AGENDA ITEM 5

REVIEW AND VOTE ON APPROVAL OF THE OCTOBER 13, 2023, COMMITTEE MEETING MINUTES.

BUSINESS, CONSUMER SERVICES AND HOUSING AGENCY • GAVIN NEWSOM, GOVERNOR
CALIFORNIA BOARD OF OCCUPATIONAL THERAPY
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*** * DRAFT * ***

PRACTICE COMMITTEE MINUTES

Friday, October 13, 2023

Committee Members Present
Christine Wietlisbach, OT, Board Member/Chair
Richard Bookwalter, OT, Board Member
Lynne Andonian, OT
Diane Laszlo, OT Retired
Carlin Daley Reaume, OT

Committee Members Absent
Lynna Do, Board Member
Danielle Meglio, OTA
Jeannette Nakamura, OT

Board Staff Present
Heather Martin, Executive Officer
Jody Quesada Novey, Manager
Rachael Hutchison - Analyst
Jeanine Orona - Analyst

Public Attendees Present
Floyd Tran, OT
Chi-Kwan Shea, OT

1. Call to order, roll call, establishment of a quorum.

   The meeting was called to order at 2:00 pm, roll was called, and a quorum was established.

2. Chairperson opening remarks.

   Chair Christine Wietlisbach thanked the committee volunteers and members of the public for their attendance at the first Practice Committee meeting of 2023. Ms. Wietlisbach stated that the list of practice related issues the committee was tasked with would be prioritized and there would be a discussion about the schedule of upcoming meetings. Lastly, if those present collectively feel the expertise is in attendance the committee would discuss a few issues. Ms. Wietlisbach closed with the announcement that the committee is still recruiting volunteers that may have skillsets not yet represented on the committee.

3. Introductions by all Committee Members.

   - Christine Wietlisbach, 30 years of experience in occupational therapy (OT), hand therapist, current California Board of Occupational Therapy (CBOT) Board member.
   - Richard Bookwalter, 27 years of OT experience mostly in geriatrics and for the last 15 years in wheelchair seating and mobility at Kaiser San Francisco, current CBOT Board member.
   - Diane Laszlo, 36 years as a certified hand therapist, recently retired and has been working per diem as a certified hand therapist.

- Carlin Daley Reaume, 16 years of experience in OT, private practice that focuses on pelvic health, prior career focus was lifestyle redesign and emerging and non-traditional areas of practice, current Assistant Clinical Professor at the University of the Pacific.
- Lynne Andonian, 35 years of experience in OT mostly focused on mental health and academia and a current professor at San Jose State University.

4. Executive Officer to provide overview of Bagley Keene Open Meetings Act and meeting requirements.

   Executive Officer Heather Martin gave an overview of the Bagley Keene Open Meetings Act requirements, emphasized that Committee members not talk about Committee matters outside of a noticed Committee meeting and to avoid a serial meeting violation and to direct inquiries to her if needed.

   Ms. Martin reported that the Governor passed a bill that allows meetings to be noticed without listing the address of each Committee or Board member through December 31, 2023.

5. Public Comment for Items Not on the Agenda.

   There were no public comments for items not on the agenda, but members of the public introduced themselves at will.

- Chi-Kwan Shea, 44 years of experience in OT. Ms. Shea has 27 years as an educator and professor, many prior years in administration, a 23-year volunteer for a community based occupational therapy training program, recently became a Board member of the National Board for Certification in Occupational Therapy.
- Floyd Tran, ten years as an OT, currently holds a supervisory role, worked in inpatient and outpatient settings but presently treats pre-mature infants in the neonatal intensive care unit.

6. Committee discussion and prioritization of practice issues delegated by the Board to the Committee for evaluation and possible recommendation(s) to the Board.

   Chair Wietlisbach prioritized the seven topics with the help of the committee as follows:

   1. *Consider whether suture removal is within OT scope of practice.*
   2. *Consider whether Advanced Practice approval in Hand Therapy is required to treat carpal tunnel syndrome, repetitive motion injuries, or finger/hand pain, wrist pain or elbow pain that is not due to trauma or surgery. (Receipt of opinion from OT with hands approval; need additional opinion from OT with background ergonomics, orthotics, or geriatrics.)*

   Chair Wietlisbach stated that items 1 & 2 would be a priority and would be addressed simultaneously at the next meeting. She and Diane Laszlo would work with Executive Officer Heather Martin on background information. She also requested that Board staff provide the 2018 AOTA position paper on Wound Care, 2023 AOTA policy on Interventions to Support Occupations, Occupational Therapy Practice Act, California Code of Regulations and AOTA Ergonomics to be forwarded by Richard Bookwalter.

3. *Review ACOTE Guidelines and consider reducing Advanced Practice education and training requirements for students graduating after a certain date (date TBD).*
4. *Review education and training requirements for licensees demonstrating competence in Advanced Practice areas and consideration of reducing education/training hours needed.*

Chair Wietlisbach asked for input on list items three and four. The discussion led to the conclusion that the items were related and that if the committee had enough time at the December 8th meeting, they could begin discussion on these two items following items one and two.

Ms. Wietlisbach requested that Board staff include relevant pages of the ACOTE guidelines along with OT Practice Act, the California Code of Regulations, as supporting documentation in the December 8th meeting materials.

5. *Recommendation on records retention requirement(s) for an Occupational Therapy business that closes or is sold or if the practitioner is no longer in private practice.*

Chair Wietlisbach polled the committee members to discover which, if any had private practice experience because she felt it would be valuable knowledge and input when discussing item five.

Carlin Daley Reaume offered that she was currently in private practice.

Ms. Wietlisbach stated that she recognized the value in waiting to discuss item five following the hopeful recruitment of an additional committee member with private practice experience to accompany the professional opinion of Ms. Daley Reaume. Item five would be added to a future agenda.

6. *Request for guidelines for OTs educating patients on "the correct weight-bearing status precautions, maintaining movement precautions (such as posterior hip precautions), following surgeon protocols, utilizing approved abbreviations in documentation, and exercising sound clinical judgement while working with and educating patients."*

A robust conversation ensued pertaining to item six which was a public comment that was assigned to the committee by the Board.

Diane Laszlo commented that the ask was difficult to understand and seemed to be a blanket statement. Ms. Laszlo recommended that the practitioner refer to the hospital of which she is employed. She concluded with a statement that all licensed practitioners have basic training that would allow them to impart clinical reasoning in all of the referenced areas.

Carlin Daley Reaume responded through an academia lens stating that she felt inclined to offer this practitioner a statement that refers to this practitioner calling upon their clinical background and skills. Ms. Daley Reaume closed by conveying that it didn't feel appropriate to offer answers when every scenario and every set of workplace guidelines varies.

Lynne Andonian agreed with the previous comments of her colleagues and stated that she felt that it would be beneficial for this practitioner to seek guidance from their employer.

Executive Officer Heather Martin stated that Board staff had enough detail to respond to the commenter in writing.

7. *Pending Board action in November, possible discussion on, among other things, whether dry needling and wound care is within occupational therapy scope of practice and whether statutory or regulatory language is needed.*

Chair Wietlisbach confirmed that the committee would wait for further instruction from the November Board meeting.

