A Conceptual Model for the Instruction and Supervision of Treatment Planning

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Key Words: education, occupational therapy, problem solving, teaching methods, treatment planning

The process of treatment planning requires the effective application of complex problem-solving skills. The occupational therapy literature has described components of this process and has identified both the difficulty educators have in teaching and the difficulty clinicians have in articulating the process of clinical problem solving.

This paper presents a conceptual model of the dynamic process of occupational therapy treatment planning based on the case method of problem solving. An analysis of the process provides a basis for academic and clinical educators to effectively instruct and supervise students in treatment planning. An analysis of critical concepts related to each stage is followed by (a) common clinical errors committed by students and new therapists and (b) suggestions for supervisory approaches specific to errors at each stage.

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Occupational therapists providing direct patient care are constantly challenged by the process of treatment planning. Regardless of the frames of reference used, populations served, or the type of setting in which practice occurs, the process of treatment planning remains the core of occupational therapy practice. Assessing the patient's current health and functional status, identifying areas of strength and weakness, facilitating goal setting, and establishing an intervention plan to accomplish those goals are common steps in treatment planning. Rogers and Masagatani's (1982) pilot study of therapists' clinical reasoning during the initial assessment of physically disabled patients revealed the difficulty therapists have in articulating the process used to determine functional problems and treatment goals. The authors state that this difficulty is generally attributed to the inadequate teaching of concepts and strategies of clinical problem solving during students' education for the occupational therapy profession. Understanding the process of treatment planning is fundamental to the appropriate application of therapeutic principles, strategies, and procedures in a clinical setting.

Effective instruction in the process of treatment planning, therefore, is a basic necessity in the education of occupational therapy personnel. Instruction in treatment planning typically begins in the classroom, under the guidance of academic educators, and continues in fieldwork placements, under the supervision of clinical educators. Day (1973) describes treatment planning as "one of the most difficult skills for the occupational therapy clinical affiliate to grasp and develop" (p. 239). Occupational therapy literature has provided minimal support for understanding treatment planning or for assisting supervisors in instructing students and new staff in this critical process.

The purpose of this paper is to present a schematic model of treatment planning that can be used by academicians as well as by clinical supervisors. In the classroom, the model can be used to give students a visual presentation of theory-based clinical problem solving. In the clinic, supervisors can use the model to provide students and new staff with specific feedback about their strengths and weaknesses in treatment planning.

Literature Review

Treatment planning is a cognitive problem-solving task. The issue of whether, and to what extent, problem-solving skills can be taught has a long and confused history in psychology and education (Ausubel, 1968). There are conflicting views about how people learn, and how people should be taught, high-level cognitive processes. Cognitive style, with respect to general strategies, considerably influences problem solving. It has been postulated that thought processes
evolve in a logical sequence; consequently, it is important to use teaching strategies that take this sequence into account. Students may best be taught treatment planning in a series of steps presented as a visual model, which serves as a cognitive guide for this complex task.

The cognitive processes involved in treatment planning can be analyzed through studying the sub-skills of problem solving. McPherson (1968) outlines 18 methods that have been developed by several authors. An accurate analysis of the clinical problem-solving process used in occupational therapy treatment planning is essential for effective instruction in the classroom and in the clinic.

The case method of problem solving, particularly valuable for problems with many variables, was examined and supported by Line (1969). Although the model is not fully described, the process incorporates several essential aspects of treatment planning: Data collection is based on a frame of reference, and adjustment between steps is acknowledged.

Day's model of teaching treatment planning (1973) focuses on two steps of critical thinking outlined by Line (1969). It clarifies the clinical reasoning which takes place between problem identification and establishment of goals. Olsen's (1983) adaptation of Day's model also focuses on the cognitive processes between problem identification and goal establishment. Both of these models describe problem identification as the first step of the treatment planning process. Neither identifies the critical steps of treatment planning which precede and enable problem identification.

