

**The American Occupational Therapy Association
Report to the AOTA Board of Directors**

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TO: AOTA Board of Directors

TOPIC: Rehabilitation, Disability and Participation Ad Hoc Work Group: Recommendations for Education and Practice

Executive Summary:

The ad hoc work group on Rehabilitation, Disability and Participation was convened at the request of AOTA President Dr. Carolyn Baum and President Elect Dr. Penny Moyers. The group met and accomplished their work via 3 conference calls, and the use of Sharepoint and e-mail to address the following nine questions from the perspective of rehabilitation, disability and participation:

- Who are our external partners in this area of practice and what organizations are central to building strong networks to achieve our objectives?
- What are the critical education issues in this area of practice? Include foundational knowledge, OT specific knowledge and practice skills
- What are the OT issues that should be addressed in each of the following: acute care, rehabilitation, institutional (i.e., schools or organizations) and community?
- What are OT outcomes in this area of practice and how do they relate to participation? How do they relate to the outcomes valued by consumers or payers?
- What key research would inform practice in this area?
- What key policy issues should we be tracking and leading?
- What internal and external barriers are limiting our practice?
- What is our unique contribution to the needs of people who need rehabilitation, habilitation or prevention services?
- What links to other organizations, federal agencies, foundations related to this practice area should be posted on AOTA's website for our members?

Process: Initially, the group had an extensive discussion about how to define participation and what the anticipated participation level outcomes would be of occupational therapy services. There was consensus that, regardless of practice setting, the profession can and should be a leader in the area of societal participation and community integration, e.g., we can and should be a link or facilitator to support people with disabilities in participation level goals related to community living, community participation, social integration, citizenship and employment.

The alignment of the *Occupational Therapy Practice Framework* (OTPF) with the World Health Organization's International Classification of Functioning (ICF) is a positive step but as a profession, we need to clearly articulate and translate our language used within occupational therapy to the language of the ICF which is widely used outside the profession. The group used the 7 performance areas defined in the OTPF as an overarching framework for their discussion around engagement in occupations that result in participation outcomes. Those areas are: activities of daily living, instrumental activities of daily living, education, work, play, leisure and social participation. The core of the rehabilitation process is the use of OT skills and knowledge to address individual and environmental issues in any/all of these areas that may limit the person's ability to engage in occupations, and ultimately to fully participate in society (OTPF, 2002).

The group also discussed the concept of occupational deprivation as "a state of preclusion from engagement in occupations of necessity and/or meaning due to factors outside the immediate control of the individual" (Whiteford, 2000). This concept correlates to participation restriction, defined by the ICF as "problems an individual may experience in involvement in life situations" (WHO, 2001). The lack of environmental resources to engage in meaningful occupations and roles in context is directly and negatively related to quality of life (Wilkie et al, 2004), thus we can begin to tie participation restrictions and occupational deprivation to individual and societal level outcomes; however, there is a great need for rigorous research to document this relationship.

At the same time, we also need to respect, respond to and closely collaborate with people with disabilities, the disability and older adults rights movements, and their constituency organizations that are also conceptualizing participation and advocating for the rights and resources to support participation opportunities as a civil right. These areas also correlate to ICF categories of participation which is defined as "involvement in a life situation" (WHO, 2002). The disability rights community has also conceptualized community participation as the "degree of connection that citizens with disabilities have to their physical and social surroundings." (NOD, 2006, p. 1). This conceptualization moves beyond a functional performance definition to one of freedom and citizenship that involve "being a part of," actively engaging in, and contributing to communities of choice. Equal access to the community and the right to live, work and participate in the community with supports, is a central tenet of the disability rights movement that was reified in the Americans with Disabilities Act and reinforced in the Olmstead decision. The 2004 NOD/Harris Survey (NOD, 2004) reports that Americans with disabilities face significant disadvantages in 10 key areas of life participation as compared to other Americans. These areas include employment, education, social life, religious participation, entertainment, political participation, income, transportation, health care, and satisfaction with life. Emerging research related to participation also verifies participation restrictions and gaps among people with disabilities; pointing to environmental barriers and lack of information on how to address these barriers as key factors influencing participation choice, control and opportunity (Cott, 2005; Gray et al, 2006; Hammel et al, 2006; Hammel et al, Article under Review). In research conducted within the RRTC on Stroke Survivors and Societal Integration and the RRTC on Aging with Intellectual Disability by Hammel & Jones (2006), 110 people with disabilities completed over 275 community and work environments participation assessments, documenting the barriers and supports to full participation. The most commonly documented barriers were environmental, including issues with physical access and safety, transportation, bathroom use, cognitive access (e.g., navigation, orientation, memory, decision making), information access and awareness of supportive resources, social support in public, communication in public and system policies related to integrated, accessible participation. This evidence is in line with trends in disability rights legislation and health care policy reform and rebalancing initiatives, such as the New Freedom Initiative, that are going beyond client-centered to right to consumer-directed programming, control and choice related to living in the least restrictive environment and having equitable access to full participation in society. These sociopolitical trends have great implications for future OT practice, research and community alliances.