Public Comment
There were no additional public comments.

7. Discussion on scheduling time(s) for future meetings.

The results of the Doodle poll for the second meeting of the Practice committee were discussed and it was confirmed that the next meeting would be held December 8th from 5:00 – 6:30 pm.

Chair Wietlisbach reported that based on the number of items currently assigned to the Practice committee she felt a need to schedule at least a third meeting. Ms. Wietlisbach stated that the Board could assign additional items to the committee at any time and those items would prioritized at the future meetings along with discussion regarding dates and times.

Executive Officer Heather Martin stated the committee members could expect an emailed invite to participate in a Doodle poll to choose the time for a tentative March 1, 2024, meeting.

Public Comment
There were no additional public comments.

8. New suggested agenda items for a future meeting.

There were not any new suggested items for a future agenda.

Public Comment
There were no additional public comments.

Meeting adjournment.

Chair Wietlisbach thanked the committee members for their great comments and input.

The meeting adjourned at 3:00 pm.

Opportunity for public comment is provided for each agenda item.

The meeting may be cancelled without notice. For verification, please check the Board's website at www.bot.ca.gov or call 916-263-2294 to verify meeting details.

Public comments will be taken on agenda items at the time the item is heard. Discussion and action may be taken on any item listed on the agenda. Agenda items may be taken out of order for convenience, to accommodate speakers, or to maintain a quorum.

The Committee may discuss agenda items in any order on each day, unless noticed as "time certain." Agenda Items may be taken out of order or tabled or held over to a subsequent meeting for convenience, to accommodate speakers, or to maintain a quorum.

The Committee Chair may apportion available time among those who wish to provide comment.

The meeting is accessible to the physically disabled. A person who needs disability-related accommodations or modifications in order to participate in the meeting shall make a request to Rachael Hutchison at (916) 263-2294, by sending an email to cbot@dca.ca.gov, or by mailing a written request to CBOT, 1610 Arden Way, Suite 121, Sacramento, California, 95815.

Providing at least five working days' notice before the meeting will help ensure the availability of accommodations or modifications.

For further information on this meeting or notice/agenda, contact Rachael Hutchison at (916) 263-2294, by sending an email to cbot@dca.ca.gov, or by mailing a written request to CBOT, 1610 Arden Way, Suite 121, Sacramento, California, 95815.

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AGENDA ITEM 6

CONSIDERATION AND POSSIBLE RECOMMENDATION TO THE BOARD ON WHETHER SUTURE REMOVAL IS WITHIN THE OCCUPATIONAL THERAPY SCOPE OF PRACTICE.

AOTA Position Paper

Role of Occupational Therapy in Wound Management

The American Occupational Therapy Association (AOTA) asserts that the prevention and amelioration of wounds and their impact on daily life occupations are within the scope of occupational therapy practice. Occupational therapists and occupational therapy assistants routinely work with individuals and populations who are at risk for or have sustained wounds.

In the *Healthy People 2020* initiative, the U.S. Department of Health and Human Services (DHHS; 2010) called for a 10% reduction in pressure injury–related hospitalizations in persons ages 65 years or older by 2020, identifying this area as one of significant concern for individuals and society. This position paper informs internal and external audiences, including employers and payer sources, about the role of occupational therapy related to preservation and restoration of the ability of the individual to participate in meaningful, desired, and necessary daily life occupations through prevention and amelioration of wounds.

Types, Incidence, and Prevalence of Wounds

Wounds, or impaired skin integrities, include abrasions, punctures, bites, surgical wounds, diabetic ulcers, pressure injuries, traumatic wounds, venous stasis ulcers, and arterial ulcers. Certain groups either exhibit or are at risk for wounds and related complications. These groups include people with spinal cord injuries (SCIs), cerebral palsy, hand injuries, diabetes, cancer, and burns, as well as those with sensory or mobility impairments, including older adults. For example, the Centers for Disease Control and Prevention (CDC) has reported that in 2014, 108,000 of the documented 7.2 million hospitalizations for persons with diabetes were due to lower-extremity amputations caused by nonhealing wounds (5 per 1,000 persons with diabetes; CDC, 2017).

Wounds and related conditions can negatively affect a person's ability to participate in their life roles, routines, and useful habits and can impact their performance with self-care, work, educational activities, leisure activities, social participation, and rest and sleep. Wounds affect both the physical and psychological well-being of individuals and can adversely affect quality of life. Pain, depression, social isolation, and anxiety can result from the existence of wounds, particularly those that are chronic in nature (Fearns, Heller-Murphy, Kelly, & Harbour, 2017). In addition, a person may have difficulties or require assistance with activities and contexts specifically related to the wound itself, such as

- Management of the wound site, including applying wound care treatments and products to promote healing as well as manage drainage or odor;
- Management of clothing and footwear that may no longer fit correctly or that may worsen the wound condition;
- Care, use, and application of pressure garments for scar management;
- Engaging in restful sleep due to the presence of pain;
- Functional mobility due to the wound site or associated pain;
- Engaging in physical activity necessary to prevent impairments in endurance, overall strength, cardiovascular status, pulmonary status, and cognition;

- Reduced social participation, self-efficacy, and reported quality of life due to discoloration of the skin, visible scars, contracting or hypertrophic scars, and conspicuous use of compression garments; and
- Financial stability that can be affected by the inability to work due to a significant wound.

Occupational Therapy's Role in Wound Management

The profession of occupational therapy is grounded in the principle that participation in meaningful and relevant life activities leads to life satisfaction, longevity, health, and wellness (AOTA, 2014b; Christiansen, 2011). The ability to actively pursue and participate in desired life tasks and activities can be altered temporarily or for sustained periods due to the presence of a significant or chronic wound. In addition, according to Sleight et al. (2016) and the Braden Scale wound risk assessment tool (Kring, 2007), diminished engagement in activity and mobility are considered risk factors for pressure ulcer–type wounds.

Occupational therapy practitioners[1] working in this area combine an understanding of the benefits of participation in everyday activities; the mechanism and progression of acute and chronic wound healing and management; overall impact of related body functions and structures; and contribution of mental health to well-being as they address the expressed needs of the client. Through their understanding and appreciation of the transactional relationship between client factors, including body functions and body structures, as well as performance skills and performance patterns, and occupations, an occupational therapy practitioner may focus on the wound itself as part of the overall intervention plan to prevent or reduce possible resultant occupational dysfunction (AOTA, 2014b).

