standard of education for some institutions and health care education programs, but requirements are lacking or vary greatly across professions.^{16,17} Students may participate in lectures and interactive activities with students from different educational programs to learn about each other’s roles and how to work together to improve client outcomes. There is a plethora of literature related to interprofessional education: how to conduct it, key components to include, and the efficacy of various approaches, yet not all health care professionals have received formal training for collaborative practice.

The Kawa (river in Japanese) model, an occupational therapy conceptual model of practice, has traditionally been used to improve collaboration between a client and a single care provider.¹⁸⁻²¹ The metaphor of a river is used in the model to view one’s life from a metaphysical perspective with consideration given to the interaction between social and physical environments, life circumstances, assets, and liabilities. In the model, various elements of the river, such as the river banks, rocks, and driftwood, are used to represent supports, barriers, challenges, and opportunities. An occupational therapist, for example, might use this model to help a client identify his or her strengths, challenges, supports, and environmental factors in order to determine the most appropriate treatment plan or course of action that promotes well-being or unabated river flow. In prior research, it has been suggested that the Kawa model may be an effective tool for collaboration among the rehabilitative professions, but researchers employing the model with more diverse groups of health care professionals have not been undertaken.²² Therefore, the purpose of this pilot study was to determine if the Kawa model could serve as an effective collaboration tool for a diverse health care team.

METHODS

Study Design

A pilot study was chosen to explore the potential use of the Kawa model as a tool to enhance interprofessional collaboration. A pilot study "is a requisite initial step in exploring a novel intervention or an innovative application of an intervention."²³ Because there is a paucity of research about the potential value of the Kawa model as a tool for enhancing interprofessional collaboration with only one study identified that explored this topic to date, a pilot design was used to align with the research objective.²² The objective for this study was to provide an interprofessional team with education about the Kawa model and allow the team to apply the model a hypothetical client in order to elicit their opinions about the potential for the Kawa model to enhance interprofessional collaboration in preparation for a larger scale study on the topic. Pilot studies are also useful to test and identify any design flaws, and this objective was secondary because further study of this topic is planned.²⁴ Surveys were used before and after the education and application of the Kawa model to elicit study outcomes. In this case, the investigators were interested in the interprofessional team's attitudes toward collaboration and its baseline knowledge of the Kawa model prior to the education and interactive activity in comparison with its opinions about if or how the Kawa model might enhance interprofessional collaboration.

Study Participants

Convenience sampling was used to recruit a naturally occurring interprofessional team from one skilled nursing facility in Pennsylvania (United States). The facility from which the participants were recruited is a 120-bed facility that serves both short- and long-term clients, and it was chosen as it offered a variety of health care professionals who consistently collaborate to serve the client population. Eligibility criteria for participants included being a full-time employee and a member of an interprofessional team whose primary role was coordination and delivery of patient care. Contract and part-time employees were excluded from this study as they typically are not included in client care plan meetings in this setting. The interprofessional team ($N = 10$) consisted of 6 nurses, 1 activities coordinator, 1 administrator, 1 rehabilitation director/occupational therapist, and 1 social worker. While the distribution of team members varied among disciplines, this diversity accurately represented the interprofessional team in this facility and was appropriate for inclusion in this study. Ninety percent of the participants had at least 7 years of experience in their respective discipline. While all participants currently practiced in a skilled nursing facility, some had experience practicing in a variety of other settings: 40% had experience in home health care, 40% had experience in acute care, 30% had experience in assisted living/personal care, 20% had experience in outpatient rehabilitation, and 10% had experience in pediatrics. The distribution of participants by years of experience and professional discipline is included in Table 1.

