

Examining provider perspectives on the role of occupational therapy in postpartum care: An exploratory study

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Abstract

Background: Postpartum individuals in the United States face substantial risk for morbidity and mortality, indicating a need for increased accessibility to postpartum services. Occupational therapy (OT) practitioners are uniquely equipped to support this period of occupational transition, through education and retraining of occupations specific to caregiving roles, routine and habit staking, and parent–infant co-occupations, alongside functional recovery and maternal mental health. Researchers examined healthcare provider perspectives on the necessity, barriers, and opportunities for OT in acute postpartum care.

Methodology: Participants included 23 health care providers of Obstetrics and Gynecology (OB-GYN) and labor and delivery services and allied health professionals at a level I trauma hospital in the Midwest region of the United States. Participants completed an one-time electronic survey examining providers' perceived importance and confidence in domains related to OT in postpartum care. A follow-up interview was completed with 10 participants to further explore providers' perspectives regarding occupational therapy related to acute postpartum care.

Results: Findings identified gaps in perceived importance and confidence among healthcare providers specific to acute postpartum care, particularly in the domains of functional recovery and mental health, and Intervention. Barriers to OT implementation in this setting included knowledge of the scope of OT, the referral process, and reimbursement concerns.

Discussion: Researchers identified perceived gaps and practical priorities providing opportunity for occupational therapy referral pathway development and future intervention research in acute postpartum care. Identified opportunities for OT in acute postpartum care include interdisciplinary collaboration, education and training, and optimizing the referral process.

Keywords: Acute Care, Maternal Health, Occupational Therapy, Postpartum

Introduction and Background

The United States is experiencing a maternal health crisis in which postpartum mothers face a substantial risk for maternal mortality and both psychological and physical morbidity, with heightened risks in the first six weeks after birth (Chinn et al., 2020; Howard & Khalifeh, 2020; Segraves et al., 2024). These risks are not evenly distributed; Black birthing people experience higher rates of maternal morbidity and mortality and reduced access to rehabilitative services compared with non-minority populations (Chinn et al., 2020; Segraves et al., 2024), underscoring the stakes of any gap in postpartum service access. OT practitioners are uniquely equipped to address the physical, social, and psychological factors that both contribute to the maternal health crisis and impact postpartum mothers' occupational performance (Da Conceição et al., 2020; Fernandes, 2018; Rich & Skuthan, 2025). Despite this potential, OT remains largely absent from postpartum care in the United States.

Rehabilitation and Postpartum Care

Parents report a need for accessible, family-centered care that supports continuity across the transition from birth to postpartum and neonatal follow-up (Cardin, 2020; Hermans et al., 2025; Xia et al., 2023). Interprofessional collaboration and comprehensive discharge education, in particular, have been linked to greater parental competency and readiness for hospital discharge (Hermans et al., 2025; Xia et al., 2023). A recent systematic review and meta-analysis further demonstrated that structured discharge planning, combining predischARGE education, post-discharge follow-up, and ongoing channels for consultation, significantly improved mental health,

physiological indicators, and maternal–neonatal self-care among postpartum women (Huang et al., 2026).

While the effects of acute rehabilitation in postpartum care remains limited, existing evidence supports increased access to rehabilitative services to improve maternal health outcomes (Ali et al., 2020; Fernandes, 2018; Segraves & Segraves, 2021). Ali et al. (2020) found that post-cesarean exercise programs improved functional activity and mobility. Notably, however, the limited referral recommendations that do exist in this literature address physical therapy rather than occupational therapy: Segraves and Segraves (2021) advocated for earlier PT referral following cesarean birth to improve recovery and reduce complications, identifying opportunities for education on wound protection, safe mobility, and positioning for infant care. No comparable referral recommendations have been established for OT, and OT practitioners' own understanding of their role on the acute postpartum unit remains largely undefined (Sidar & Skuthan, 2024). This absence of role definition and referral guidance, rather than an absence of relevant skill, may explain why OT remains underutilized in a setting where its scope is directly applicable.

Unique Role of Occupational Therapy

The postpartum period is fundamentally a period of occupational transition, making it well aligned with occupational therapy's domain of practice. The Occupational Therapy Practice Framework identifies performance patterns, including roles, routines, habits, and rituals, as central to occupational participation (American Occupational Therapy Association [AOTA], 2020). Birth disrupts nearly all of these simultaneously: sleep and rest patterns are fragmented, established self-care and instrumental activities

are renegotiated around infant care demands, and the birthing person assumes a new caregiving role under significant physical and emotional load. Much of this occurs through co-occupation, in which the occupations of parent and infant are mutually shaped and cannot be performed independently of one another, as in feeding, soothing, and co-regulation. OT practitioners are distinctly prepared to address this reorganization of roles and routines, rather than recovery from birth as an isolated physiological event. Within this domain, OT addresses both physical and psychosocial dimensions of recovery. Fernandes (2018) identified common upper extremity conditions in postpartum women, highlighting OT's role in managing these physical challenges through postural training, strengthening, and activity modification — needs that arise directly from repetitive infant care occupations such as lifting, feeding, and carrying.