Following a plan of care established by an occupational therapist and as allowed by federal and state regulations and third-party payer requirements, and within each practitioner's level of competence and scope of practice (AOTA, 2014c, 2015a), the occupational therapy practitioner can provide interventions, including the following targeted preparatory methods (AOTA, 2014b):

- Application of clean dressings using the principles of moist wound care with both exudating and nonexudating wounds;
- Application of wound closure strips;
- Removal of sutures and wound closure strips;
- Monitoring of wound status;
- Mechanical debridement using forceps, cotton-tipped applicators, wet-to-dry dressings, and pulsed lavage;
- Sharp debridement using scalpel or scissors to remove denatured tissue;
- Application of appropriate topical agents to facilitate wound healing and debridement;
- Application of silver nitrate for reduction of hypertrophic granulation tissue;
- Application of enzymatic agents (e.g., collagenase) for debridement;
- Application of negative pressure wound therapy;
- Application of physical agent modalities such as whirlpool, electrical stimulation, and ultrasound;

[1]When the term *occupational therapy practitioner* is used in this document, it refers to both occupational therapists and occupational therapy assistants (AOTA, 2015b). *Occupational therapists* are responsible for all aspects of occupational therapy service delivery and are accountable for the safety and effectiveness of the occupational therapy service delivery process. *Occupational therapy assistants* deliver occupational therapy services under the supervision of and in partnership with an occupational therapist (AOTA, 2014a).

- Education of clients and caregivers in techniques for donning and doffing pressure garments to manage swelling; and
- Use of specialized techniques for the management of upper-extremity lymphedema.

This care may be offered as part of a team approach to intervention or in collaboration with the referring physician. In addition, occupational therapy practitioners may provide modifications and accommodations to the occupation, environment, and context while the wound is healing. For example, education and adaptive equipment can allow a client to assist with or perform dressing changes, basic activities of daily living (ADLs), instrumental activities of daily living (IADLs), and tasks within all other areas of occupation.

Occupational therapy practitioners also are skilled in the *prevention* of wounds for people with various acute and chronic conditions such as SCIs, burns, lymphedema, cancer, diabetes, hand injuries, and other sensory and mobility impairments. In these cases, individual attention is given to the client's health status, environment and context, patterns of activity, and lifestyle choices as part of an overall plan to maintain skin integrity. Some interventions focus on the client (persons, groups, and populations), others address the way activities are performed, and still others seek to change the context or environment that surrounds the client and influences performance. Interventions may focus on treatment of the actual wound, treatment of the resulting dysfunction, or prevention of the wound from occurring.

The following are examples of types of interventions and intervention approaches used in the delivery of occupational therapy services:

- *Restore habits and routines:* Disruptions to habits and routines by changes in client factors, performance skills and the context and environment can interfere with the quality and ease of completing daily activities. Occupational therapy practitioners can offer substitutes and adaptations for habits or can work with a client on establishing new habits to mitigate the impact of chronic or acute wounds.
- *Prevent loss of roles:* Roles define behaviors and activities in which the client expects to engage on a daily basis. Changes to client factors, skills, and the environment as a result of a wound negatively affect role execution and lead to occupational dysfunction. Occupational therapy practitioners can suggest modifications and adaptations to the activities required to continue with roles as part of an intervention plan.
- *Prevent occurrence of wounds:* Occupational therapy practitioners can position the body to alleviate points of pressure, including positioning techniques to ensure postural alignment, distribution of weight, balance, and stability. Practitioners can recommend support surfaces, such as specialized beds and customized wheelchairs, cushions, and seating systems, and can also work with clients to identify ways to incorporate recommended prevention measures into their ongoing daily routines. These measures include pressure-relief activities (techniques and frequency) and pressure redistribution equipment such as tilt-in-space wheelchairs and seat cushions.
- *Modify context and environment:* Occupational therapy practitioners work to address the physical and social environments and personal context of the client that are changed by a wound or that must change to accommodate changes in abilities. For example, a client with an SCI may not be able to use his power wheelchair in the community due to a pressure ulcer on his ischial tuberosity that requires him to stay in a prone position. An occupational therapist can make suggestions for changes to his immediate environment, including adaptive body positioning and changes to his computer setup that allow him to continue to work as a computer programmer from his home office.
- *Fabricate or provide orthotic devices:* Occupational therapy practitioners can fabricate or provide orthotic devices to help protect healing structures, prevent deformity, and secure dressings.
- *Educate about techniques:* Occupational therapy practitioners can educate clients and caregivers in skin care techniques, including moisture control and dry skin prevention; in precautions and safety techniques for all areas of occupation; and in transfer techniques to minimize risk of skin tears.

In addition, occupations and activities are designed and provided to engage the client in tasks that are meaningful and relevant and that support the mind, body, and spirit. Skilled selection of appropriate activities will minimize the detrimental effects of physical inactivity; loss of habits, roles, and routines; and social isolation that may result from the presence of wounds (AOTA, 2014b). Activities selected should always hold meaning and have purpose to the client and can include things such as community outings, shopping, socializing, homemaking, care of others, and pet care.

Occupational therapy practitioners recognize that, in addition to neuromusculoskeletal concerns, clients experiencing wounds also may exhibit diminished sense of self and self-efficacy, anxiety, and depression that interfere with their ability to manage currently existing wounds or participate in relevant daily occupations. Individuals who currently do not present with a wound may be at risk due to various lifestyle choices or environmental situations. Practitioners engage the qualities of their personality; verbal and nonverbal communication; listening skills; and empathy to encourage, facilitate, and motivate clients as they seek and achieve personal health, wellness, and occupational participation (AOTA, 2014b). Practitioners consider the contextual issues that affect availability and choice with regard to wound care methods and access to tools. Advocacy efforts are initiated by practitioners as appropriate to prevent and treat wounds when individuals are faced with these concerns.

Cultural issues are also considered in the course of occupational therapy intervention. The impact of beliefs and choices is considered and integrated as part of the holistic approach to treatment. For example, parents may prefer that only organic debridement agents be used on their child's wound. An occupational therapy practitioner who is aware of this decision may advocate for the family through a team conference in which a discussion about the use of autolytic debrident versus pharmaceutical agents can take place. In another example, a male family member can be instructed in techniques for changing a dressing for an older man who is uncomfortable with several different home health care providers caring for the wound on his sacrum.

Education

Occupational therapy practitioners are knowledgeable in the areas of human biology and physiology and treatment methods and interventions used as part of wound management. According to the Accreditation Council on Occupational Therapy Education's *Standards* (ACOTE, 2012), occupational therapists and occupational therapy assistants must demonstrate knowledge and understanding of the structure and function of the human body to include the biological and physical sciences. They select and provide interventions and procedures to enhance safety, health and wellness, and performance in all areas of occupation (i.e., ADLs, IADLs, work, play, leisure, social participation, education, rest, and sleep). In addition, occupational therapy practitioners provide development, remediation, and compensation for physical, mental, cognitive, perceptual, sensory function, neuromuscular, and behavioral skills and are able to design, fabricate, apply, fit, and train in assistive technologies and devices (e.g., electronic aids to daily living, seating and positioning systems) used to enhance occupational performance and foster participation. Occupational therapy practitioners are able to demonstrate safe and effective application of superficial thermal and mechanical modalities as a preparatory measure to manage pain and improve occupational performance.

Occupational therapy practitioners who are interested in working with individuals with chronic or acute wounds are able to participate in continuing professional development activities that specifically target the properties or causes of wounds and wound care techniques. Educational programs targeting health care professionals are available through various companies and organizations.