All of this information points to the critical need to integrate and emphasize occupation-based interventions that support participation level outcomes across all settings. Internally, we also need to

ensure that OTs and OTAs think globally about their role in promoting participation, particularly during transitions that occur across the continuum of rehabilitation, thinking beyond where clients are at a particular moment in time to a lifespan approach, and thinking beyond the individual to the environment (social, physical, cultural, economic) using ecological, sociopolitical and cultural approaches. To this end, we as a profession need to represent the benefit of the work we do to enable participation in natural settings both as a process (e.g., therapeutic medium) and as an end goal (e.g., participation level outcomes). Best practice exemplars and models for the expansion and promotion of OT services in natural settings (in everyday contexts of the home, community, workplace and schools), and the need for advocacy to support payment for these models is a strong recommendation of the group. As a result, a significant discussion focused on what effective occupation-based practice that results in participation level outcomes looks like, how we can model it for practitioners, and what the implications of this trend are for education, research, policy, and community alliances. This expansion should also include focusing on how occupational therapy practitioners can consult with communities to design, implement and evaluate environments that support lifelong participation. Finally, recommendations for research on the need for and impact of occupation and context-based interventions such as these, and the tools to measure outcomes of such interventions, are outlined in this report and will have a positive impact on recognition of occupational therapy's role and expertise in facilitating participation across settings.

Question 1: Who are our external partners in this area of practice and what organizations are central to building strong networks to achieve our objectives?

Response	Action Items
<ul style="list-style-type: none"> ▪ Collaboration with groups working on participation research & assessment tools (e.g. David Gray at Washington University, Allen Heinemann & the Rehabilitation Outcomes Center at Rehabilitation Institute of Chicago, Wendy Coster & Alan Jette at Boston University, Gale Whiteneck and group at Craig Hospital. ▪ American Congress of Rehabilitation Medicine (ACMR) is taking the lead on defining participation measures (mainly physiatrists and researchers) – OT should have more voice and alliance with this group, in collaboration with The Trialliance (APTA, ASHA) ▪ Direct alliances with the disability community including organizations that are key in advocacy and policy making, such as: National Organization on Disability (NOD), National Council on Disability (NCD), National Council on Independent Living (NCIL) and the state IL networks, American Association of People with Disabilities (AAPD), World Institute on Disability (WID) & ADAPT, Rehabilitation International & Disabled People International ▪ Health Care Policy Groups: Centers for Medicare & Medicaid (CMS), CARF & other accreditation & health care policy organizations ▪ NCMRR & its mission to fund is participation-based research, as well as other institutes at NIH ▪ Alliance for Assistive Technology & the state AT Act Center network & Rehabilitation Engineering & Assistive Technology Society of North America (RESNA), DME provider organizations, & National Center for Accessible Media ▪ University Centers of Excellence in Disabilities (UCEDDS & AUCD) which have a link with the university training programs. ▪ Maternal Health & Child Development Bureau & related network of centers ▪ Disability organizations that represent key constituencies such as: American Foundation for the Blind, National Association of the Deaf & Gallaudet Univ., Autism Speaks, National Alliance for the Mentally Ill (NAMI), Mental health and psychiatric disabilities groups, American Academy of Cerebral Palsy, Consumer support groups (e.g. Nat’l Brian Injury, National Stroke Assoc., MS Society, American SCI Society, Arthritis Associations, etc.), ▪ Senior groups such as: American Association of Retired Persons (AARP), Assisted living facilities/ organizations ▪ Disabled American Veterans, Paralyzed Veterans of America, the VA network & other veteran groups ▪ For pediatrics: ASPIRE Partners; Department of Education 	<ul style="list-style-type: none"> ▪ Overall recommendation that AOTA establish more direct, focused alliances with groups already working on participation level initiatives and advocacy ▪ Consider partnering with insurance companies, participation research consortia, and/or rehabilitation hospitals to have pilot projects (grant funded) related to “participation-focused rehab without walls” in home/ community and measure the outcomes. Also with insurance groups to fund research on participation (e.g. Kaiser) ▪ Explore potential partnership programs with area agencies on aging, EI programs, non-medical programs where we could offer OT participation-based services ▪ Explore funding through home and community-based waivers (OTs are listed in the waiver) ▪ Recommend that AOTA consider providing/linking specialty certification to payer requirements