Occupational therapy practitioners are simultaneously positioned to support maternal mental health, an area increasingly recognized as central to the profession's contribution in this population. Rich and Skuthan (2025) as well as Barbic and colleagues (2021) argued for OT's role in addressing postpartum psychosocial factors including risk for postpartum depression, stress management, and role transition. A recent systematic review of psychosocial OT interventions in high-risk pregnancy similarly supports the profession's contribution to maternal mental health across the perinatal continuum (Khan et al., 2025), and emerging intervention research has begun to test these applications directly: Carpenter et al. (2026) piloted an OT intervention in the NICU targeting postpartum depression risk, with preliminary effects on maternal role perception, while Karakus and Akyurek (2026) examined awareness-centered OT and maternal role preparation training on anxiety, depression, emotion regulation, and

quality of life in pregnancy. Together, this work positions OT practitioners to empower postpartum mothers and facilitate participation in meaningful occupations through interventions aimed at self-care, self-regulation, role adaptation, and advocacy (AOTA, 2020; AOTA, 2025; Da Conceição et al., 2020; Fernandes, 2018).

Importantly, practitioners recognize this fit. In a phenomenological study of practitioners preparing to serve acute postpartum patients, participants identified existing skills as directly applicable to this population, expressed willingness to shift clinical focus toward the birthing person, and simultaneously described a need for additional training to build competence (Sidar & Skuthan, 2024). This suggests that OT's limited presence in acute postpartum care reflects structural and knowledge-related barriers rather than a mismatch of scope.

Barriers to Referral

Occupational therapy referrals in postpartum care occur at the provider and organization/system level. Provider implicit bias may limit referral: because childbearing individuals are often perceived as young, independent, and healthy, providers may underestimate their need for rehabilitative or supportive services (Segraves et al. 2024). Limited awareness of OT's scope of practice has similarly been identified as a provider-level barrier to access in other inpatient settings; in a national qualitative study of VHA inpatient psychiatric providers, limited awareness of OT's scope of practice was among the most commonly cited barriers to referral (Kinney et al., 2026). Postpartum referrals are also constrained by competing clinical priorities for referring providers, with mood screening, contraception, and infant-related concerns often taking precedence over physical recovery and functional needs in time-limited visits (Krishnamurti et al., 2020).

Postpartum units often lack a standardized OT referral pathway, and facility-level staffing constraints have been shown to restrict OT utilization in other settings even when clinically indicated (Kinney et al., 2026). These organization-level challenges are reinforced, and arguably produced, at a guideline level. Across three major sources of national postpartum guidance, OT and PT referral is most commonly absent or narrowly confined to a single indication. The American College of Obstetricians and Gynecologists ([ACOG], 2018) foundational postpartum care opinion only mentions physical therapy referral in the instance of urinary incontinence, and its more recent opinion on postpartum physical activity makes no mention of OT or PT, despite endorsing exercise as safe and essential in prevention of depression during the postpartum period and acknowledging this population has specific anatomic and physiologic changes (ACOG, 2020). The omission of OT and PT completely is perhaps most alarming in the Enhanced Recovery After Surgery Society's 2025 recommendations for postoperative cesarean care, which report strong evidence to support early mobilization, breastfeeding support, promotion of rest, and a patient-centered transition to discharge to enhance outcomes after cesarean delivery, yet do not identify OT or PT as a mechanism for achieving either (Sultan et al., 2026). National guidelines repeatedly address the physical and functional dimensions of postpartum recovery but consistently stop short of naming rehabilitation referral as a pathway to meet them, a pattern that likely reflects and reinforces the limited provider awareness of OT's role described above.

Referral is also not evenly distributed once need is identified. In a broad acute care population, greater functional need predicted OT utilization, but this relationship

was moderated by age, race, insurance type, and social support (Kinney et al., 2022), suggesting that referral decisions reflect factors beyond clinical indication alone.

Facilitators to Occupational Therapy Access

Despite these barriers, prior researchers have found facilitators regarding access to occupational therapy services. Rouhi and colleagues (2026) identified interprofessional teamwork, targeted provider training, and continuity of care as key facilitators of postpartum care delivery across a synthesis of 23 studies. In a related inpatient setting, Kinney et al. (2026) similarly found that provider-level "OT champions," patient education, and a standardized facility-level referral process each promoted access to OT services. Together, these findings suggest that referral barriers are not fixed, but responsive to targeted, multilevel strategies — provided they are grounded in an accurate understanding of where and why breakdowns occur.

Currently, there is limited research related to obstetric providers' knowledge of, attitudes toward, or referral patterns for OT in the postpartum setting. Understanding provider perspectives is therefore a necessary first step toward designing the kind of targeted training and standardized referral processes shown to improve access in other clinical populations — the gap researchers of this study aims to address.

Methodology

Aim

The purpose of this study was to explore and identify healthcare provider perspectives on the necessity, barriers, and opportunities for occupational therapy services in acute postpartum care.

Research Design

Researchers examined healthcare provider perspectives on the necessity, barriers, and opportunities for OT services in acute postpartum care. Institutional Review Board review and approval was granted study (25090803-IRB01) to Rush University with coordination of the Occupational Therapy Department (Acute Medicine and Acute Psychiatry) at Rush University Medical Center. This exploratory study employed a convergent mixed methods approach with the administration of an one-time electronic survey and semi-structured interview. Following the parallel administration of quantitative and qualitative methods, results were first analyzed independently. Then, quantitative and qualitative results were analyzed through a joint display to provide a greater understanding of healthcare provider perspectives (Creswell & Zhang, 2009; Fetters et al., 2013).