Major texts on occupational therapy illustrate the initial step of treatment planning as "data collection" or "data gathering," without instructing the student to base data collection on theoretical frameworks or fixed data collection schedules (Hemphill, 1982; Hopkins & Tiffany, 1983; Pedretti, 1985; Trombly, 1983). The narratives in these texts, which support the treatment planning diagrams, focus more on methods and sources of data collection and on what to collect. If the illustrative model of treatment planning does not incorporate the selection of frames of reference or models of practice in occupational therapy as a specific step in the process, the student may not be instructed adequately in the cognitive processes which precede the data collection. Students must be taught to adjust this critical perspective.

Adjustment within the treatment planning process occurs constantly and often imperceptibly. Many of the models conceptualize treatment planning as a step-by-step, linear system with adjustment happening only at the reevaluative stage (Hemphill, 1982; Hopkins & Tiffany, 1983; Trombly, 1983). Actually, therapists continually adjust their perceptions and directions throughout the problem-solving process. Therefore, linear models, which do not incorporate and encourage this constant change, provide inaccurate and misleading pictures of treatment planning.

Current schematic models of treatment planning neglect the importance of considering referrals to other disciplines, as well as the usually unavoidable step of discharging a patient or client from occupational therapy services (Day, 1973; Hemphill, 1982; Hopkins & Tiffany, 1983; Line, 1969; Pedretti, 1985; Trombly, 1983). If a model does not incorporate these considerations, the model cannot help students learn how and when referrals and discharges should occur.

Finally, although the literature claims that occupational therapists value patients' competence, values, and interests, most of the models encourage students to focus on the patient's problems (Day, 1973; Hemphill, 1982; Hopkins & Tiffany, 1983; Pedretti, 1985; Trombly, 1983). A major hallmark of our discipline is our ability to build upon, develop, and use the assets a patient or client brings to us. It is critical that our models of treatment planning reflect our commitment to the identification of strengths as well as weaknesses.

In summary, an accurate visual model of the treatment planning process can be used by occupational therapy educators and supervisors to instruct students in the complex process of clinical problem solving. Analysis of the strengths and weaknesses of current models indicates that an improved teaching model should

- Incorporate the concepts of the case method of problem solving
- Conceptualize the cognitive stages which precede problem identification
- Show that data collection is based on theoretical frameworks
- Emphasize the need for continual adjustment between the various stages of treatment planning
- Encourage the identification of strengths
- Indicate the need to refer to other disciplines
- Regard "discharge" as a part of the treatment planning process

History of the Model

A conceptual model of treatment planning, consistent with the aforementioned characteristics, was developed in partial fulfillment of the requirements for the master of science degree in health sciences education and evaluation from the State University of New York at Buffalo in 1981 (Pelland, 1981). Since that time, the model has been revised and used by the author and other clinical supervisors to instruct staff and...
students in the treatment planning process at the Rehabilitation Institute of Chicago. The model has been used in many continuing education courses; it has been useful in providing a foundation and structure for teaching the application of various theories used in occupational therapy. The model has been used in the classroom at the University of North Carolina at Chapel Hill to instruct occupational therapy students in the process of treatment planning. It has been used to teach clinical educators how to instruct students more effectively in the treatment planning process and faculty members of the University of North Carolina have used the model to help with course and curriculum development.

A Conceptual Model of Treatment Planning

Figure 1 presents a conceptual model of treatment planning which is a modification of the case method of problem solving. The following section presents an analysis of each step in the treatment planning process, summarizing (a) significant cognitive tasks, (b) common clinical errors, and (c) supervisory input to support development of skills at each stage.