(OSEP especially); MCH; American Academy of Pediatrics, NASDSE, CEC (many divisions); DoJ-Juvenile Justice.

- The American Society of Hand Therapists (Chicago, IL)
- American Association of Orthopedic Surgeons and American Society for Surgery of the Hand (Rosemont, IL)
- Specialty board/certifications – increasingly payers are looking for these and will latch onto any which exist as validation of competency – need to be cautious about too many areas of advanced specialization by other organizations versus working to advocate that OTs are qualified at the entry-level to provide services (e.g., assistive technology).

Question 2. What are the critical education issues in this area of practice? Include foundational knowledge, OT specific knowledge, and practice skills.

Response	Action Items
<ul style="list-style-type: none"> ▪ We need to educate practitioners out in the field about an occupation-based paradigm that specifically focuses on and leads to participation level outcomes (e.g., how to do this as a general approach regardless of setting, how to start at participation outcomes versus impairment levels) ▪ Need to define the following for Entry level programs: <ul style="list-style-type: none"> ▪ What should AOTA be doing? ▪ What should schools do? ▪ What should focus be? ▪ Where are gaps in entry level education? ▪ Look at ACOTE standards. What is best practice as to ways these concepts can be taught with examples? Evidence-based teaching with case studies or scenarios which demonstrate how to deliver participation-based services. ▪ Developing critical reasoning, evidence based practice and emphasizing life-long learning on participation supported by innovative teaching methods ▪ Need to look at entry level programming as well as life-long learning as new students are more likely to get participation information and research than are clinicians who have been practicing a long time. ▪ Lifelong learning: <ul style="list-style-type: none"> - CE opportunities - Problem or case-based learning should be promoted: show practitioners how occupation-based therapy can meet reimbursement and productivity demands that are current deterrents for application of participation in the field. - Use examples of creative goal and intervention planning/writing from clinicians who actually do it. 	<ul style="list-style-type: none"> ▪ FAQs for web site with examples of occupation-based goal/intervention documentation that link directly to participation-level outcomes ▪ Analysis of existing practice, such as whether OT practitioners are writing goals and documenting changes in the ability of the client to "participate" or is focus on client factors that do not directly transfer to participation? And: Are OT's using a client centered approach to ensure that they are responding to clients' participation needs and preferences? ▪ Highlight ACOTE standards specific to occupation and participation-based practice and ways for educational programs to integrate this material more (e.g., ICF, participation assessments, etc.) ▪ OT/OTA partnerships is an educational issue that needs further exploration and modeling educational materials/case studies that highlight how the two can work together in participation –based interventions ▪ Life-long learning CE suggestions to focus on realistic, occupation-based practice to achieve participation outcomes: <ul style="list-style-type: none"> - Life planning- new field that would be a good market for OT: AOTA could do this as CE modules by SISs that apply participation level outcomes in specific settings and strategies to implement and fund - Web site links to practice examples and to model sites/settings - Annual Conference sessions - Link to courses on innovative design (e.g. Andrus Center course on delivering home modifications in the community, etc.)

Question 3: What are the OT issues that should be addressed in each of the following: acute care, rehabilitation, institutional (i.e., schools or organizations) and community?