Sampling and Recruitment

The sample included a total of 23 providers of Obstetrics and Gynecology (OB-GYN) services, labor and delivery services, and allied health professionals across acute medicine settings at one urban level I trauma center in the Midwest region of the United States. Participants were recruited through convenience sampling over a 12-week period from January through March of 2026. Of the 23 providers who completed the electronic survey, 10 consented to participate in a one-time semi-structured virtual interview. The anticipated population for the qualitative methods was expected to be a smaller sample size to focus on depth of analysis for qualitative research (Castro et al., 2010).

Inclusion criteria included organization stakeholders (e.g., leadership, administrative staff), referring healthcare providers (e.g., physicians, nurse practitioners, physician assistants), and non-referring healthcare providers (e.g., nursing, lactation specialists) of OB-GYN and labor and delivery services. Additionally, allied health practitioners (e.g., physical and occupational therapy) employed at the acute care institution were invited to participate. Exclusion criteria included healthcare professionals who did not work in OB-GYN or labor and delivery services. The study did not recruit from protected populations including minors, students, or individuals with cognitive impairment. Participants were recruited via institutional email and professional networks at Rush University Medical Center. For *Part 1* of data collection (electronic survey), screening for demographic information, consent, and data collection were collected via Research Electronic Data Capture (REDCap) electronic survey (Harris et al., 2019). For *Part 2* of data collection, participants were invited to contact study staff via email for participation.

Data Collection

As data collection followed a convergent mixed-methods approach, the administration of *Part 1* (Quantitative Methods) and *Part 2* (Qualitative Methods) occurred in parallel over a 12-week period from January through March of 2026. The data collection occurred in two parts simultaneously:

- *Part 1* (Quantitative Focus). The first part of this study included the administration of a REDCap electronic survey (Appendix A). The electronic survey examined provider perspectives (i.e., confidence, importance) related to OT and current acute postpartum referral practices.

- *Part 2 (Qualitative Focus)*. In the optional second part of data collection, semi-structured interviews were conducted. Follow-up interviews were conducted with interested participants to explore in greater depth the perceived value of OT, existing referral processes, and interprofessional collaboration.

Measures

Part 1

Quantitative methods included the administration of a self-developed one-time electronic survey. Existing literature findings guided the development of survey questions. Research highlights that OT practitioners can play an integral role in supporting postpartum patients through the following: 1) Promoting participation in daily activities and roles, 2) Promoting functional recovery post c-section (e.g., positioning, wound protection, safe mobility), and 3) Addressing mental health and psychosocial challenges (e.g., stress management, postpartum symptoms) (Barbic et al., 2021; Fernandes, 2018; Rich & Skuthan, 2025; Segraves & Segraves, 2021). Survey questions were developed and reviewed by the first author and their doctoral capstone faculty advisor with 15+ years of clinical practice in occupational therapy in acute care settings. Neither reviewer had prior clinical experience in postpartum practice.

The survey consisted of 14 closed ended questions such as: 1) Demographics (4 Questions) and 2) Perspective and confidence in postpartum care. Demographic information was collected on professional roles, number of practice years, and practice settings. Participants were asked to rate their importance and confidence, using a 5-point Likert scale, for the following areas related to OT practice and maternal health care: 1) Promoting postpartum patient participation and competency in Activities of

Daily Living (e.g., bathing, showering, dressing); 2) Promoting postpartum patient participation and competency in Health Management (e.g., symptom management, medication management); 3) Providing treatment or education on managing postpartum transition into new roles and routines; 4) Providing treatment or education on functional recovery post-cesarean section (e.g., positioning, wound protection, safe mobility); 5) Screening or providing intervention on stress management and postpartum symptoms (e.g., depression, anxiety, psychosis). No open-ended questions were included in the electronic survey. At the end of the survey, all respondents were invited to participate in *Part 2* of the study, which included an one-time semi-structured interview.

Part 2

Qualitative methods included the administration of semi-structured interviews to collect comprehensive information on health care providers' perspectives on the necessity, opportunities, and barriers for OT services in acute postpartum care. Semi-structured interviews took no longer than 45 minutes and took place virtually (e.g., Microsoft Teams) or in person. Semi-structured interview questions were guided by the 5D Cycle of Appreciative Inquiry, an approach that focuses on identifying strengths and opportunities within an institution to facilitate organizational change (Cooperrider & Whitney, 2005). This approach was chosen in the initial stages of study development to ground the qualitative methods in theoretical-based practice. The appreciative inquiry approach has been cited as an approach to shift perspectives of perceived problems within an organization to ultimately implement change (Luhailima et al., 2022).

The 5D Cycle of Appreciative Inquiry consists of five steps: 1) Definition, 2) Discovery, 3) Dream, 4) Design and 5) Destiny/Delivery (Cooperrider & Whitney,

2005). Through its core components, the 5D Cycle of Appreciative Inquiry informed the development of semi-structured interview questions to gather provider perspectives on the necessity, opportunities, and barriers for OT services in acute postpartum care. The semi-structured interview script was reviewed by two researchers, including a faculty advisor with 15+ years of clinical practice in acute care occupational therapy (Appendix B).