Table 1. Participant Demographics

Participant #	Years of Experience in Discipline	Discipline
1	7-10 years	Nursing (wound care)
2	>25 years	Nursing (restorative)
3	7-10 years	Social Work
4	11-15 years	Nursing (education)
5	11-15 years	Activities
6	>25 years	Administration
7	11-15 years	Rehab Director/OT
8	21-25 years	Nursing (director of nursing)
9	16-20 years	Nursing
10	4-6 years	Nursing

Procedures

An educational session, including a review of the Kawa model and creation of individual Kawa models by all participants, was provided to the interprofessional team by the first author (a registered occupational therapist) and 3 occupational therapy students. During the education session, the Kawa model and its components and how the components could inhibit or contribute to one's health and well-being was overviewed in a slide presentation. Existing literature on the Kawa model and instructions for constructing an individual Kawa model were also provided. Following the presentation, participants created individual Kawa models representative of their individual life circumstances to gain a better understanding of the model, its components, and how it might be applied to an individual client. After this baseline education was provided, the interprofessional team was asked to apply the Kawa model to a fictitious case study (See Appendix, Ethel Case Study), generated by the first author based upon her years of experience in a skilled nursing facility. In the case study, "Ethel," a 76-year-old female who recently experienced a hip fracture and was simultaneously dealing with several other co-morbidities, emulated a typical client admitted to the facility. This interactive

application was facilitated by the first author; Ethel's Kawa model was created on a large easel in the front of the room, and individual health care professionals made contributions to the model by drawing in driftwood (Ethel's attributes and liabilities) and rocks (Ethel's challenges/barriers), based upon their areas of concern related to their professional discipline. The first author provided neutral prompts, such as "Does anyone else have a rock to add?" or "Is there additional driftwood that should be considered?", in an effort to facilitate the team's ability to tell Ethel's story from their own perspectives.²⁰ The result was a holistic picture of Ethel that showcased each health care professional's unique perspective, which was interwoven with the perspectives of the rest of the team.

The education and interactive activity lasted approximately 1.5 hours, and author-generated surveys were administered before and after the education and activity. This study was approved by Internal Review Board (IRB) of Chatham University in Pennsylvania. Informed consent was obtained from all participants.

Surveys

Author-generated pretest and posttest surveys were used to elicit views about the use of the Kawa model for interprofessional collaboration. The pretest survey included 3 demographic questions; a question asking participants if they were at all familiar with the Kawa model; and five Likert Scale questions to obtain participants' views about the importance of interprofessional collaboration, the current quality of collaboration in the facility, and the existing methods of collaboration. The posttest survey included 6 Likert scale questions to elicit participants' opinions about the utility of the Kawa model for interprofessional collaboration and their likelihood of using the model in the future for this purpose. Both surveys were administered in paper format; the pretest survey was completed just prior to the education and interactive activity, and the posttest survey was completed immediately following the education and interactive activity. Survey language and formatting was reviewed by several experts in the field of occupational therapy who were familiar with the model as well as survey design to increase content validity.

Data Analysis

Descriptive statistics, namely measures of central tendency, were used to summarize the data collected from the pretest and posttest surveys. The pilot nature of this study, the small sample size, and the lack of randomization or use of a control group limited further inferences from the data. Inferential statistics were not employed as the pretest survey was designed to elicit baseline views of the team related to collaboration and prior knowledge of the Kawa model, and the posttest survey was used to garner opinions about the potential to use the Kawa model in collaborative practice. Survey questions were not designed to measure changes as a result of the educational session and activity, but rather to determine if the team valued the use of the Kawa model for future collaboration.

RESULTS

Pretest Survey

In addition to several demographic questions, the pretest survey asked participants if participants were familiar with the Kawa model; as expected, responses indicated that none of the participants had any prior knowledge of it. The varying clinical backgrounds of the participants likely contributed to this lack of knowledge and ensured that no other experience with or information on the model had influenced their opinions. Participants were also asked to rate how well they felt their team collaborated on a scale of 1 to 10 with 1 being "not well at all" and 10 being "very well"; the mean of all responses was 6.8/10. Only one participant (participant 1) rated the current quality of collaboration below a 5 with a rating of 1/10 or "not well at all"; the mean of all responses with this outlier removed was 7.4/10. The range of all 10 responses were 1 to 9, and the mode (Mo) was 8. The final items on the pretest survey were several Likert Scale questions used to extract participants' views on the importance of interprofessional collaboration and current collaborative practices within their facility. Mean responses to these questions are depicted in Figure 1.