Response	Action Items
<ul style="list-style-type: none"> ▪ As much as possible, need to use or simulate real life occupations & activities to maximize early performance & generate discussion on participation. ▪ Significant discussion about the disconnect between reimbursement systems and where/how intervention is likely to promote the best outcomes in terms of occupational performance and participation. Home care is a good example of therapy in a “real life setting” and the trend in school systems has gone from the pull out model to most therapy done in the classroom. It’s a participation framework. There are very few “rehab without walls” services for clients who don’t qualify for home care. These organizations provide outpatient therapy in the home/natural environment which should lead to better outcomes but funding is an issue in increasing these services. <p>Acute care:</p> <ul style="list-style-type: none"> ▪ Participation is not funded directly in acute care—must be creative in presentation to third party payers and need to model how to do this to OTs. ▪ Short lengths of stay coupled with strict medical reimbursement requirements interfere with participation level focus ▪ Role of OT in acute care sets the stage for the rest of the rehabilitation process- need to focus immediately on participation vs. deficits, and what is important to client long term—the issue is how to model this? ▪ Sometimes patients get to rehab. without having had any OT and do not get a participation level focus—education issue to physicians and other health care professionals on what we offer and why it’s important ▪ Acute care is far from a natural environment—goals may be very limited and short term and it’s not always clear what a realistic participation level outcome will be; however, OT should force themselves to do so as we offer that focus when other professionals may not. ▪ Need to focus on transition planning as the issue is that consumers aren’t getting the long term benefits of participation-based therapy and we are not necessarily setting up our treatments to advocate for that effectively—how do we do a better job on transition planning with a 	<ul style="list-style-type: none"> ▪ Advocate for policies and funding that supports more therapy in the home (not limited to client being home-bound) and community—this includes the need for getting the word out on existing best practices and evidence-based research on such interventions ▪ Apply EI model (federal mandate to provide services in natural setting) to adult rehabilitation contexts as an exercise to show participation level outcomes can and should be focused on ▪ Promote assessments which relate to occupation-based practice and participation level outcomes (e.g., see Gray, Heinemann, Whiteneck, Jette, etc. for examples). Examples include: <ul style="list-style-type: none"> ▪ COPM, MOHO-based assessments, ▪ Newer participation/participation restriction level tools to supplement such as Community Integration Scale, Participation Assessment out of RIC, CHART, CHIEF, ALSARS, CCAP, CIQ, Life Space, etc. ▪ <u>Quality of life scales such as:</u> http://www.utoronto.ca/qol/qolPublications.htm http://www.partnersagainstpain.com/content/C5110-1_54.htm http://www.cdc.gov/hrqol/hrqol14_measure.htm#2 ▪ QOLID (Quality of Life Instruments Database) – from Mapi Research

participation focus?

- Harder to incorporate occupation-based interventions- activities often don't translate to occupational performance and ultimately participation within acute care—need to think long term and also consider collaboration with family & significant others here.

Inpatient Rehabilitation:

- Reimbursement mandates 3 hours of therapy per day with issues of endurance, fatigue and ability to incorporate participation level activities into this setting, and whether the funders support this level of intervention. Again, need to have models of how to do & still get funding.
- Entire team needs to work collaboratively with client on participation level goals—difficult for OT alone to realize if no one else is working on them or supporting them.
- Lack of tools and/or awareness of how to use existing tools to assess participation needs & to show outcomes.
- Clients are in a milieu where medical body/structure and impairment are the focus, and how to “fix these”; participation is a very different framework with the goal to be a part of rather than to “fix” the individual. How to even work with clients to increase their awareness of and appreciation for participation level activities and outcomes.
- Along with this, need for more models on how to collaborate with peer mentors and members of community who can share first hand strategies for participation.

Hand Therapy:

- Evaluation/intervention focus on biomechanical deficits (bottom up-client factor level) vs. client-centered frame of reference.
- Must respect tissue healing timeline which can negatively impact occupational engagement so need to be creative in how participation is integrated into therapy sessions.
- Assessments & outcomes need to include occupation-based, participation outcomes in addition to body functions/structures

School Systems/Services under IDEA:

- Moving from impairment model to mostly inclusion/participation so school systems in many ways represent a model for highlighting participation level outcomes as the primary intervention planning tool—can we highlight this setting and apply to others?