Data Analysis

A mix of quantitative and qualitative data analysis informed the development of this exploratory mixed-methods study and meeting the objective of evaluating the necessity, barriers, and opportunities for OT practice in acute postpartum care. Quantitative data and qualitative data were first analyzed separately. Following the completion of initial analysis, data merging and integration were achieved through the construction of a joint display. Joint displays show quantitative and qualitative data side-by-side and are an effective tool for analyzing mixed data (Nessle et al., 2023). Data from surveys and interviews were analyzed to identify gaps and opportunities in current postpartum services. Quantitative data were analyzed using Microsoft Excel for Windows. Descriptive statistics were used to analyze frequencies, percentages, and means of provider importance and confidence related to acute postpartum care and current referral practices. For qualitative data analysis, content analysis was used to analyze semi-structured interview data. Content analysis aims to organize and summarize large interview scripts through forming categories or themes (Erlingsson & Brysiewicz, 2017). Transcripts of completed interviews ranged from two to five pages in length as the length of responses to the five interview questions varied in depth.

To conduct content analysis, transcripts of completed interviews were consolidated and organized by response to each of the five interview questions. One researcher then conducted an initial review of the transcribed responses line-by-line, identifying meaning units to develop initial codes which would later be appraised and grouped into categories (Erlingsson & Brysiewicz, 2017). Following this initial review, a second researcher reviewed the coded transcripts to ensure agreement of developed codes and categories. The use of content analysis was appropriate for data analysis as categories and themes from semi-structured interviews provided an in-depth understanding of provider perspectives on acute postpartum care.

Results

Of the 136 eligible healthcare providers, 26 consented to participate in *Part 1* of study. Three of the consented participants were lost to follow up, resulting in a total of 23 participants indicating a 16.9% response rate. Descriptive statistics were calculated on demographic information and provider perspectives. Of the sample, 56.5% of participants were a Registered Nurse (RN). For the unit/department, 65.2% of respondents worked primarily in the mother-baby unit.

A total of 10 participants completed *Part 2* of the study. Of those 10 participants, the professional role distribution included: 1) Lactation consultant (n=1); 2) Occupational Therapist (n=3); 3) Physical Therapist (n=1); and 4) Registered Nurse (n=5). Additionally, the number of years practiced distribution was as follows: 1) 3-5 years (n=4); 2) 6-10 years (n=3); 3) 11-15 years (n=1); and 16+ years (n=2) (Table 1).

Table 1*Characteristic Information of Survey Respondents (n=23)*

Characteristic	Number (n)	Percentage (%)
Professional Role		
Physician	3	13
Registered Nurse	13	56.5
Lactation Consultant	1	4.3
Physical Therapist	1	4.3
Occupational Therapist	4	17.4
Other	1	4.3
Years Practiced		
0-2 years	5	21.7
3-5 years	5	21.7
6-10 years	5	21.7
11-15 years	2	8.7
16+ years	6	26.1
Unit/Department		
Labor and delivery	8	34.8
Mother-baby unit	15	65.2
Other	4	17.4

Descriptive Data

Overall, survey respondents indicated the five listed areas related to OT as very to extremely important (Mean = 4.5) with the highest mean scores of importance in the following: 1) Managing postpartum transition into new roles and routines (mean 4.65 and SD 0.47) and 2) Providing screening or intervention for stress management and postpartum symptoms (mean 4.65 and SD 0.65; Table 2). Simultaneously, survey respondents consistently indicated decreased confidence compared to importance across the five listed areas related to occupational therapy. The greatest differences between importance and confidence were found in the following areas related to OT: 1)

Functional recovery post c-section (Difference = 0.83), 2) Screening on stress management and postpartum symptoms (Difference = 1.04), and 3) Intervention on stress management and postpartum symptoms (Difference = 1.26).

Table 2

Provider-Rated Importance and Confidence Across Postpartum Care Domains (N = 23)

Domain	Importance M (SD)	Importance Mdn [IQR]	Confidence M (SD)	Confidence Mdn [IQR]	Difference (I – C)
Activities of daily living	4.30 (1.06)	5.0 [4.0–5.0]	4.22 (0.90)	4.0 [4.0–5.0]	0.09
Health management	4.43 (0.66)	5.0 [4.0–5.0]	4.13 (0.81)	4.0 [4.0–5.0]	0.30
Managing postpartum transition	4.65 (0.57)	5.0 [4.0–5.0]	4.00 (0.74)	4.0 [4.0–4.0]	0.65
Functional recovery post-cesarean	4.61 (0.58)	5.0 [4.0–5.0]	3.78 (0.85)	4.0 [3.0–4.0]	0.83
Stress management and postpartum symptoms	4.65 (0.65)	5.0 [4.5–5.0]	—	—	—
Screening			3.61 (1.03)	4.0 [3.0–4.0]	1.04
Providing intervention			3.39 (0.99)	4.0 [3.0–4.0]	1.26

Note. Ratings were made on a 5-point scale (1 = *not at all important/confident*, 5 = *extremely important/confident*). Difference (I – C) = mean importance rating minus mean confidence rating.