Ethical Considerations

The *Occupational Therapy Code of Ethics (2015)* (AOTA, 2015a) provides principles that guide safe and competent professional practice in all areas, including wound management. It is the professional and ethical responsibility of occupational therapy practitioners to provide services only within each practitioner's level of competence and scope of practice. The Code of Ethics establishes principles that guide safe and competent professional practice and that must be applied when providing care to clients with wounds. Practitioners should refer to the relevant principles from the most current Code and comply with state and federal regulatory requirements.

Table 1 presents case examples of occupational therapy's role in wound management.

Table 1. Case Examples of Occupational Therapy's Role in Wound Management

	Geneva
Client and Background	**Geneva, age 68,** was referred to an OT specializing in hand rehabilitation following an extensive palmar fasciotomy resulting from progressive Dupuytren's contracture. A full-thickness skin graft harvested from her volar wrist/forearm was used to close a full thickness wound on the volar surface of the small finger proximal phalanx and palm that sustained extensive loss of tissue due to long-standing MP and PIP contracture. At the time of the initial occupational therapy evaluation, about 4 days post surgery, it was noted that the donor site (about 2 cm by 5 cm) was left to heal by secondary intention. Physician orders called for the initiation of a moist wound care regimen following removal of the postsurgical dressing.
Evaluation and Findings	Evaluation included the gathering of information for the occupational profile (AOTA, 2017) and the use of assessment tools to determine the status of various client factors and performance skills as part of the analysis of occupational performance (AOTA, 2014b). A thorough assessment of the wound was also completed. Following a saline rinse, the OT visually inspected the wound site and measured it using a disposable tape measure. Possible undermining and tunneling were assessed using a sterile cotton swab; no undermining or tunneling was found. The depth of the wound (2 mm) was measured with a tongue depressor and tape measure overlay. Observation of wound color and exudate indicated a clean red wound with early granulation tissue. Exudate was minimal/moderate and clear, as would be expected for this type of donor site. No signs of infection were present. Circumferential measurements were taken of the arm just distal and proximal to the wound; when compared with the noninvolved side, no significant differences were noted. The measurements served as a baseline for levels of edema. An analog pain scale revealed that Geneva had very minimal pain, with a score of 2 on a scale of 1–10. The COPM was used as an outcome measure and assisted the OT, with input from the client, to determine 4 goals for treatment: 1. Return to volunteer activity of delivering meals on wheels within 1 week. 2. Ability to feed and walk family dog within 2 weeks. 3. Ability to complete all self-care activities within 1 week. 4. Return to gardening activities within 3 weeks.
Interventions	The OT initiated moist wound care using hydrogel to maintain an appropriately moist environment for granulation tissue growth. She covered the wound and hydrogel with semipermeable film dressing to ensure adequate oxygenation and minimize the potential for anaerobic bacterial proliferation. A secondary dry gauze dressing was applied to protect the film dressing during splint wear and functional tasks. Geneva was instructed to keep the dressing in place until her next occupational therapy visit, at which time the wound was reassessed and redressed as appropriate. This wound care regimen was administered by the OT and OTA for 2 weeks until granulation tissue bed was established. Geneva was then instructed to continue with the program at home. To return to her volunteer duties as a Meals on Wheels delivery person, the OT strategized with Geneva with regard to options for driving 1 week post surgery. It was determined that Geneva's husband could drive her to the Meals on Wheels kitchen to pick up her meals and consumer list each day but that she would be able to carry meals to the homes for delivery. Once her wound was fully epithelized and she was no longer taking any medications for pain, her doctor would release her to drive and she could return to independent volunteer activities. The OT and Geneva also worked on strategies for pet care and determined that she would be independent in feeding her small dog if the dog food container was placed in a more convenient location and that she use a smaller scoop to transfer dry kibble from the container to the dog dish. Since her dog was also fed one container of moist food per day, it was decided that she would use a butter knife to pierce the foil covering vs. attempting to pinch and pull with her affected hand. It was recommended to Geneva that she use a large latex glove to cover her hand during all self-care activities to keep her dressing in place and clean. She was instructed in an adaptive bra-donning technique to reduce twisting of her forearm during donor site healing. About 2 weeks later, moist wound care was discontinued, as the wound had epithelialized fully. All initially established occupational therapy intervention goals had been achieved.

(Continued)

Table 1. Case Examples of Occupational Therapy's Role in Wound Management *(cont.)*

	Adam
Client and Background	**Adam, age 71,** was referred to home health care services following a recent fall, resulting in a pelvic fracture; increased BP; and chronic Parkinson's disease. He was discharged home from the ER with no inpatient hospitalization. On admission to home care, a Stage II ischial tuberosity ulcer was discovered. According to Adam, he preferred to stay in a recliner during the day and occasionally sleeps there at night if he doesn't "feel strong." Adam lives with his daughter and son-in-law, both of whom work during the day. Adam reported decreased appetite and that family are available to help with bathing if needed. He prefers to wear protective undergarments, as he occasionally "cannot get to the toilet in time."
Evaluation and Findings	During a visit to the home, the OT visually assessed the covered wound (a nurse provided documentation of measurements and granulation tissue, and occupational therapy documentation described the type of wound and dressing present). The nurse and OT collaborated to determine whether the wound dressing was appropriate for Adam to shower. A hydrocolloid dressing was recommended to the doctor to allow a moist healing environment but provide a waterproof seal to allow bathing and prevent contamination. On further visual assessment of skin integrity and evaluation of clinical factors (i.e., decreased mobility with prolonged sitting, occasional incontinence with moistness leading to potential maceration, and decreased nutrition due to poor meal planning), the OT noted 2 additional reddened areas over bony prominences on the coccyx. In addition, Adam presented with decreased pain awareness and fragile skin due to decreased weight, which contributed to pressure ulcer formation. The OT consulted with the nurse case manager to discuss a recommendation for a nutritionist consult, for which the nurse followed up and received from the doctor. The COPM (Law et al., 2014) was administered to Adam as part of the occupational profile (AOTA, 2017) component of the occupational therapy evaluation. It was learned that prior to his fall, Adam enjoyed spending time on his front porch and talking with the neighborhood children on their way home from school. He also enjoyed playing card games such as gin rummy. It was also learned that he has a Chihuahua that he cared for independently before his fall and that he was carrying the dog when he tripped on a throw rug in the living room. Adam and his OT determined that it would be beneficial for him to resume several of his previous activity routines in an effort to improve his mood, maintain his overall cardiovascular health, and improve his appetite.
Interventions	Although the home care nurse initially provided the direct application of the hydrocolloid dressing to the Stage II ulcer and monitored the wound status with photographs and diagrams, the OT was imperative in the wound care. As the wound began epithelialization, the dressing changes were reduced to every 4 days, and the nurse instructed the family in proper application, which the OT was able to reinforce during the performance of bathing. The OT instructed Adam and his caregivers on the effects of prolonged pressure, shear forces, friction, and incontinence on the development of future ulcers and prevention of healing in the current ulcer. Bathing and toileting were addressed for thoroughness of drying skin as well as techniques for self-inspection. A toileting routine was established. Pressure relief was addressed (Adam and his caregivers were instructed on changing position every hour, and a pressure redistribution device was introduced for the recliner). Adequate nutrition needs (to assist with healing) were met after meal preparation alternatives were addressed with Adam, his caregivers, and a nutritionist. Adam and his OT worked with his family members to bring a supportive chair to the front porch in which he could sit during the day as he did prior to his injury. A gate was also placed on the entry to the porch to ensure that his dog could not leave the porch unexpectedly. As a result, Adam was able to enjoy several hours a day in the sunshine and talk with the neighborhood children as had been his routine. A small table was also provided that fit over his lap and allowed him to play card games with his family and friends when he was outside. The OT also completed a full safety check of the areas of the home that he frequented to ensure that there were no trip or fall hazards remaining. His family agreed to remove the throw rug that caused his fall. The wound was considered healed after full epithelialization, and as the last health care professional involved, the OT completed proper Medicare documentation and staging of the healed wound.