Institute

- Hand Therapy tools such as: Disability of Arm, Shoulder, Hand assessment (DASH)

<http://www.dash.iwh.on.ca/>

- AT Tools such as: MPT (Matching Person and Technology)- outcome measurement tool for fit between person and technology, PIADS (Psychosocial Impact of Assistive Devices Scale)- self rating scale to measure impact of AT products on quality of life of users & QUEST (Quebec User Evaluation of Satisfaction with Assistive Technology)
- Useful references to assessments of participation include:
- Dijkers MPJM, Whiteneck G., and El-Jaroudi, R (2000). Measures of social outcomes in disability research. *Arch Phys Med Rehabil*, 80(Suppl. 2), S63-S80.
 - Cott C (2005). Conceptualizing and measuring participation. University of Toronto, Canada.
 - Gray D, Hollingsworth HH, Stark SL, and Morgan KA. (2006). Participation survey/mobility: Psychometric properties of a measure of participation for people with mobility impairments and limitations. *Arch Phys Med Rehabil*, 87(Feb),

- Issue here is lack of/need for more research/direct evidence to validate occupation-based practice & participation level outcomes.

Work Programs:

- Are outcomes better for on-site work programs vs. stand-alone, separate clinics? This would provide evidence on occupation-based interventions done in context.
- OTs will need to sell their services to employers, negotiate rates and integrate the work culture into the intervention plan and goals; as a field we are potentially losing ground in this area rather than gaining it even though this area represents a prime participation focus like schools.

Assistive Technology:

- Adoption of assistive technologies is a complex process which depends on many factors including users, environmental context, occupations, the devices themselves and professional support throughout the process. Easy to lose a participation focus; OTs' role in matching the user's AT needs to participation level outcomes is at risk and services here are being cut and other specialists are taking over.

189-197.

- Grimby G. (2002). 'On autonomy and participation in rehabilitation. *Disability and Rehabilitation*, 24(18), 975-976.

Pediatric transdisciplinary inventories

that review roles/tasks associated with these environments and the supports available/needed within them:

- EI: Asset Based Context Matrix
 - Schools: The School Function Assessment, Functional Behavioral Assessment
 - WATI Assessment Procedures for AT
 - Student Environment, Task and Tools (SETT)
 - Cornell Ergonomic Checklists
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- **Models for therapists to market OT** in the context of their own setting using vignettes which illustrate quality of life and participation level outcomes to demonstrate what OT can offer

Question 4: What are OT outcomes in this area of practice and how do they relate to participation? How do they relate to the outcomes valued by consumers or payers?

Response	Action Items
<p>Overall. Participation level outcomes should correspond to the OTPF, ICF and disability community conceptualizations of participation categories (a lot of overlap between them)—need to provide examples though of which would be highest priority in specific contexts, which cut across contexts, and how to write transition goals to follow person as their age and their participation level goals change over time.</p> <p>Primary outcomes are contained in the initial summary of the group process as outlined in the OTPF, ICF, and by key disability organizations.</p> <p>Acute Care:</p> <ul style="list-style-type: none"> ▪ Clients will be able to participate in desired occupational performance when they leave acute care, and will have an action plan for participation long term (e.g. elective procedures like hip replacement) ▪ Individuals may need to engage in preparatory techniques or activities related to short term goals that will lead to participation level outcomes so they don't get discouraged or depressed when the goals seem far away or not doable. ▪ The individual's medical status influences their ability to participate; in some cases, the individual may not necessarily be "participating" as ICF defines it; the profession needs to support that this is still OT; for example, a goal of tolerating the head of the bed at 60 degrees for 5 minutes may still work however we as OTs need to tie this goal to long term participation so the client sees why you are doing this and where it can lead to long term. <p>Technology:</p> <ul style="list-style-type: none"> ▪ Goal is to minimize incompatibility between client abilities and occupational demands of the environment in which they participate—any area of participation fits here (e.g., community mobility, community living, etc. can all have an environmental match goal) ▪ Must identify factors that account for under-usage and non-usage of AT that denote lack of integration within participation level goals and outcomes—e.g., what is best practice? ▪ Consumer satisfaction (with process, devices, 	<p>General:</p> <ul style="list-style-type: none"> ▪ Guide to Practice type recommendations re: vignettes that illustrate participation-level outcomes in different settings; what assessments can be used to evaluate & document participation; & how to market yourself as an OT in each setting as a participation level specialist ▪ Payers are interested in saving money. Disseminate and fund studies that support the positive financial impact when a client regains the ability to participate in desired life tasks. ▪ Document the impact of client-centered and/or consumer-directed approaches to prioritize participation level outcomes