Identification of Frames of Reference and Models of Practice

All treatment planning begins with the selection of organizational structures to guide the collection of data. Clinicians often rely on forms used in a clinic or treatment setting for collecting the data needed for treatment planning. Many students and new therapists do not consider the frame of reference or model of practice that was used in developing the form. However, all forms are based upon the designer’s conscious or unconscious selection of specific models of practice. A therapist’s philosophy of the purpose and focus of occupational therapy provides a basis for the selection of models of practice to be used for clinical problem solving. Occupational therapy is in the early stages of developing and describing models of practice. Reed (1984), in Models of Practice in Occupational Therapy, has provided a useful categorization and analysis of existing practice models in the profession. She describes generic models of practice (e.g., the Model of Adaptive Responses, the Model of Occupational Behavior, the Model of Human Occupation) as addressing the acquisition and purpose of occupation, and descriptive models (e.g., Activities of Daily Living Model, Developmental Model, Reflex Development Model, Sensorimotor Model, the Model of Recapitulation of Ontogenesis) as describing the structure and performance of occupation. Analysis of this categorization suggests that the application of only one descriptive model would not provide enough guidance for the comprehensive collection of data required for effective occupational therapy treatment planning. Judicious selection and combination of generic and descriptive models of practice can provide the guidance for effective clinical problem solving.

The identification and application of specific models either constrains or enables comprehensive and appropriate data collection. For example, a therapist working with a 32-year-old homemaker, disabled from a head injury as the result of an automobile accident, would need several models of practice to consider the many areas of function and dysfunction that should be incorporated in the treatment plan. A therapist who used only Rood’s sensorimotor model would not consider issues related to daily living activities, temporal adaptation, prevocational readiness, or habit retraining. Effective treatment planning, therefore, necessitates the careful and appropriate selection of practice models to guide data collection properly.

Rogers (1983) supports the use of a “fixed data collection schedule” (p. 611), such as the Occupational Therapy Uniform Evaluation Checklist, to assure comprehensive data collection. She encourages the use of models that will assure the collection of data which include both assets and liabilities for every aspect of occupational performance, as well as data
about the patient's social and physical environments. These suggestions emphasize the importance of using models which guide comprehensive data collection so that therapists can develop treatment plans to meet the unique needs of the patient. The selection of models of practice is the most critical stage of the clinical problem-solving process.

Common clinical errors. There are common symptoms and complaints associated with a student's difficulty in initiating the collection of data. Students often relate feelings of being overwhelmed, and they candidly state that they “don't know where to begin” when they are initially presented with a patient. Some students may “overselect,” collecting an inordinately large amount of data, or they may choose inappropriate data. Other students tend to “underselect,” and they must be prodded to reconsider what data will be needed for proper treatment planning. Students often have difficulty recalling all the models and principles that they have been taught to help them in determining what data must be collected. Finally, this stage often stimulates great emotional turmoil in students. They are fearful, lack confidence in their ability to succeed, and are acutely aware of the lack of depth in and integration of their knowledge base.

Supervisory support. The supervisor must begin by identifying why a student is having difficulty in this first critical stage. Approaches and methods should be geared to specific problems. Students who “don't know where to begin” may be referred to fixed data collection schedules or lists of various models of practice and asked to consider what information is significant in a particular case. This approach may also be helpful for students who “underselect.” Students who have a difficult time recalling basic academic information should be supported in developing plans to review and study what they have been taught. Supervisors who identify high anxiety (or procrastination) when a referral is initially given may do well to talk with the student, identify the source of the anxiety, and provide the direction or support needed to initiate the treatment planning process.

Data Collection

Although the selection of a model precedes and guides the data collection, the therapist must make many cognitive decisions during the assessment period that may call for an adjustment of the data collection process. Rogers (1983) classifies three methods of data collection: testing or measurement; questioning, including history taking and interviewing; and observation. The bow of data collection is determined by selecting one or more of these methods. The when and where of data collection must also be considered and documented as part of the assessment process—the time of day and environment in which assessment takes place can alter the patient’s response. As data are collected, the therapist may become aware of a need to apply an additional model of practice to assess the patient adequately. For instance, in the case of the disabled homemaker mentioned earlier, assessment may identify a secondary diagnosis of rheumatoid arthritis. In this case, the occupational therapist would select models of practice to guide the collection of data related to musculoskeletal changes and the application of joint preservation and work simplification techniques. The need to adjust model selection is incorporated into the conceptual model of treatment planning presented in Figure 1.

Common clinical errors. Students often have problems prioritizing data collection needs. Other students may not have mastered the technical skills for properly collecting or recording data. Many students falter if patients do not respond in an expected or typical manner. Students often have not yet developed any flexibility in using the techniques and approaches of data collection. Sometimes students are not attentive to the environment in which data are collected. Supervisors may also find students who tend to isolate themselves because they fear failure or criticism.