(Continued)

Table 1. Case Examples of Occupational Therapy's Role in Wound Management *(cont.)*

	Tanner
Client and Background	**Tanner, age 10,** qualifies for special education services at school due to multiple impairments (e.g., orthopedic, cognitive, visual). As a result of a disability, Tanner is not able to independently change his position to relieve pressure points created by the gravitational pull on his body in any position. Tanner is supported with a customized wheelchair for mobility, adapted stander, and adaptive seating in the school setting to facilitate his highest level of participation in instructional activities. Tanner is recovering from a medical intervention to address a pressure area.
Evaluation and Findings	Occupational therapy services evaluated Tanner's participation at school using observation, parent and teacher interviews, and the School Function Assessment (SFA) (Coster, Deeney, Haltiwanger, & Haley, 2008). From the evaluation process, it was determined that Tanner required alternative positioning options at school to facilitate his highest level of functional participation in the instructional activities presented in this setting. Additionally, the classroom personnel required training on the necessity to provide Tanner with a daily schedule for change in position to facilitate healing of the pressure area.
Interventions	The OT provided training for the classroom personnel on how to transfer and position Tanner in the various positioning options provided in the classroom and the functional performance they should expect from Tanner in each option. The OT also collaborated with the classroom teacher to develop a daily positioning schedule for Tanner while at school that not only facilitated function in the setting but also provided Tanner with continuity of his typical routines and classroom roles as well as a change in position at least every hour. The frequency of positional changes at school was determined in consultation with Tanner's orthopedic surgeon, who is medically managing the pressure area healing process.
	Brian[a]
Client and Background	**Brian, age 36,** had a complete SCI at the T-8 level 2 years ago as a result of motor vehicle crash. He lives alone and uses a manual wheelchair for mobility. He drives a vehicle adapted with hand controls. He has been employed as a computer programmer and has had a history of pressure injuries for the past year. Currently, he is admitted to the hospital for a UTI and a Stage 3 pressure ulcer on his left ischial tuberosity.
Evaluation and Findings	The rehabilitation team worked with the hospital urologist to determine the cause of Brian's recurrent UTIs. Brian uses intermittent catheterization and may not have always used the safest techniques. The team also reviewed Brian's pressure ulcer history. The pressure ulcer was cultured and treated according to the hospital's protocol, which may include dressings, whirlpool, vacuum-assisted closure, or surgery. Brian remains prone as much as possible while in the hospital. The OT evaluated Brian's ability to participate in bladder management and work. All equipment pertaining to seating (e.g., wheelchair, cushion) was evaluated for appropriateness, condition, and effectiveness. Pressure mapping may be necessary to find a wheelchair pressure redistribution device that helps reduce the risk of pressure injuries.
Interventions	The OT reviewed with Brian strategies for reducing infection during intermittent catheterization. She discussed strategies for continued engagement in work and leisure tasks while he is hospitalized in the prone position. If necessary, Brian's wheelchair will be modified or replaced (if finances are available). Brian will participate in group and individual pressure ulcer prevention and management education sessions and will be provided with a home program to follow. Brian will be instructed on managing the ulcer (surgical site if he had surgery) with dressings and pressure redistribution (weight shifts if he is allowed to sit) during sitting or lying in bed, on nutrition, on transfers, and on sitting tolerance. Home and work site visits are recommended to help Brian identify situations that may be contributing to his recurrent pressure injuries. He may be referred for home health services while the ulcer heals.

Note. BP = blood pressure; COPM = Canadian Occupational Performance Measure; ER = emergency room; MP = metacarpophalangeal; OT = occupational therapist; OTA = occupational therapy assistant; PIP = proximal interphalangeal; SCI = spinal cord injury; SFA = School Functional Assessment; UTI = urinary tract infection.

[a]The case study on Brian was contributed by Susan L. Garber, MA, OTR, FAOTA, FACRM.

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Policy E.18: Interventions to Support Occupations

Purpose

- AOTA asserts that interventions to support occupations including but not limited to physical agent modalities (PAMs), dry needling, and other techniques may be used in preparation for, or concurrently with occupations and activities or interventions that ultimately enhance a client's engagement in occupation.
- Occupational therapists and occupational therapy assistants are members of interdisciplinary teams and require access to provide interventions necessary to support client care. Loss of care provided or referral to other providers for specific techniques may compromise or restrict consumer access to occupational therapy services and could result in duplication of services and increased costs of care.
- Clinical research on intervention effectiveness in occupational therapy for new and emerging techniques should not be limited by restrictions on practice to provide responsive care as health conditions and health care technologies continue to evolve.
- Occupational therapy practitioners, as experts in various areas of practice, are placed at a disadvantage when there is not a defined policy or guidance for the use of existing and emerging interventions to support occupations.

Policy

1. Interventions to support occupations, including but not limited to PAMs, are utilized by occupational therapy practitioners as part of occupation-based practice. Use of these techniques is designed to prepare the client for occupational performance to support clients' engagement and independent participation in meaningful occupations (e.g., ADLs, IADLs).
2. Interventions to support occupations should not be used in isolation or in the absence of occupation-based assessment and intervention.
3. Use of interventions to support occupations may include the application of PAMs, mechanical modalities, instrument-assisted (manual) modalities (e.g., dry needling), and other new and emerging techniques. It is important to differentiate that little or no published evidence for new and emerging techniques does not equate to a lack of effectiveness. It is an indicator that further research is needed.
4. In the case of new and emerging techniques in which there is not a strong body of evidence, it is essential that practitioners fully disclose the benefits, risks, and potential outcomes of an intervention and reasonable alternatives. Informed consent should be obtained after disclosing information and answering questions to ensure autonomous and voluntary participation in the treatment plan or research study.
5. Decisions on whether to continue or discontinue use of new and emerging techniques should be based on professional reasoning and outcomes including documented progress toward clients' goals to ensure the client is receiving benefit to engage and participate in meaningful occupation.
6. Interventions to support occupations may not be entry-level skills and may require advanced training and/or certification. New treatment techniques and interventions are routinely developed based on currently available evidence. Practitioners are responsible formaintaining their awareness of these developments as well as their competency in the safe and effective application of new treatment approaches.
7. States vary in the inclusion of interventions to support occupations within the defined scope of practice and requirements for training and continuing education for these techniques. There is no consensus from state to state on the minimum standards for evaluating competency or certification in the use of interventions to support occupations.