Referring Provider Perspectives

Referring providers (i.e., physicians) were prompted to answer additional survey questions regarding referral practices in acute postpartum care. Three out of 23 total participants were referring providers (i.e., physicians); thus, the following results are representative of preliminary referring provider perspectives. In the past 12 months, only one out of three referring providers had referred postpartum to occupational therapy services. Referring providers identified that the following areas would benefit from OT involvement in postpartum care: 1) Mobility and positioning post c-section; 2) Activity modifications and energy conservation; 3) Mental health support and stress management; 4) Role and identity transitions (e.g., returning to work); and 5) Education on adaptive equipment. Referring providers identified barriers preventing them from referring patients to occupational therapy which included, 1) Lack of awareness of OT scope in maternal health; 2) Unclear referral process; and 3) Insurance/reimbursement concerns. Three out of three referring providers expressed interest in additional training or education on the role of occupational therapy services related to postpartum care.

Qualitative Data

Define

Initial codes were grouped together by similarities to create the following categories: 1) Occupational participation (e.g., I/ADLs, health management); 2) Precautions/condition considerations (e.g., c-section); and 3) Environment / contexts (e.g., discharge/social determinants of health. Participants most frequently identified challenges related to co-occupations (n=5), role transitions (n=6), and medical

management (n=6) experienced by postpartum birthing parents in acute care.

Participant 2 described the challenge of co-occupations and role transitions, stating, "I think a big challenge I see is moms trying to learn or relearn how to take care of a new baby while also taking care of themselves". Regarding medical management, Participant 9 noted, "With C-section patients or even vaginal [deliveries] if they had a laceration and had stitches... they are also in pain so that can impact their mobility and ADLs".

Discover

Initial codes were grouped together by similarities to create the following categories: 1) Occupational participation education and intervention; 2) Allied health referral/consult; and 3) Consideration of environment/context. Participants most frequently identified education with breastfeeding (n=4), education with new roles (n=4), and medical intervention (n=4) as examples of when postpartum birthing parents received support that positively impacted their acute postpartum experience. Participant 1 highlighted support in the following example: "Education on (the mother's) new role... breastfeeding, going over things like swaddling the baby, taking care of herself, and what to expect postpartum." Similarly, Participant 6 highlighted the integration of adaptive equipment in their treatment: "Being able to introduce... and really facilitate that return demonstration of using adaptive equipment, this patient was able to improve confidence and independence in what was meaningful to [them]" (Table 3).

Table 3

Content Analysis Initial Coding, Categories, and Key Insights (n = 10)

Question	Initial Codes (Transcript Frequency)	Categories	Key Insights
#1: What are the most urgent challenges experienced by postpartum mothers in postpartum acute care?	Medical management (N = 6) Role transitions (N = 6) Co-occupations (N = 5) Self-care (N = 4) Mental Health (N = 4) C-section (N = 4) Functional/community mobility (N = 4) Recovery time (N = 3) Precautions/condition-specific considerations (N = 3) Discharge planning (N = 3)	(1) Occupational participation (e.g., I/ADLs, health management) (2) Precautions/condition considerations (e.g., c-section) (3) Environment/contexts (e.g., discharge, SDOH)	<i>Participant 2: "I think a big challenge I see is moms trying to learn or relearn how to take care of a new baby while also taking care of themselves"</i> <i>Participant 9: "With C-section patients or even vaginals if they had a laceration and had stitches... they are also in pain so that can impact their mobility and ADLs."</i>

#2: Share an example of a time when a postpartum mother received support (e.g., intervention, education) that positively impacted her acute postpartum experience?	Education – breastfeeding (N = 4) Education – new roles (N = 4) Education – new roles (N = 4) Medical intervention (N = 4) Intervention – functional mobility and body mechanics (N = 3) Home/environment (N = 2) Additional referral (N = 2) Intervention – self-care (N = 1) Intervention – adaptive equipment (N = 1) Bonding/time (N = 1) Advocacy (N = 1) Education – precautions/lifting restrictions (N = 1)	(1) Occupational participation education & intervention (2) Allied health referral/consult (3) Consideration of environment/context	<i>Participant 1: “Education on her new role... breastfeeding, going over things like swaddling the baby, taking care of herself, and what to expect postpartum.”</i> <i>Participant 6: “Being able to introduce... and really facilitate that return demonstration of using adaptive equipment, this patient was able to improve confidence and independence in what was meaningful to [them]”</i>
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#3: Imagine a scenario in which OT was part of the interprofessional care team in acute postpartum care. What would that look like for postpartum mothers, parents, and the interprofessional team?	Infant handling and UE positioning (n = 4) Functional mobility, body mechanics/precautions/lifting restrictions (n = 4) Interdisciplinary collaboration (n = 3) Referral process (n = 3) OT evaluation (n = 3) Adaptive equipment/DME (n = 3) Lack of knowledge of OT (n = 2) Self-care (n = 2) Leisure (n = 1) Active listening/therapeutic use of self (n = 1) C-section and 3rd and 4th degree lacerations (n = 1) Abdominal binders (n = 1) Antepartum (n = 1) Mental health (n = 1)	(1) Promotion of occupational participation for birthing parents (2) Therapeutic use of self (3) Interdisciplinary collaboration	<i>Participant 7: "Having OT available - that could help patients and really drive home some of the education and some of the support that's required in in the postpartum period. It would really transform how we deliver care in the postpartum period."</i> <i>Participant 18: "To have an OT on the unit, just seeing everyone would be ideal... Getting an OT eval, identifying any barriers that they have, asking about their environment, asking about the support that they have at home, and then identifying any barriers."</i>
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#4: What would need to happen to bring this vision to life (e.g., education, resources, training)?	Education/training (n = 8) Referral process (n = 5) OT competency/process (n = 3) Nursing job demands (n = 3) Staff buy-in (n = 3) Workflow/discharge process (n = 3) Reducing hospital readmissions (n = 2) Outcome measures (n = 1)	(1) Education and training (2) Referral process and workflows (3) Outcome measures	<i>Participant 12: "Definitely a lot of multidisciplinary education... We are a big evidence-based hospital – so bringing the evidence to both the physicians as well as the nurses."</i> <i>Participant 17: "I think there needs to be a streamlined kind of way in the documentation system... but ultimately, I think [providers and physicians] need more education on what OT can do and what they can provide"</i>
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#5: What steps could be taken to implement and sustain the integration of OT into the interprofessional care team in acute postpartum care moving forward?	Interdisciplinary collaboration (N = 9) Referral process (N = 4) Organization stakeholders (N = 3) Outcome measures (N = 1) Existing work culture (N = 1)	(1) Interdisciplinary collaboration and education (e.g., management, nurses, lactation, social work, physicians) (2) Outcome measures (3) Referral process	<i>Participant 22: "I think educating the nurses and the providers on that unit on the benefit of occupational therapy."</i> <i>Participant 2: "It's starting from the top and or starting from the bottom, working your way up and just having a lot of different conversations with management, with nursing, with attendings and residents, and everyone."</i>
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Dream