<p>service) and comparison of goal achievements with/without the AT and overall change in quality of life should be evaluated as these influence outcomes.</p> <p>Hand Therapy:</p> <ul style="list-style-type: none"> ▪ Intervention plan which includes LT goals related specifically to the client’s participation across different areas of life. ▪ Pay immediate attention to acute difficulties within performance areas, including adaptive equipment and compensatory techniques to maximize early participation <p>School Systems/EI:</p> <ul style="list-style-type: none"> ▪ In Early Intervention (EI), participation means being part of a family/being able to do kinds of activities children birth to 3 years of age would do (e.g. express feelings, being loved, eating meals with family, playing, learning, age-appropriate self care) ▪ Best practice in EI involves using naturally occurring routines/activities of a family and other environments to foster growth, development and participation. This very OT approach is now mandated as the way to provide services within EI so we should be leading the implementation of this initiative but we are not. ▪ In school, participation means being part of the classroom and the school. Primarily, it means being educated with same age peers, following same curriculum with appropriate modifications/adaptations (e.g. eating in cafeteria, dressing in locker room, riding same bus as siblings/neighbors, turning work in on time). Having a student role and friends at school ▪ Best practice in the schools includes the ability to represent what the profession offers to individuals planning school buildings, organizing/arranging classrooms, designing curriculums, selecting materials/tools and assisting teachers in implementing teaching strategies to address diverse learning styles of all students (universal design for learning). It also means visibility in the school culture and active participation on the part of the therapist- service provision in natural contexts (e.g. classroom, cafeteria, playground) 	
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Question 5: What key research would inform practice in this area?

Response	Action
<ul style="list-style-type: none"> ▪ We must research the qualitative processes and quantitative outcomes of occupation/ based treatment and how it 	Support research documenting effects of occupation-based

<p>specifically leads to participation level outcomes, with exemplars in different areas of practice or across the lifespan that OTs can readily and easily use to justify participation level focus.</p> <ul style="list-style-type: none"> ▪ Monitor outcomes of OT services with regards to participation level outcome attainment. We cannot continue to focus research on component outcome only (finger ROM improved). ▪ Look to strong existing evidence of participation level outcomes that highlight how OT influences these—such as research by Florence Clark in the Well Elderly study and follow-on studies; Laura Gitlin & Mary Corcoran Environmental Interventions; Bill Mann AT studies; Joy Hammel AT studies. Additional references include: <ul style="list-style-type: none"> ▪ Case-Smith, J. (2003). Outcomes in hand rehabilitation using occupational therapy services. <i>American Journal of Occupational Therapy</i>, 57(5).(measured functional outcomes after Outpatient OT for upper extremity injured clients) ▪ Bhavnani, G. (2000, December). Toward occupation-based practice in hand rehabilitation. <i>Physical Disabilities Special Interest Section Quarterly</i>, 23, 1-2. (documents importance of occupation-based approach and found that it is not typical in hand rehab. settings.) ▪ Eyres, L., Unsworth, C.A., (2005). Occupational therapy in acute hospitals: The effectiveness of a pilot program to maintain occupational performance in older clients. <i>Australian Occupational Therapy Journal</i>, 53, 218-224. ▪ Griffin, S. D., McConnell, D., (2001). Australian occupational therapy practice in acute care settings. <i>Occupational Therapy International</i>, 8(3). 184-197. ▪ Research from Houston, TX schools and Iowa’s statewide handwriting research ▪ Society’s gain from environmental adaptation was confirmed in an analysis of 13 studies performed on people who returned to work after acquiring a physical disability (Krause, Dasinger & Neuhauser, 1998). The analysis showed a two-fold rate of integration into work, as well as a 50% reduction of lost work days among those who received adaptations. In addition, costs, which so many employers fear, were found to be lower and more effective than expected (Krause et al., 1998; Schwochau & Parker, 2003). Research about effectiveness of on-site work programs is attractive to employers, and needed. 	<p>practice on participation level outcomes across areas of practice.</p> <p>Review assessment tools and see if they’re relevant/appropriate to measure participation and quality of life (e.g., develop an assessment matrix for clinicians) - if not, develop them or collaborate with groups that are doing participation tools.</p>
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- **Assistive Technology & Environmental Modifications Research:** The assistive technology evaluation and prescription process is complex, its cost is usually high, and clinical data demonstrate that the rate of technology adoption and abandonment are high. There is a great need for in-depth follow-up studies to document and characterize the phenomenon (Scherer & Galvin, 1994; Phillips & Zaho, 1994). Most studies carried out in the past on the subject of assistive technology and work environment for people with disabilities have shown direct outcomes for efficiency of use, duration of use, frequency of use, and satisfaction with a specific adaptation (e.g., Day, Jutai, Woolrich & Strong, 2001; Demers, Weiss-Lambrou & Bernadette, 1996; Smith, 1996). Article: “Patterns of engagement in leisure activities by older adults using assistive devices” by J. Schweitzer, W. Mann, S. Nochajski and M. Tomika, Univ. of NY at Buffalo-use of assistive devices to enhance engagement in desired leisure activities.