Supervisory support. Supervisors can ask students to list and rank daily plans prior to each session until the student establishes a pattern of setting appropriate priorities. Discussion that focuses on the rationale for establishing priorities may be beneficial. Students who do not have the necessary technical, psychomotor skills should be encouraged to develop plans to review cognitive procedures; they should also receive direct supervision in developing these skills. When students have difficulty modifying approaches, it may be helpful to discuss or demonstrate adaptations of techniques which the supervisor knows have been successful. It is typical for students to need support and guidance through this type of problem solving. Supervisors who monitor when and where data collection occurs help students attend to these important factors. Finally, students who isolate themselves need to be assured of the sincere commitment of clinical supervisors to providing input for the development of the student's therapeutic skills. Students are much more likely to perform optimally in the presence of a supervisor if the student believes that the supervisor's motives for observing her or him are constructive.

Data Analysis

As data are collected and analyzed, therapists often recognize a need for further or more in-depth data collection in a particular area. Consideration of the patient's diagnosis and prognosis can direct the therapist to collect and interpret data according to the unique needs of the patient. The clinical problem-
solving process is characterized by a dynamic process of model selection, data collection, data analysis, and subsequent modification of the direction and emphasis of further investigation. The conceptual model of treatment planning in Figure 1 indicates the potential for readjustment at this stage.

Therapists must also analyze data in terms of their reliability and validity. The standard question to be answered must be, "Is there an adequate amount of valid and reliable data to properly describe this patient's strengths and weaknesses?" To increase the validity of data, a therapist can increase the number of data while using the same method and the same sources. To increase the validity of the data collected, a therapist can change or increase the number of sources or methods used to assess an area of function.

The goal of data analysis is to enable the therapist to produce an accurate description of the patient's strengths and weaknesses. During the analysis, the therapist may realize the need for assessment or intervention by other health care professionals. (For example, while assessing an elderly patient, the therapist may suspect that a hearing loss is interfering with the patient's ability to respond appropriately to environmental demands. In this case, the therapist should immediately require a referral to an audiologist.) Referrals to other health care professionals might properly be made at this stage in the treatment planning process.

**Common clinical errors.** Some students may have difficulty recalling critical information related to the diagnosis and prognosis of a specific case. This may not only preclude the collection of important data, but it may make it difficult to prioritize data, as well as foster erroneous perceptions about the significance of the data. Another common weakness in this stage is the student's lack of confidence in the reliability of his or her data collection skills. To assure reliability, the student collects and re-collects data; often, this is why a student's evaluation takes an inordinate amount of time. Although such an overly meticulous collection may help increase reliability and confidence, it certainly is not a cost-effective or practical method. Students often question the validity of the data that have been collected. Some students tend to believe what they see and hear, and thus may be manipulated or fooled by patients or clients. Finally, students enter clinical affiliations with limited knowledge of the services offered by other allied health professionals and medical specialists; this limitation often results in a failure to refer patients to the care of other professionals.

**Supervisory support.** As in the other stages, students who have difficulty recalling academic information should be encouraged to take the responsibility and initiative to master the knowledge needed for treatment planning. It may be helpful to ask the student to list all the characteristics of a diagnosis and related problems or other information which may be significant in treatment planning. Supervisors can take an active role if the problem at this stage is related to the student's lack of confidence in his or her data collection skills. Instead of permitting a student the "freedom" to collect and re-collect information, the supervisor can observe the process during the first attempt and provide the positive reinforcement a student may need to move on to the next step of procedure. Another way to assure or demonstrate to a student that the data collected are reliable is for the supervisor to gather data (same method, same source) after the student has completed the assessment, and to compare results. Unless there are significant differences in the results, a student can then be encouraged to trust his or her skills. On the other hand, supervisors may need to encourage the student to use a variety of methods and sources to collect data to ensure a valid conclusion is made about an individual's strengths and weaknesses. Finally, clinical education programs should make sure that orientation programs include significant information about the services of those professionals to whom therapists often refer patients.