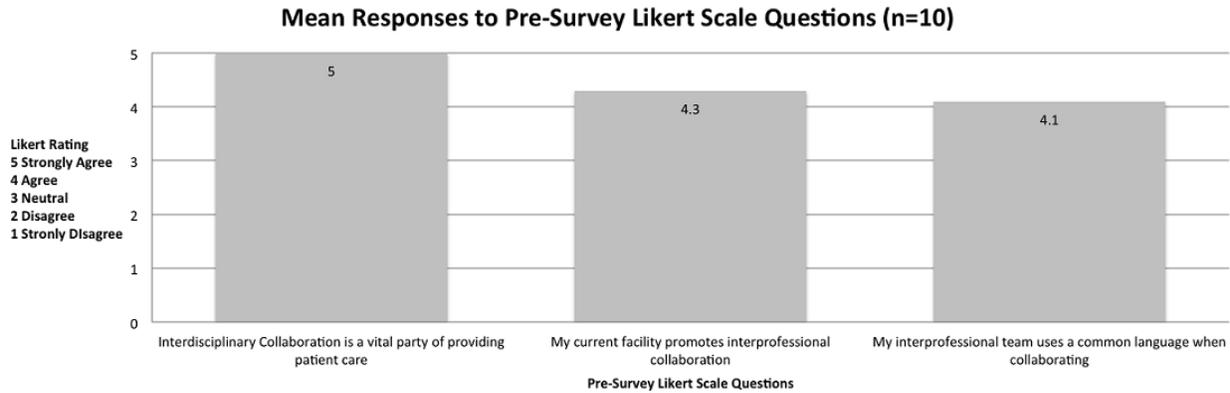


Figure 1. Mean Responses to Pretest Survey Likert Scale Questions

Posttest Survey

The posttest survey included a series of Likert scale questions to elicit participants' opinions about the utility of the Kawa model for interprofessional collaboration after participating in the educational session and applying the model to a hypothetical case. Mean responses to these items are illustrated in Figure 2. The final question of the posttest survey asked participants how likely they were to use the information they learned about the Kawa model in their practice; the mean of all responses was 7.9/10 with 10 indicating "very likely" and 1 indicating "not likely at all." The range of all responses was 5 to 10, and the mode (Mo) was 8. In addition, the collaborative activity of constructing the Kawa model for the hypothetical client showcased all team members' perspectives of the client and their individualized concerns based upon their respective professional disciplines. The result was a comprehensive visual assessment of the client, which could be used collaboratively by all team members to make care decisions (Figure 3).