Question 6: What key policy issues should we be tracking and leading?

Response	Action Item
<ul style="list-style-type: none"> ▪ The Rehabilitation Act & the Americans with Disabilities Act mandate equitable participation opportunities and are key in framing participation in society. The ensuing Olmstead Decision further mandates the right to least restrictive living decision making, and has since led to an entire paradigm shift in policy, as exemplified by the New Freedom Initiative, that focuses on rebalancing long term care resources toward supporting least restrictive living and full participation in society. This legislation and these national policy initiatives are critical for OTs to be aware of, as they also lead to the opening of new funding streams, such as Home & Community based waivers, which are under tapped and underutilized but are there to provide participation level supports. At the same time, OTs can and should be involved in identifying areas where ADA has not worked (e.g., employment outcomes) or gaps in enforcement that they can advocate with the disability rights community to improve participation level opportunities and supports. ▪ IDEA and its impact on participation-level service delivery in schools. ▪ RTI (Response to Intervention); No Child Left Behind (NCLB); Autism Act; Maternal and Child Health focus and initiatives; Chaffee Act and NIMAS (accessible print materials). Also mental health initiatives related to children and youth. ▪ The Older Americans Act, the Developmental Disabilities, and others that specifically reinforce ADA and the right to full participation. ▪ Acute care, inpatient rehabilitation, and long term care policies related to what is or is not funded (e.g., can easily get into a nursing home but more difficult to stay in home and get needed supports to do so) ▪ Therapy cap policies ▪ The challenge of hospital productivity requirements and the impact on the ability of practitioners to pursue desired models of practice requires continued attention. 	<ul style="list-style-type: none"> ▪ CMS- propose demonstration projects or partnerships between educational, clinical & disability organizations to show that it's less expensive and more effective to provide in-context participation level interventions that lead to participation level outcomes such as deinstitutionalization/ community living, employment, school/learning, etc. ▪ AOTA should work with payers to increase utilization of home care OTs to promote continuity of intervention which began in rehab/inpatient settings to promote participation level outcomes (e.g., apply Gitlin/Corcoran research to a study of cost effectiveness to validate delivery) ▪ Hand therapy - AOTA may consider creating more educational materials and support for research in this area of practice to encourage OT's to maintain their professional identities as OT's and focus on participation level outcomes.

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| <ul style="list-style-type: none">▪ The American Society of Hand Therapists and the Hand Therapy Certification Commission appear to be invested in creating “hand therapy” as a profession separate and distinct from OT. They support Physical Therapists as well as OT’s as practitioners in this area so obviously cannot be invested in one profession exclusively (despite the fact the well over 90% of hand therapists are OT’s). Concerns arise in light of the current specialty climate where third party payers are seeking evidence of specialty education/certification in order to pay for services typically provided by generalist OT’s (also applies to assistive technology, etc.). At the same time, this is a strong practice area for OT’s and one that can benefit by the infusion of participation based treatment. | |
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Question 7: What internal and external barriers are limiting our practice?