**Identification of Strengths and Weaknesses**

Proper model selection and data collection and analysis provide a basis for summarizing the patient's condition from the unique perspective of the occupational therapist. The summary should include the identification of

- The functional capabilities and limitations related to self-care, work, and play/leisure activities
- Biopsychosocial factors that enable or inhibit function
- Environmental factors that support or inhibit function

As strengths and weaknesses are identified, the therapist may realize the need for more data and for an analysis of specific areas of function or dysfunction. The identification of strengths and weaknesses may also indicate a need for referral to other health care professionals or community resources. For example, the occupational therapist who discovers acuity and oculomotor deficits in a patient's visual system may request a referral to a developmental optometrist or other eye specialist. The therapist who recognizes the need for ongoing emotional support may refer a patient to a patient support group. There is also the possibility that the therapist may determine that there is no need for occupational therapy intervention; if this is the case, the therapist should recommend that...
the patient be discharged from the program. All of these options are diagrammed in the conceptual model of treatment planning (see Figure 1).

Common clinical errors. Students often have difficulty interpreting the results of data. This is particularly true when results show insignificant abnormalities which do not merit further action. Students, in general, may have difficulty realizing which deficits are more significant than others. Students sometimes find it hard to properly relate pieces of information. This is exemplified by the difficulty students often have relating biopsychosocial dysfunction to occupational disorders. Students may be able to identify an area needing intervention but unable to articulate the dysfunction in therapeutically appropriate terms. As in the previous step, students may also have difficulty referring patients or clients to other professionals. It is also difficult for students to recognize when occupational therapy services are not appropriate, or when a patient is ready to be discharged from the occupational therapy program.

Supervisory support. It is important when discussing data results with students to emphasize the principles or rationale on which decision making is based. Without a grasp of the therapeutic rationale underlying the determination of function and dysfunction, the student will fail to generalize his or her problem-solving skills from one patient to another. This same need should be recognized when supervisors discuss the significance or insignificance of data, or relationships between the data collected. A student having difficulty articulating observations and concepts may benefit from reading the records or notes of experienced therapists on patients or clients with similar problems. The discussion of a patient’s needs, strengths, priorities, prognosis for change, and other significant data may support a student’s recognition of the limitations of occupational therapy services.

Development of a Treatment Plan

The terminology and procedures used in the documentation of the treatment process vary among facilities and settings. Often, the initial note serves as a written treatment plan to guide the therapist. The Uniform Occupational Therapy Evaluation Checklist (AOTA, 1983) outlines major categories of demographic information and skills and performance areas that should be addressed by occupational therapists. Reports on the skills and performance areas should include a summary of the data collected, identification of goals, identification of intervention plans and methods, and identification of plans for further data collection.

1. A summary of the data collected. This section should recapitulate the identified strengths and weaknesses related to the individual’s daily living activities, biopsychosocial status, and the physical and social environments. The Uniform Occupational Therapy Evaluation Checklist recommends that the types of evaluation used be documented.

2. Identification of goals. Goals flow from the identified problems or needs documented in the summary of the patient’s strengths and weaknesses. Identified problems should have identified goals. Conversely, no goals should be set that do not stem from a described problem or need. There should be a direct and smooth flow between the summary of findings and the occupational therapy goals. Long-term goals should focus on the expected level of functional performance. (Examples of long-term goals include independence in meal preparation from an ambulatory level, or safe, independent performance of community living skills.) Some short-term goals are easily written in measurable terms. (Examples of these include full passive range of motion in the right elbow or the ability to dress independently within 20 minutes in the morning.) Some short-term goals are more difficult to measure. Often the goal is to heighten a specific trait or skill so that it will be adequate to perform a functional activity. Short-term goals can reflect this expectation and be measurable at the same time. (Examples of short-term goals written in these terms include standing balance adequate for independence in meal preparation from an ambulatory level or tactile desensitization adequate for donning and wearing of a right upper extremity orthosis.) Goals should always be measurable and written in terms of the therapist’s and patient’s mutually agreed upon expectations for patient performance.