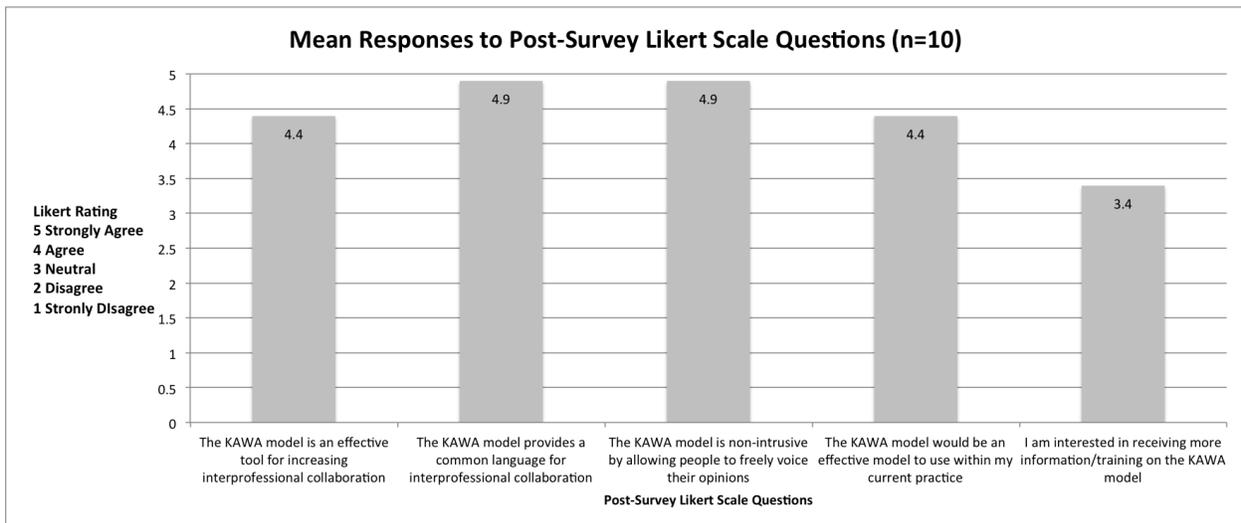


Figure 2. Mean Responses to Posttest Survey Likert Scale Questions

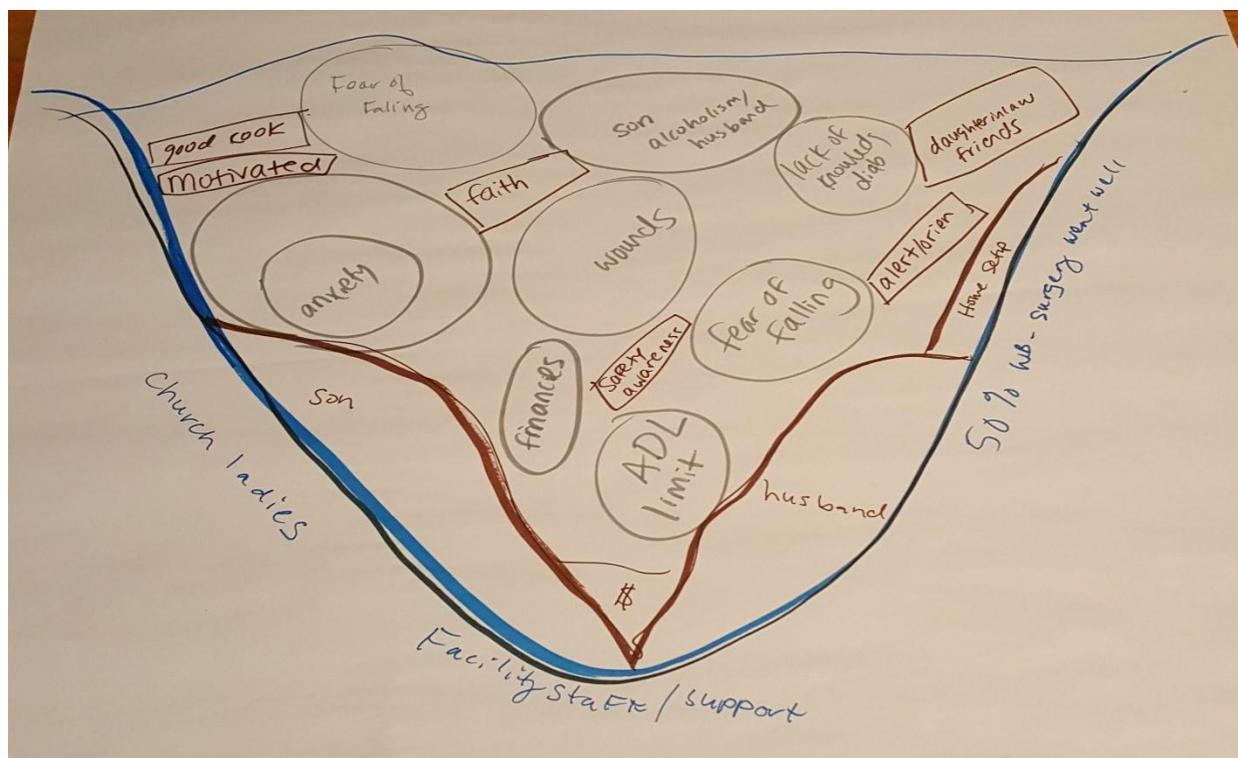


Figure 3. Kawa Model for Hypothetical Client Case

DISCUSSION

The objective of this pilot study was to elicit perceptions from an interprofessional health care team regarding the use of the Kawa model as a tool for effective collaboration. All participants agreed or strongly agreed that the Kawa model provided a common language for interprofessional collaboration, and 9 out of 10 felt it would be an effective tool to increase collaboration in their facility.

The team composition may have contributed to these positive perceptions about the Kawa model. The team was a fairly stable team with many of the professionals working together over a period of several years with only one participant (participant 1) rating the current quality of collaboration below a 5 on the 10-point scale (in which 10 represented the highest level of collaboration); this demographic is acknowledged as a team which was more disparate to begin with that may have had different perceptions of the Kawa model or been more or less willing to use it for collaboration. The pretest survey also indicated the team valued collaboration and agreed that having a common language for collaborating is important. More specifically, all participants, except participant 6, who offered a neutral response, agreed or strongly agreed that they had a common language for collaboration on the pretest survey. Participant 6 held an administrative position and may have lacked the clinical background to fully understand the complex language used by clinical members of the team to collaborate. On the posttest survey, 9 out of 10 participants strongly agreed that the Kawa model provided a common language for interprofessional collaboration. This outcome suggests that the Kawa model may provide a better approach to collaboration compared with the team's current method of collaboration.

Similar to the literature reviewed, all members of the health care team strongly agreed that interprofessional collaboration is a vital part of providing quality patient care.³⁻⁷ Overall, team members indicated they were likely to use the information learned about the Kawa model in their daily practice. However, participants 2, 6, and 8, who all had 21 years or greater experience in their fields, indicated the greatest likelihood of applying the information to practice. With their extensive experience, they may have been afforded opportunities to try a variety of methods for collaboration in the past and to compare their experience with the Kawa model to past situations and experiences. Finally, on the posttest survey, when participants