Participants most frequently identified the following scenarios in which OT was part of the interprofessional care team in acute postpartum care: 1) OT evaluation (n=3); 2) Infant handling and UE positioning (n=4), and 3) Functional mobility/body mechanics (n=4). Initial codes were grouped together by similarities to create the following categories: 1) Promotion of occupational participation for birthing parents; 2) Therapeutic use of self; and 3) Interdisciplinary collaboration. Participant 7 stated, "Having OT available - that could help patients and really drive home some of the education and some of the support that's required in the postpartum period. It would really transform how we deliver care [during] the postpartum period". Participant 18 stated, "To have an OT on the unit, just seeing everyone would be ideal... Getting an

OT eval, identifying any barriers that they have, asking about their environment, asking about the support that they have at home, and then identifying any barriers”.

Design

Developed categories from initial coding included the following: 1) Education and training; 2) Referral process and workflows; and 3) Outcome measures. Participants most frequently identified the referral process (n=10) and education/training (n=8) as needed to bring the vision of OT as part of the interprofessional care team to life.

Education and training are first needed as evidenced by the following by Participant 12: “Definitely a lot of multidisciplinary education... We are a big evidence-based hospital - so bringing the evidence to both the physicians as well as the nurses.” In addition to education, the referral process was also identified, as highlighted by Participant 17: “I think there needs to be a streamlined kind of way in the documentation system... but ultimately, I think [providers and physicians] need more education on what OT can do and what they can provide”.

Destiny / Deliver

Developed categories from initial coding included the following: 1) Interdisciplinary collaboration and education (e.g., management, nurses, lactation, social work, physicians), 2) Outcome measures, and 3) Referral process. Participants most frequently identified interdisciplinary collaboration (n=9) as a necessary step to implement and sustain the integration of OT into the interprofessional care team in acute postpartum care moving forward (Table 3). Participant 22 highlighted education and interdisciplinary education in the following: “I think educating the nurses and the providers on that unit on the benefit of occupational therapy.” This is additionally

evidenced by the Participant 2 stating, "It's starting from the top and or starting from the bottom, working your way up and just having a lot of different conversations with management, with nursing, with attendings and residents, and everyone".

Mixed Methods Analysis

Following the completion of initial qualitative and quantitative data analysis, data merging and integration were achieved through construction of a joint display. A joint display provides comparisons between quantitative and qualitative data for the remaining constructs including roles and routines, functional recovery, stress management and post-partum symptoms, and barriers to referral. Quantitative data results from the electronic survey and qualitative data results from the semi-structured interviews were first compared to create constructs based on similarities. The following constructs were identified: 1) Occupations and co-occupations, 2) Roles and routines, 3) Functional Recovery, 4) Stress management and post-partum symptoms, and 5) Barriers to referral. Across constructs, the frequency of either the necessity, challenges, or opportunities for OT demonstrated in the semi-structured interviews align with the findings from the electronic survey. For example, when examining occupations and co-occupations, participants rated this area of high importance ($M = 4.30$ for ADLs and $M = 4.43$ for health management), which align with the frequently reported urgent challenges experienced by postpartum mothers: 1) Medical management (60%) and 2) Co-occupations (50%) (Table 4).

Table 4*Joint Display of Quantitative and Qualitative Data Analysis*

Construct	Quantitative Data Results (<i>n</i> = 23)	Qualitative Data Results (<i>n</i> = 10)
Occupations and Co-occupations	Rated high importance (<i>M</i> = 4.30) with comparable confidence (<i>M</i> = 4.22) for ADLs Rated high importance (<i>M</i> = 4.43) with comparable confidence (<i>M</i> = 4.13) for health management	Frequently reported urgent challenges experienced by acute postpartum mothers: (1) Medical management (60%) and (2) Co-occupations (50%)
Roles and Routines	Rated high importance (<i>M</i> = 4.65) with lower confidence (<i>M</i> = 4.0) for managing roles and routines	Frequently reported urgent challenge experienced by acute postpartum mothers: (1) Role transitions (60%). Frequently reported examples in which postpartum mothers received support: (1) Education – breastfeeding (40%) and (2) Education – new roles (40%).
Functional Recovery	Rated high importance (<i>M</i> = 4.61) with lower confidence (<i>M</i> = 3.78) for functional recovery post c-section	Frequently reported opportunities for OT to be part of interprofessional care team: (1) Functional mobility and body mechanics (40%) and (2) Infant handling and UE positioning (40%)
Stress Management and Postpartum Symptoms	Rated high importance (<i>M</i> = 4.65) on a single item combining screening and intervention, with lower confidence for screening (<i>M</i> = 3.61) and for providing intervention (<i>M</i> = 3.39).	Reported urgent challenge experienced by postpartum mothers: (1) Mental health (40%).