Response	Action
<ul style="list-style-type: none"> ▪ Concern for 3rd party payment: OTs perceive they may be limited by reimbursement requirements and can easily fall into a routine of focusing on impairment without mentoring on how to effectively provide an occupation-based practice. ▪ Concern for productivity standards of institutions. Client centered and occupation based practice is perceived as taking more time and detracting from productivity. ▪ Emphasis on evidence-based practice but little evidence to guide participation level practice or outcomes. ▪ Lack of recognition of OT in general public, not just healthcare system, as specialists in participation level outcomes ▪ Lack of knowledge about how our skills enable better quality of life and participation level outcomes ▪ Getting OTs to utilize the ICF framework & participation level assessment tools recognized outside the field to document our impact. ▪ Need better use of outcome measures to track our effects on participation. ▪ Need to better define and effectively justify OT to others ▪ Gaps in our practice related to participation level outcomes, such as our focus on the individual versus the broader environment and issues within it influencing these outcomes. ▪ Not all OTs are on board with central focus on occupation so profession appears uncertain or too diffuse. 	<ul style="list-style-type: none"> ▪ Create AOTA products (books, CE courses) that outline and provide examples of an occupation-based approach to treating clients in multiple arenas ▪ AOTA to provide resources that offer explicit instruction on how to document occupation-based treatment in settings to alleviate reimbursement concerns ▪ Provide evidence to AMA, nurses, etc. that support the premise that early participation positively impacts future occupational performance of clients.

Question 8: What is our unique contribution to the needs of people who need rehabilitation, habilitation, or prevention services?

Response	Action Items
<ul style="list-style-type: none"> ▪ OT is unique in its focus on the function and participation of the client in the truest sense. OTs plan their intervention based on participation. OT's understand that participation in context is key and in fact, is the treatment medium and the outcome; out of context and component focus do not equal participation. OT's also have knowledge of the therapeutic use of self that makes our profession inherently skilled at motivating people and connecting them with their most valued participation level goals. 	<ul style="list-style-type: none"> ▪ Need alignment of OT with participation level initiatives outside the field (ICF, Healthy People etc.) ▪ Align OTPF with these outside documents & external yet very public initiatives. ▪ Align OTPF better with the disability community and their framing of participation and disability with an environmental focus; use societal terms that don't have medical /rehab framings of disability

Question 9: What links to other organizations, federal agencies, foundations related to this practice area should be posted on AOTA's website for our members?

Response	Action
<p>As opposed to just providing lists and web site links, we recommend that AOTA do some action planning related to participation, rehabilitation and disability to prioritize goals and activities. Then, one can prioritize alliances, collaborations and resources for each so people are not overwhelmed but instead get this knowledge in a packaged format that directly relates back to their practice and how to be a better OT in realizing participation level outcomes, as well as to AOTA as a professional organization in its priorities in advocating or policy setting related to participation level opportunities.</p> <p>As a general overview of participation, we recommend the following sites and/or documents to start :</p> <p>International Classification of Functioning, Disability & Health: http://www3.who.int/icf/icftemplate.cfm & Dahl TH (2002). International Classification of Functioning, Disability and Health: An introduction and discussion of its potential impact on rehabilitation services and research. <i>J Rehabil Med</i>, 34, 201-204.</p> <p>Institute of Medicine (2006). Marilyn J. Field, Alan M. Jette and Linda Martin, Editors, Workshop of the Committee on Disability in America: A New Look. http://www.nap.edu/catalog/11579.html#orgs</p> <p>Cott C, et al. (2005). Conceptualizing and measuring participation. University of</p>	

Toronto, Canada.

<http://www.torontorehab.on.ca/documents/ParticipationThemeWorkingReport141005.pdf#search='icf%20%26%20disability%20critique'>

National Organization on Disability: <http://www.nod.org/>

National Council on Disability: <http://www.ncd.gov/>

Healthy People 2010: <http://www.healthypeople.gov/>