were asked their level of agreement with the statement "I am interested in receiving more information or training on the Kawa model," the mean of all responses was 3.4/5 (1 = strongly disagree, 5 = strongly agree), which may indicate that the education and information was adequate to provide a foundation for use of the model in practice. This outcome could have practical implications for interprofessional development because this educational session and interactive activity took place over less than 2 hours.

Many features of existing models for operationalizing interprofessional collaboration are inherent within the Kawa model. The other models reviewed place the client centrally as a vital contributor to the team; however, the Kawa model takes this view a step further by looking at the client inextricably linked with his or her goals, values, circumstances, environment, family, and other supports and barriers.^{14,15,18-20,25}

Menefee used the Menefee model and supported use of the same process and active involvement of all members of the team, citing the process as brief, meaningful, and likely to show important pieces of information that might otherwise be missed.¹⁴ During the interactive activity of this study, the team echoed the same features in the Kawa model. Team members found the metaphor of a river easy to apply regardless of their professional background, and anecdotally, they discussed aspects of the hypothetical client's care that would not have been emphasized in traditional team meetings.

The Continuum of Interprofessional Collaborative Practice in Health and Social Care, hereafter referred to as The Continuum, was used to emphasize the dynamic nature of interprofessional collaboration and the need "to situationally adjust the intensity of collaboration according to the clients' needs."¹⁵ The Kawa model aligns with this framework as it can be individually applied to each client case, and the degree of collaboration and reassessment can fluctuate based upon the client's concerns and situation. The Continuum also proposes that in order for health care professionals to effectively collaborate, they need to reflect on their own perspectives as well as those of other team members and the client.¹⁵ During application of the Kawa model to the hypothetical case, individual team members contributed to the visual representation (Kawa or river model) of the client and shared their individualized views of the client. While the process began in parallel with each team member taking a turn, the process quickly became integrative as the professionals began to weave their concerns and thoughts about supports and barriers together to create a complete picture of the client and to problem solve.