8. Some states have additional regulatory requirements for demonstrating competence beyond entry-level education and for specific types of PAMs. Occupational therapy practitioners need to be aware of and comply with these requirements, which may include, but are not limited to, continuing professional education, institution-specific procedures for ascertaining service competence, and supervised contact hours by a qualified practitioner in the respective state.
9. Competency is outlined by standards of conduct in the Occupational Therapy Code of Ethics. It is the responsibility of occupational therapy personnel to maintain credentials, licenses, and other certifications to develop, demonstrate, and maintain competent, evidence-based practice and supervision requirements.
10. Occupational therapy practitioners should review continuing education and advanced certification courses in advance to ensure quality and alignment with state and site/facility specific law, regulation, policy and requirements prior to participation and application of any techniques with clients.
11. Occupational therapy assistants may utilize PAMs and other interventions to support occupations with appropriate supervision in accordance with local and state policies, rules, and regulations.

Resources

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Occupational Therapy Scope of Practice

Statement of Purpose

The purpose of this document is to

A. Define the scope of practice in occupational therapy by
   1. Delineating the domain of occupational therapy practice and services provided by occupational therapists and occupational therapy assistants,
   2. Delineating the dynamic process of occupational therapy evaluation and intervention services used to achieve outcomes that support the participation of clients[1] in everyday life occupations, and
   3. Describing the education and certification requirements needed to practice as an occupational therapist and occupational therapy assistant;
B. Provide a model definition of occupational therapy to promote uniform standards and professional mobility across state occupational therapy statutes and regulations; and
C. Inform consumers, health care providers, educators, the community, funding agencies, payers, referral sources, and policymakers regarding the scope of occupational therapy.

Introduction

The occupational therapy scope of practice is based on the American Occupational Therapy Association (AOTA) documents *Occupational Therapy Practice Framework: Domain and Process* (4th ed.; AOTA, 2020c) and the *Philosophical Base of Occupational Therapy* (AOTA, 2017), which states that "the use of occupation to promote individual, family, community, and population health is the core of occupational therapy practice, education, research, and advocacy" (p. 1). Occupational therapy is a dynamic and evolving profession that is responsive to consumer and societal needs, to system changes, and to emerging knowledge and research.

Although this document may be a resource to use with state statutes and regulations that govern the practice of occupational therapy, it does not supersede existing laws and other regulatory requirements.

[1]"The clients of occupational therapy are typically classified as persons (including those involved in care of a client), groups (collections of individuals having shared characteristics or a common or shared purpose; e.g., family members, workers, students, people with similar interests or occupational challenges), and populations (aggregates of people with common attributes such as contexts, characteristics, or concerns, including health risks)"; Scaffa & Reitz, 2014, as quoted in AOTA, 2020c, p. 2).

Occupational therapists and occupational therapy assistants are required to abide by relevant statutes and regulations when providing occupational therapy services. State statutes and other regulatory requirements typically include statements about educational requirements to be eligible for licensure as an occupational therapy practitioner, procedures to practice occupational therapy legally within the defined area of jurisdiction, the definition and scope of occupational therapy practice, and supervision requirements for occupational therapy assistants.

It is the position of AOTA that a referral is not required for the provision of occupational therapy services; however, laws and payment policies generally affect referrals for such services. AOTA's position is also that "an occupational therapist accepts and responds to referrals in compliance with state or federal laws, other regulatory and payer requirements, and AOTA documents" (AOTA, 2015b, Standard II.2, p. 3). State laws and other regulatory requirements should be viewed as minimum criteria to practice occupational therapy. A *Code of Ethics* and related standards of conduct ensure safe and effective delivery of occupational therapy services (AOTA, 2020a). Policies of payers such as public and private insurance companies also must be followed.

Occupational therapy services may be provided by two levels of practitioners: (1) the occupational therapist and (2) the occupational therapy assistant, as well as by occupational therapy students under appropriate supervision (AOTA, 2018). Occupational therapists function as autonomous practitioners, are responsible for all aspects of occupational therapy service delivery, and are accountable for the safety and effectiveness of the occupational therapy service delivery process.

The occupational therapy assistant delivers occupational therapy services only under the supervision of and in partnership with the occupational therapist (AOTA, 2020b). When the term *occupational therapy practitioner* is used in this document, it refers to both occupational therapists and occupational therapy assistants (AOTA, 2015a).

Definition of Occupational Therapy

The *Occupational Therapy Practice Framework: Domain and Process* (4th ed.; AOTA, 2020c) defines *occupational therapy* as

> therapeutic use of everyday life occupations with persons, groups, or populations (i.e., clients) for the purpose of enhancing or enabling participation. Occupational therapy practitioners use their knowledge of the transactional relationship among the client, their engagement in valuable occupations, and the context to design occupation-based intervention plans. Occupational therapy services are provided for habilitation, rehabilitation, and promotion of health and wellness for clients with disability- and non–disability-related needs. Services promote acquisition and preservation of occupational identity for those who have or are at risk for developing an illness, injury, disease, disorder, condition, impairment, disability, activity limitation, or participation restriction. (p. 80)

Exhibit 1 contains the model definition of occupational therapy for the AOTA (2021) Model Occupational Therapy Practice Act in a format that will be used to assert the scope of practice of occupational therapy for state regulation. States are encouraged to adopt this language in their practice acts because it reflects the contemporary occupational therapy scope of practice.

Scope of Practice: Domain and Process

The scope of practice includes the domain and process of occupational therapy services. These two concepts are intertwined, with the *domain* (Exhibit 2) defining the focus of occupational therapy and the *process* (Exhibit 3) defining the delivery of occupational therapy.

The *domain* of occupational therapy includes the everyday life occupations that people find meaningful and purposeful; aspects of the domain are presented in Exhibit 2. Within this domain, occupational therapy services enable clients to participate in their everyday life occupations in their desired roles, contexts, and life situations.

Clients may be persons, groups, or populations. The domain of occupational therapy consists of the following occupations in which clients engage throughout the life course (AOTA, 2020c, pp. 30–34, Table 2):

- ADLs (activities oriented toward taking care of one's own body and completed on a routine basis; e.g., bathing, feeding, dressing)
- IADLs (activities to support daily life within the home and community that often require complex interactions; e.g., household management, financial management, child care)
- Health management (activities related to developing, managing, and maintaining health and wellness routines, including self-management, with the goal of improving or maintaining health to support participation in other occupations; e.g., medication management, social and emotional health promotion and maintenance)
- Rest and sleep (activities relating to obtaining restorative rest and sleep, including identifying the need for rest and sleep, preparing for sleep, and participating in rest and sleep)
- Education (activities needed for learning and participating in the educational environment)
- Work (activities for engaging in employment or volunteer activities with financial and nonfinancial benefits)
- Play (activities that are intrinsically motivated, internally controlled, and freely chosen)
- Leisure (nonobligatory and intrinsically motivated activities during discretionary time)
- Social participation (activities that involve social interaction with others and support social interdependence).