3. Identification of intervention plans and methods. Every short-term goal established should have intervention plans identified and documented in the written treatment plan; correspondingly, no plans for intervention should be made in the absence of an established goal. The intervention plan may include a description of therapeutic programs, approaches, media, methods, equipment, and other techniques to accomplish the established goals. The amount of technical or specific information documented is determined by the individual therapist or director, according to the demands or needs of the specific setting, case, or therapist.

4. Identification of plans for further data collection. Data collection has been described as a critical component of treatment planning. Often, when initial notes or progress notes are due, the therapist has not had sufficient time to assess all the areas which require investigation. The written treatment plan, therefore, should include specific plans for further data collection. These are considered assessment plans, not intervention plans. Assessment plans can be added to the “plans” section without documenting
edge should be encouraged to study or do more research to fill in the gap.

Implementation of the Treatment Plan

A well-written treatment plan provides the therapists with critical information about the content of the treatment sessions; goals, intervention plans, and assessment plans have been established. Implementation requires a careful use of the documented plan, prioritization of intervention and assessment plans, application of time-management skills, and a mastery of therapeutic media and methods. Most initial notes or treatment plans do not require a therapist to document priorities. However, prioritization of plans is a critical, yet difficult, step in treatment planning. The models of practice which guide data collection may provide principles and theories to assist the therapist in this critical stage. Treatment plans are prioritized (for assessment and intervention) for each patient. Problems that require intervention to prevent further complications or reduce pain are usually addressed prior to a comprehensive collection of data. With the exception of this type of intervention plan, assessment plans are typically given priority in treatment sessions. Intervention plans can be considered as either remedial or adaptive. Typically, remedial plans, aimed at reducing dysfunction, are given priority during the initial stages of the treatment program. Adaptive intervention plans are established to compensate for residual dysfunction. The occupational therapist must balance the number of remedial and adaptive intervention plans used within a treatment session or program. The patient's goals, prognosis, and the length of programming must be considered. In addition, principles of therapeutic management must be applied in sequencing intervention plans. For example, plans to stabilize the trunk and develop functional arm placement skills would precede intervention that focuses on the development of fine-motor coordination skills. Therapeutic prioritization of plans requires the application of effective time management skills in patient programming.

Common clinical errors. Students may forget to use the documented plan. More often, students have a difficult time prioritizing the plans that have been made. This may be caused by an inability to recognize what is critical in a case, or simply by a lack of knowledge of developmental principles related to recovery or skill acquisition. In addition, students initially have misperceptions about the length of time it will take to perform an evaluation or participate in an activity; thus, one day the student may plan too much and the next day, too little. Students are further challenged to implement treatment in a "foreign" environment. It is often difficult simply to locate the patient, the equipment and supplies, and the treat-
The management skills often need development. The student's lack of confidence and experience are especially thwarting at this stage.

**Supervisory support.** Time management forms adapted to the typical schedule of the fieldwork site can often be used as an effective supervisory tool. Students can be directed to list plans for a client's next three treatment sessions and to indicate (asterisk, underline, etc.) which plans will be of *highest* priority for the day. It may benefit some students to rank the plans for the day. Other students may be asked to set down an expected time frame in parentheses behind each plan. In this way, misconceptions or misplaced priorities can be discussed. Crist (in press) has developed a model for fieldwork education which describes the amount and type of supervision evolving in three stages. Each stage incorporates task supervision (communication to get the job done) and relationship supervision (to provide support, trust, and confidence). In Stage 1, supervision focuses on setting high standards and developing a good relationship (high relationship/high task). In Stage 2, the supervisor demonstrates trust while supporting the development of skills (high relationship/low task). In Stage 3, the student is given freedom to practice (low relationship/low task). Supervisors are encouraged (a) to not remove socioemotional support too early, (b) to encourage students to voice their needs, (c) to reinforce successful approximations, (d) to expect backsliding, and (e) to view the supervision of each student as a new opportunity to develop skills. Supervision of the psychomotor skills related to treatment plan implementation must be direct and offer feedback. It is often helpful, especially when dealing with complex skills or fearful students, to have an experienced clinician demonstrate the skill before expecting the student to perform the task in a supervised setting.