Finally, reflecting on the four core competencies for effective interprofessional collaboration put forth by the Interprofessional Education Collaborative (IPEC), 9 out of 10 study participants felt the Kawa model provided a common language for interprofessional communication and a non-intrusive method to freely share thoughts and opinions. This platform could be a useful manner of addressing the competencies of mutual respect and shared values, recognition of one's professional role and the roles of other professionals, and effective communication skills.² In summary, as shown by these preliminary outcomes, the Kawa model may be an appropriate tool to promote effective interprofessional collaboration among diverse health care teams, and further study is warranted.

Limitations

Limitations include the use of a small convenience sample from one facility and the absence of an actual client and his or her family as part of the sample. While the sample of 10 interprofessional team members represented a typical interprofessional team in a skilled nursing facility and was appropriate for this pilot study, the ability to generalize the results to other interprofessional teams or facilities is limited. Furthermore, the researchers used a case study of a typical client in the setting in this study but failed to include an actual client and his or her family as part of the interprofessional team as is the standard practice in this setting. While the team members primarily agreed that the Kawa model was useful for collaborating related to a hypothetical client case, the value of this approach when viewing an actual client or the client's or family's perspectives are unknown. Finally, while the surveys used for data collection in this study were author-developed, expert review was used to increase content validity as there were no established tools available to collect the targeted outcomes.

CONCLUSIONS AND RECOMMENDATIONS

There is research to support interprofessional collaboration improves efficiency, communication, job performance and satisfaction, and quality and safety of client care, but specific tools or methods of collaboration are limited. Results of this pilot study suggest the Kawa model may provide a common language for interprofessional collaboration and could be an effective tool for interprofessional discussions when making decisions about a client's care. In contrast to existing Western models of practice in occupational therapy, the Kawa model stems from Eastern origins, and uses terminology and concepts that can be understood cross-culturally. Using a metaphorical model that all professionals can relate to regardless of personal background or professional discipline could increase ease of communication and mutual understanding and respect for the views of others. Future research should include replicating this study with larger, more diverse teams of health care professionals as well as incorporation of an actual client and his or her family in the team because client-centered practice is the norm, and health care decisions are seldom made without considering the views of the client and family. Furthermore, the inclusion of a focus group to this design could provide richer qualitative data regarding how the Kawa model could be used to operationalize interprofessional collaboration. Finally, to further validate use of the Kawa model for this purpose, studies could be conducted to compare information generated and level of collaboration with use of the model against current methods of information sharing and collaboration.

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Appendix

Ethel Case Study

Ethel is a 76-year-old female of Polish descent who was admitted to the SNF after a fall resulting in a right hip fracture and subsequent hospitalization and surgery (ORIF). Her past medical history includes diabetes, hypertension, and recurrent urinary tract infections.

Prior to her fall, Ethel was independent in basic ADLs and simple home management but had assistance from her daughter-in-law for transport in the community for doctor visits, banking, and shopping. She was independent with ambulation without a cane or walker. She lived in a two-story home with 4 steps to enter with no railings and 13 internal steps to the second floor (railing on one side). The home's 2 bedrooms and only bathroom are located on the second floor. Her bathroom includes a tub/shower combination, a toilet, and large vanity with a sink. She reports using no adaptive equipment in the bathroom previously and that the space is "tight," and a walker or wheelchair may not fit within the space. Ethel resides with her husband, whose health has steadily declined over the last year. He underwent a triple bypass 10 months ago, uses a cane to get around, and has occasional periods of confusion, limiting his ability to assist her with care of their home. While he is still able to bathe and dress himself, she takes responsibilities for other aspects of his care, including medication management, and provision of meals.