Within their domain of practice, occupational therapists and occupational therapy assistants consider the repertoire of occupations in which the client engages, the contexts influencing engagement, the performance patterns and skills the client uses, the demands of the occupation, and the client's body functions and structures. Occupational therapy practitioners use their knowledge and skills, including therapeutic use of self, to help clients conduct or resume daily life occupations that support function and health throughout the lifespan. Participation in occupations that are meaningful to the client involves emotional, psychosocial, cognitive, and physical aspects of performance. Participation in meaningful occupations enhances health, well-being, and life satisfaction.

The domain of occupational therapy practice complements the World Health Organization's (2008) conceptualization of *participation* and *health* articulated in the *International Classification of Functioning, Disability and Health* (*ICF*). Occupational therapy incorporates the basic constructs of the *ICF,* including context, participation, activities, and body structures and functions, in interventions to enable full participation in occupations and maximize occupational engagement.

The *process* of occupational therapy refers to the delivery of services and includes evaluating, intervening, and targeting of outcomes, as detailed in Exhibit 3. Occupation remains central to the occupational therapy process, which is client centered, involving collaboration with the client throughout each aspect of service delivery. There are many service delivery approaches, including direct (e.g., providing individual services in person, leading a group session, interacting with clients and families through telehealth systems) and indirect (services on the client's behalf; e.g., consultation to teachers, multidisciplinary teams, and community planning agencies), and services can be delivered at the person, group, or population level. This process includes the following key components:

- Evaluation and intervention may address one or more aspects of the domain that influence occupational performance.
- During the evaluation, the occupational therapist develops an occupational profile; analyzes the client's ability to carry out everyday life activities; and determines the client's occupational needs, strengths, barriers to participation, and priorities for intervention.
- Intervention includes planning and implementing occupational therapy services, including education and training, advocacy, group interventions, and virtual interventions. The occupational therapist and occupational therapy assistant in partnership with the client use occupation-based theories, frames of reference, evidence, and clinical reasoning to guide the intervention (AOTA, 2020c).

Exhibit 1. Definition of Occupational Therapy for Use in State Regulations

The practice of occupational therapy means the therapeutic use of everyday life occupations with persons, groups, or populations (clients) to support occupational performance and participation. Occupational therapy practice includes clinical reasoning and professional judgment to evaluate, analyze, and diagnose occupational challenges (e.g., issues with client factors, performance patterns, and performance skills) and provide occupation-based interventions to address them. Occupational therapy services include habilitation, rehabilitation, and the promotion of physical and mental health and wellness for clients with all levels of ability-related needs. These services are provided for clients who have or are at risk for developing an illness, injury, disease, disorder, condition, impairment, disability, activity limitation, or participation restriction. Through the provision of skilled services and engagement in everyday activities, occupational therapy promotes physical and mental health and well-being by supporting occupational performance in people with, or at risk of experiencing, a range of developmental, physical, and mental health disorders.

The practice of occupational therapy includes the following components:

A. Evaluation of factors affecting activities of daily living (ADLs), instrumental activities of daily living (IADLs), health management, rest and sleep, education, work, play, leisure, and social participation, including
   1. Contexts (environmental and personal factors) and occupational and activity demands that affect performance
   2. Performance patterns, including habits, routines, roles, and rituals
   3. Performance skills, including motor skills (e.g., moving oneself or moving and interacting with objects), process skills (e.g., actions related to selecting, interacting with, and using tangible task objects), and social interaction skills (e.g., using verbal and nonverbal skills to communicate)
   4. Client factors, including body functions (e.g., neuromuscular, sensory, visual, mental, psychosocial, cognitive, pain factors), body structures (e.g., cardiovascular, digestive, nervous, integumentary, genitourinary systems; structures related to movement), values, beliefs, and spirituality.
B. Methods or approaches to identify and select interventions, such as
   1. Establishment, remediation, or restoration of a skill or ability that has not yet developed, is impaired, or is in decline
   2. Compensation, modification, or adaptation of occupations, activities, and contexts to improve or enhance performance
   3. Maintenance of capabilities to prevent decline in performance in everyday life occupations
   4. Health promotion and wellness to enable or enhance performance in everyday life activities and quality of life
   5. Prevention of occurrence or emergence of barriers to performance and participation, including injury and disability prevention
C. Interventions and procedures to promote or enhance safety and performance in ADLs, IADLs, health management, rest and sleep, education, work, play, leisure, and social participation, for example,
   1. Therapeutic use of occupations and activities
   2. Training in self-care, self-management, health management (e.g., medication management, health routines), home management, community and work integration, school activities and work performance
   3. Identification, development, remediation, or compensation of physical, neuromusculoskeletal, sensory–perceptual, emotional regulation, visual, mental, and cognitive functions; pain tolerance and management; praxis; developmental skills; and behavioral skills
   4. Education and training of persons, including family members, caregivers, groups, populations, and others
   5. Care coordination, case management, and transition services
   6. Consultative services to persons, groups, populations, programs, organizations, and communities
   7. Virtual interventions (e.g., simulated, real-time, and near-time technologies, including telehealth and mobile technology)
   8. Modification of contexts (environmental and personal factors in settings such as home, work, school, and community) and adaptation of processes, including the application of ergonomic principles
   9. Assessment, design, fabrication, application, fitting, and training in seating and positioning, assistive technology, adaptive devices, and orthotic devices, and training in the use of prosthetic devices
   10. Assessment, recommendation, and training in techniques to enhance functional mobility, including fitting and management of wheelchairs and other mobility devices
   11. Exercises, including tasks and methods to increase motion, strength, and endurance for occupational participation
   12. Remediation of and compensation for visual deficits, including low vision rehabilitation
   13. Driver rehabilitation and community mobility
   14. Management of feeding, eating, and swallowing to enable eating and feeding performance

(*Continued*)

Exhibit 1. Definition of Occupational Therapy for Use in State Regulations (*cont'd*)

15. Application of physical agent and mechanical modalities and use of a range of specific therapeutic procedures (e.g., wound care management; techniques to enhance sensory, motor, perceptual, and cognitive processing; manual therapy techniques) to enhance performance skills
16. Facilitating the occupational participation of persons, groups, or populations through modification of contexts (environmental and personal) and adaptation of processes
17. Efforts directed toward promoting occupational justice and empowering clients to seek and obtain resources to fully participate in their everyday life occupations
18. Group interventions (e.g., use of dynamics of group and social interaction to facilitate learning and skill acquisition across the life course).

Source. From American Occupational Therapy Association. (2021). *Definition of occupational therapy practice for the AOTA Model Practice Act*, p. 1. Available at https://www.aota.org/Advocacy-Policy/State-Policy/Resource-Factsheets.aspx

- The outcomes of occupational therapy intervention are directed toward "achieving health, well-being, and participation in life through engagement in occupations" (AOTA, 2020c, p. 5). Outcomes of the intervention determine future actions with the client and include occupational performance, improvement, enhancement, prevention (of risk factors, disease, and disability), health and wellness, quality of life, participation, role competence, well-being, and occupational justice (AOTA, 2020c). "*Occupational adaptation*, or the client's effective and efficient response to occupational and contextual demands, is interwoven through all of these outcomes" (AOTA, 2020c, p. 26).