**Evaluation of the Program's Effectiveness**

The effectiveness of the program is determined primarily by goal accomplishment. The patient's status, in relationship to the goals set, should be reassessed at planned intervals. Progress notes should include a report of the updated status, goal accomplishments, goal revisions, critical plans that have been followed (e.g., equipment provided, or family instructions given), and plans for further intervention and reassessment. Accomplishment of all goals signals readiness for discharge from the treatment program.

**Common clinical errors.** Students typically are prepared to observe overt signs of progress, which may appear during the course of the intervention. It is common for students to neglect to establish a specific time frame for formal reassessment to evaluate program effectiveness. Students do not have enough clinical experience to judge how often evaluations need to be made. Students may err by scheduling too much reevaluation. (For example, a student may schedule an isolated muscle test of all upper extremities musculature on a weekly basis. This would be too often because most patients will not experience significant strength changes of all upper extremities musculature within the time period of 1 week. On the other hand, a specific muscle or muscle group could be monitored at weekly intervals.) It is also common for students to neglect setting a specific time frame for formal reassessment to evaluate program effectiveness. In other instances, students may balk when told a progress note is due because they do not understand that progress notes flow from the initial note or treatment plan. Finally, students often have difficulty recognizing a need to expand the treatment program or to discharge the patient from occupational therapy.

**Supervisory support.** Students should be encouraged to schedule specific dates for a formal reassessment of critical areas of function. Supervisors can then provide feedback on the appropriateness of the time frame. Time management forms, discussed earlier, can include deadlines for turning in progress notes, with reassessment plans underlined in red. Progress reports can be a source of difficulty for students because notes must often be reviewed and revised before deadlines are met. Supervisors can help relieve student anxiety by recognizing and pointing out that this area typically requires more effort early in the affiliation between student and supervisor than in the later weeks. Students who feel overwhelmed or "lost" at the thought of writing a progress note should be re instructed in the purpose and process of this stage of treatment planning. Supervisors may need only to remind the student that the progress note should flow from the goals and plans documented in the initial note.

**Summary**

Treatment planning is a complex basic skill of occupational therapy practice. Occupational therapy students begin learning how to plan intervention programs during their academic coursework and continue learning about this process during the clinical affiliation. Academic and clinical educators must have an accurate conceptual model of treatment planning in order to effectively instruct and supervise students in this process. In an academic setting, students can be provided with an overview of the process and schooled in the cognitive, affective, and psychomotor skills necessary at each state. In the fieldwork setting, a conceptual model can help the clinical educator guide the treatment planning of affiliated students.

As in treatment planning, where clinicians use
models of practice and various frames of reference to guide data collection, the clinical supervisor can use the conceptual model to help analyze a student’s strengths and weaknesses in clinical problem solving. The conceptual model can direct the clinical supervisor to collect data about the student’s skills at each stage of treatment planning. The supervisor can then provide feedback to the student on skills related to data collection, data analysis, the identification of a patient’s strengths and weaknesses, the establishment of treatment plans, the implementation of treatment plans, the evaluation of treatment plan effectiveness, the modification of treatment plans, and the referral and discharge of patients. This process enables the supervisor to provide specific, constructive input regarding each stage of treatment planning. Educators and supervisors should be equipped to describe the part of treatment planning that a student is able to perform and the part of treatment planning that is difficult for the student to perform. This analysis eliminates broad, generally unhelpful comments such as “the student has problems with treatment planning” (unless a student, indeed, had difficulty with every stage of the process). Instead, we can more effectively analyze a student’s treatment-planning skills, support the development of those aspects in need of improvement, and provide reinforcement for those aspects done well.

Acknowledgments

I would like to thank Marlys Mitchell, PhD, OTR/L, FAOTA, and Cathy Nielson, MPH, OTR/L, for the support, encouragement, and editorial assistance they so kindly and skillfully provided.

References