Socially, Ethel was active in her local church making pierogies for fundraisers once per month. Ethel has always enjoyed cooking and sharing her love of homemade Polish traditions with her church community and friends. She takes pride in the fact that the church uses *her* family recipe for the pierogies and expresses extreme concern that the women's group cannot make them the same without her guidance. She is friends with all the women in the group but is especially close with two of them—Millie and Frances. They live on her street and they sometimes meet on her porch to chat. She spends her free time at home making nut rolls and other Polish treats to share with her family and friends. She also volunteers once per week at the local library for children's story time. Having only one grown son and no grandchildren of her own, she takes great joy in this time spent with the children in her community and is concerned that no one else will volunteer to fill this position in her absence. Since her fall, she has been perseverating on concerns over these two volunteer activities, and in both the hospital and nursing facility, she talks to anyone willing to listen and repeats her concerns over and over.

Ethel's surgery went well, and the orthopedic doctor discharged her to the SNF with orders for PT, OT, and 50% WB to the right leg until her follow-up appointment in 3 weeks.

Upon admission to the facility, Ethel was assessed by all departments, including rehab, nursing, social services, wound care, and dietary. Representatives from case management/administration also met with her to complete admission paperwork and review insurance coverage. Results of these assessments are as follows:

- Setup required for UB ADLs, total assist with LB ADLs due to inability to bend related to pain. She refused to have a male nurse aide assist her with care and was even hesitant with the female therapist and nurse aides assisting her.
- Total assist for all homemaking tasks and cooking.
- Alert and oriented x 3 and demonstrated good safety awareness.
- UB ROM and strength WFLs, but somewhat decreased in bilateral shoulders due to arthritic changes. Full grasp bilaterally. Left hand dominant. Her fine motor coordination and sensation are WFLs, although she reports occasional difficulty manipulating small buttons due to her neuropathy related to her diabetes.
- L LE ROM and strength WFLs. R LE ROM WFLs for the ankle and knee with strength at 3/5. R Hip flexion to ~10 degrees actively, 2-/5 strength.
- Presence of Stage III wound to right lateral malleolus (new) and Stage II wound to L lateral 5th toe (onset ~ 5 months ago per Ethel). Sensation is grossly intact in both lower extremities.
- Moderate assist to roll in bed with use of the assist rails on the bed and to complete supine to sit with increased time required due to pain. Ethel has a regular double bed at home.

- During transfers, Ethel was fearful to place any weight on her right leg and, therefore, had difficulty assuming an upright standing posture with the use of a wheeled walker. She required maximum assistance to transfer from her bed to the wheelchair and yelled out repeatedly during the transfer “I’m going to fall.”
- Concerns voiced over returning home to care for herself and her spouse as well as the previously noted concerns regarding her participation in social activities.
- Confided in the social worker that she believes her son is an alcoholic and that he is not able to reliably provide any help. Her daughter-in-law helps and has limited availability.
- Blood sugars have been somewhat uncontrolled since the surgery, and the doctor initiated insulin injections during the hospitalization. Ethel is apprehensive that she will need to continue the injections and stated, “I’ll never be able to do that on my own.”
- Decreased appetite at the hospital; upon admission to the SNF, Ethel seems to only eat items high in carbohydrates and sugars from her tray and frequently requests up to 4 extra sugar packets for the coffee that she enjoys with each meal.
- Her stated goals include returning home and getting around without a walker, making pierogies at her church, reading to the children at the library, and helping her son to “get back on track.”
- Ethel has been approved for 7 days in the SNF for therapy and nursing care with an insurance update at the end of 7 days required to determine authorization for continued coverage.
- Ethel’s insurance plan covers the first 10 days of her stay with a 20% copayment required per day for days 11 thru 30. This copay equates to around \$161 per day. Her insurance covers a maximum of 30 days of skilled care under her plan with Part B coverage available after that (with Ethel responsible for charges for room and board at the facility). After receiving this news, Ethel breaks down in tears, noting that she and her husband have nearly depleted their savings trying to help their son “handle his issues” and that they have other bills to pay, too.