Sites of Intervention and Areas of Focus

Occupational therapy services are provided to clients across the life course. Practitioners work in collaboration with clients to address occupational needs and issues in areas such as mental health; work and industry; participation in education; rehabilitation, disability, and participation; productive aging; and health and wellness.

Along the continuum of service, occupational therapy services are provided to clients in a variety of settings, such as

- Institutional (inpatient) settings (e.g., acute care, rehabilitation facilities, psychiatric hospitals, community and specialty-focused hospitals, nursing facilities, prisons),

Exhibit 2. Aspects of the Domain of Occupational Therapy
All aspects of the occupational therapy domain transact to support engagement, participation, and health. This exhibit does not imply a hierarchy.

Occupations	Contexts	Performance Patterns	Performance Skills	Client Factors
Activities of daily living (ADLs) Instrumental activities of daily living (IADLs) Health management Rest and sleep Education Work Play Leisure Social participation	Environmental factors Personal factors	Habits Routines Roles Rituals	Motor skills Process skills Social interaction skills	Values, beliefs, and spirituality Body functions Body structures

Source. From American Occupational Therapy Association. (2020). Occupational therapy practice framework: Domain and process (4th ed.). *American Journal of Occupational Therapy, 74*(Suppl. 2), 7412410010, p. 7. https://doi.org/10.5014/ajot.2020.74S2001

Exhibit 3. Operationalizing the Occupational Therapy Process

Ongoing interaction among evaluation, intervention, and outcomes occurs throughout the occupational therapy process.

Evaluation
Occupational Profile • Identify the following: ◦ Why is the client seeking services, and what are the client's current concerns relative to engaging in occupations and in daily life activities? ◦ In what occupations does the client feel successful, and what barriers are affecting their success in desired occupations? ◦ What is the client's occupational history (i.e., life experiences)? ◦ What are the client's values and interests? ◦ What aspects of their contexts (environmental and personal factors) does the client see as supporting engagement in desired occupations, and what aspects are inhibiting engagement? ◦ How are the client's performance patterns supporting or limiting occupational performance and engagement? ◦ What are the client's patterns of engagement in occupations, and how have they changed over time? ◦ What client factors does the client see as supporting engagement in desired occupations, and what aspects are inhibiting engagement (e.g., pain, active symptoms)? ◦ What are the client's priorities and desired targeted outcomes related to occupational performance, prevention, health and wellness, quality of life, participation, role competence, well-being, and occupational justice? Analysis of Occupational Performance • The analysis of occupational performance involves one or more of the following: ◦ Synthesizing information from the occupational profile to determine specific occupations and contexts that need to be addressed ◦ Completing an occupational or activity analysis to identify the demands of occupations and activities on the client ◦ Selecting and using specific assessments to measure the quality of the client's performance or performance deficits while completing occupations or activities relevant to desired occupations, noting the effectiveness of performance skills and performance patterns ◦ Selecting and using specific assessments to measure client factors that influence performance skills and performance patterns ◦ Selecting and administering assessments to identify and measure more specifically the client's contexts and their impact on occupational performance. Synthesis of Evaluation Process • This synthesis may include the following: ◦ Determining the client's values and priorities for occupational participation ◦ Interpreting the assessment data to identify supports and hindrances to occupational performance ◦ Developing and refining hypotheses about the client's occupational performance strengths and deficits ◦ Considering existing support systems and contexts and their ability to support the intervention process ◦ Determining desired outcomes of the intervention ◦ Creating goals in collaboration with the client that address the desired outcomes ◦ Selecting outcome measures and determining procedures to measure progress toward the goals of intervention, which may include repeating assessments used in the evaluation process.
Intervention
Intervention Plan • Develop the plan, which involves selecting ◦ Objective and measurable occupation-based goals and related time frames; ◦ Occupational therapy intervention approach or approaches, such as create or promote, establish or restore, maintain, modify, or prevent; and ◦ Methods for service delivery, including what types of intervention will be provided, who will provide the interventions, and which service delivery approaches will be used.

(*Continued*)

Exhibit 3. Operationalizing the Occupational Therapy Process (*cont'd*)

Evaluation
• Consider potential discharge needs and plans. • Make recommendations or referrals to other professionals as needed. Intervention Implementation • Select and carry out the intervention or interventions, which may include the following: ◦ Therapeutic use of occupations and activities ◦ Interventions to support occupations ◦ Education ◦ Training ◦ Advocacy ◦ Self-advocacy ◦ Group intervention ◦ Virtual interventions. • Monitor the client's response through ongoing evaluation and reevaluation. Intervention Review • Reevaluate the plan and how it is implemented relative to achieving outcomes. • Modify the plan as needed. • Determine the need for continuation or discontinuation of services and for referral to other services.
Outcomes
Outcomes • Select outcome measures early in the occupational therapy process (see the "Evaluation" section of this table) on the basis of theirproperties: ◦ Valid, reliable, and appropriately sensitive to change in clients' occupational performance ◦ Consistent with targeted outcomes ◦ Congruent with the client's goals ◦ Able to predict future outcomes. • Use outcome measures to measure progress and adjust goals and interventions by ◦ Comparing progress toward goal achievement with outcomes throughout the intervention process and ◦ Assessing outcome use and results to make decisions about the future direction of intervention (e.g., continue, modify, transition, discontinue, provide follow-up, refer for other service).

Source. From American Occupational Therapy Association. (2020). Occupational therapy practice framework: Domain and process (4th ed.). *American Journal of Occupational Therapy, 74*(Suppl. 2), 7412410010, p. 16. https://doi.org/10.5014/ajot.2020.74S2001

- Outpatient settings (e.g., hospitals, clinics, medical and therapy offices),
- Home and community settings (e.g., residences, group homes, assisted living, schools, early intervention centers, day care centers, industry and business, hospice, homeless shelters, transitional living facilities, wellness and fitness centers, community mental health facilities, public and private transportation agencies, park districts, work sites), and
- Research facilities.

Education and Certification Requirements

To practice as an occupational therapist, the individual trained in the United States

- Has graduated from an occupational therapy program accredited by the Accreditation Council for Occupational Therapy Education (ACOTE®; 2018) or predecessor organizations;

- Has successfully completed a period of supervised fieldwork experience required by the recognized educational institution where the applicant met the academic requirements of an educational program for occupational therapists that is accredited by ACOTE or predecessor organizations;
- Has passed a nationally recognized entry-level examination for occupational therapists; and
- Fulfills state requirements for licensure, certification, or registration.

To practice as an occupational therapy assistant, the individual trained in the United States

- Has graduated from an occupational therapy assistant program accredited by ACOTE or predecessor organizations;
- Has successfully completed a period of supervised fieldwork experience required by the recognized educational institution where the applicant met the academic requirements of an educational program for occupational therapy assistants that is accredited by ACOTE or predecessor organizations;
- Has passed a nationally recognized entry-level examination for occupational therapy assistants; and
- Fulfills state requirements for licensure, certification, or registration.

AOTA supports licensure of qualified occupational therapists and occupational therapy assistants (AOTA, 2016). State and other legislative or regulatory agencies may impose additional requirements to practice as occupational therapists and occupational therapy assistants in their area of jurisdiction.

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