Referral Barriers and Opportunities	Identified barriers to referral included insurance/reimbursement concerns, unclear referral process, and lack of awareness of OT scope in maternal health	Most frequently identified opportunity to integrate OT as part of interprofessional team: (1) Education/training (80%) Most frequently identified action step to integrate OT as part of interprofessional team: (1) Interdisciplinary collaboration (90%)
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Discussion and Conclusion

Researchers successfully explored the necessity, barriers, and opportunities for OT services in acute postpartum care from the perspective of providers and allied health professionals. Provider perspectives included low confidence in areas such as functional recovery post c-section, stress management, and post-partum symptoms (e.g., depression, anxiety, and psychosis). Researchers identified opportunities for interdisciplinary collaboration and improving the referral process to address barriers in knowledge, education, training, and the existing referral process. Furthermore, a gap in postpartum care was identified descriptively from multiple postpartum health care providers.

Opportunities

Quantitative results showed the perceived high importance (Mean = 4.5) across identified domains related to OT in acute postpartum care including: 1) ADLs; 2) Health management; 3) Role and routine transitions; 4) Functional recovery post-c-section; and 5) Stress management and postpartum symptoms (e.g., depression, anxiety, and psychosis). While participants perceived the domains of high importance, they reported decreased confidence in promoting or providing screening/intervention in the following: 1) Functional recovery post-c-section and 2) Stress management and postpartum

symptoms (e.g., depression, anxiety, and psychosis). These findings indicated a gap in current services at this acute care site, specifically related to functional recovery post c-section and stress management and postpartum symptoms. They also underscore an opportunity for OT practice and align with existing literature that argue for the role of OT in promoting functional recovery post-c-section and maternal mental health (Ali et al., 2020; Barbic et al., 2021; Rich & Skuthan, 2025; Segraves & Segraves, 2021).

The semi-structured interviews provided in-depth perspectives on the necessity, barriers, and opportunities for OT in acute postpartum care. Participants most frequently identified co-occupations, role transitions, and medical management as the most urgent challenges faced by postpartum mothers and pointed to education and medical interventions as the most impactful forms of support. These findings align with existing literature indicating that OT practitioners are well-positioned to support maternal health through health promotion and disease prevention and acute care rehabilitation post c-section (Da Conceição et al., 2020; Fernandes, 2018; Rich & Skuthan, 2025).

Barriers

Both quantitative and qualitative data pointed to systemic barriers limiting referrals in acute postpartum care. Referring providers most frequently cited insurance/reimbursement concerns, unclear referral process, and limited awareness of OT's scope in maternal health. Qualitative data reinforced these themes, with participants highlighting the referral process and gaps in education/training as key obstacles. Notably, interdisciplinary collaboration was identified as the primary mechanism for integrating OT into the interprofessional care team, suggesting that relationship building across disciplines may be as important as formal policy change

(Fernandes, 2018; Segraves & Segraves, 2021). Together, these findings underscore the need for targeted efforts to increase provider awareness of OT's role in postpartum care, particularly given that participants rated OT domains as highly important while reporting lower confidence in their ability to provide certain services.

Acute Care Implications

Provider identified interdisciplinary collaboration, education and training, and optimizing the referral process as mechanisms to support OT's presence in acute care maternal health. Acute care practitioners can use these findings, alongside existing literature, to advocate for OT's role in post-birth recovery units. Providers in this study reported the lowest confidence in screening and intervening stress management and postpartum symptoms, addressing functional recovery post-cesarean birth, and supporting the postpartum transition. These are precisely the domains in which OT's distinct contribution lies: addressing recovery in the context of daily occupations, roles, and routines rather than as an isolated physiological event. Because birthing individuals in the United States face the highest risk for maternal mortality and morbidity in the first six weeks postpartum, increasing access to acute OT services during this window may support both maternal health outcomes and the reestablishment of daily routines and habits. Developing referral protocols specific to post-birth timeframes would support access to bedside OT care prior to discharge.

Limitations

Researchers note several limitations that should be considered when interpreting reliability, validity, and clinical utility. First, the small sample size and limited diversity in demographics limits the ability to generalize results to other medical institutions and

provider perspectives in acute settings. Specifically, three out of 23 survey respondents were referring providers, with the majority of respondents identifying as registered nurses working in the mother-baby unit, which limits generalizing results to other hospital and provider types. Second, the electronic survey was self-developed by the researchers, which impacts validity and reliability of the survey tool. Third, there may be survey bias based on the self-report of the *Part 1* of the study, influencing the overall findings. Finally, given the convergent mixed methods design of this project, immediate clinical utility of the findings remains limited, needing further investigation.

Future Considerations

Future research should build on the findings of this exploratory mixed-methods study to advance OT's role in acute postpartum care. Because this study recruited a small sample from a single urban academic medical center, the highest priority is replication with larger and more diverse samples across multiple sites to determine whether these descriptive trends hold among providers elsewhere. Referring providers warrant particular attention given their gatekeeping role in patient access to OT services. Future research should also establish construct validity for measures of provider perceptions of OT in postpartum care, which the present study timeframe did not permit. Subsequent studies could then evaluate the efficacy of OT interventions on maternal health outcomes and support the development of referral pathways in acute postpartum settings..

Conclusion

Postpartum providers in this study rated OT-relevant domains as highly important while reporting lower confidence in their ability to address them, with the widest gaps in

functional recovery following cesarean birth and in stress management and postpartum mental health symptoms. Providers also identified barriers to referral including limited awareness of OT's scope of practice, unclear referral processes, and reimbursement concerns, while pointing to education and interdisciplinary collaboration as the most actionable mechanisms for integrating OT into the care team. These findings identify perceived gaps and practical priorities that may inform referral pathway development, program proposals, and future intervention research in acute postpartum care.

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Appendix A. Survey Questions

Demographic Information

1. What is your professional role? (Select one)
2. How many years have you been practicing in your current role?
3. Does your patient population include postpartum mothers?
4. What unit or department do you primarily work in?

Section 1 | Importance of postpartum care contributing to overall patient care and maternal health outcomes (5-Point Likert Scale)

1. Promoting postpartum patient participation and competency in Activities of Daily Living (e.g., bathing, showering, dressing)
2. Promoting postpartum patient participation and competency in Health Management (e.g., symptom management, medication management)
3. Providing treatment or education on managing postpartum transition into new roles and routines
4. Providing treatment or education on functional recovery post-cesarean section (e.g., positioning, wound protection, safe mobility)
5. Screening or providing intervention on stress management and postpartum symptoms (e.g., depression, anxiety, psychosis)

Section 2 | Confidence in addressing the following postpartum care needs:

1. How confident are you in promoting postpartum patient participation and competency in Activities of Daily Living (e.g., bathing, showering, dressing)
2. How confident are you in promoting postpartum patient participation and competency in Health Management (e.g., symptom management, medication management)
3. How confident are you in providing treatment or education on managing postpartum transition into new roles and routines
4. How confident are you in providing treatment or education on functional recovery post-cesarean section (e.g., positioning, wound protection, safe mobility)
5. How confident are you in screening patients for co-morbid postpartum conditions (e.g., depression, anxiety, psychosis)?
6. How confident are you in providing intervention on stress management and co-morbid postpartum conditions (e.g., depression, anxiety, psychosis)

Section 3 | Provider Specific Questions

1. Have you referred postpartum patients to occupational therapy in the past 12 months? Yes / No; Frequency ____
2. In your opinion, which of the following areas would benefit from OT involvement in postpartum care? (Check all that apply)
 - ☐ Mobility and positioning post C-section
 - ☐ Activity modifications and energy conservation
 - ☐ Mental health support and stress management
 - ☐ Role and identity transitions (e.g., returning to work)
 - ☐ Education on adaptive equipment
 - ☐ None of the above
 - ☐ Other: _____
3. What barriers (if any) prevent you from referring patients to occupational therapy? (Check all that apply)
 - ☐ Lack of awareness of OT scope in maternal health
 - ☐ OT not available in my facility
 - ☐ Unclear referral process
 - ☐ Insurance/reimbursement concerns
 - ☐ Patients decline or are not interested
 - ☐ Other: _____
4. Would you be interested in receiving training or education on the role of OT in postpartum care? Yes / No / Maybe

Appendix B. Interview Guide

Introduction

“Thank you for taking the time to speak with me today. This interview is part of a capstone project exploring the role of occupational therapy (OT) in postpartum care to increase referrals and improve maternal health outcomes. The goal of this interview is to understand provider perspectives to evaluate the necessity, barriers, and opportunities for OT services in acute postpartum care. This interview will take approximately 30 minutes. With your permission, I’d like to record the conversation for transcription and analysis. Your responses will remain confidential and de-identified. You can skip any question or stop at any time”.

Question 1: Define – What is the topic of inquiry?

- What are the most urgent challenges experienced by postpartum mothers in postpartum acute care?

Question 2: Discover – Appreciating the best of ‘what is’

- Can you share an example of a time when a postpartum mother received support (e.g., intervention, education) that positively impacted her acute postpartum experience?

Question 3: Dream – Imagining ‘what could be’

- Imagine a scenario in which OT was part of the interprofessional care team in acute postpartum care. What would that look like for postpartum mothers, parents, and the interprofessional team?

Question 4: Design – Determining ‘what should be’

- What would need to happen to bring this vision to life (e.g., education, resources, training)?

Question 5: Destiny/deliver – Creating ‘what will be’

- What steps could be taken to implement and sustain the integration of OT into the interprofessional care team in acute postpartum care moving forward?

Conclusion

Thank you for your participation in my study aimed at exploring the role of OT in postpartum acute care.

Reference

Cooperrider, D.L., & Whitney, D. (2005). *Appreciative Inquiry: A positive revolution in change*. Berrett-Koehler Publishers.