AGENDA ITEM 12

CONSIDERATION AND POSSIBLE ACTION TO INITIATE A RULEMAKING PACKAGE TO AMEND CALIFORNIA CODE OF REGULATIONS, TITLE 16, DIVISION 39, ARTICLE 6, SECTION 4151, HAND THERAPY, AND SECTION 4155, APPLICATION FOR APPROVAL IN ADVANCED PRACTICE AREAS.

INCLUDES THE FOLLOWING:

12.1 MEMORANDUM.

12.2 BUSINESS AND PROFESSIONS CODE 2570.3 AND CALIFORNIA CODE OF REGULATIONS SECTIONS 4151, 4155.

12.3 PROPOSED LANGUAGE TO REDUCE TRAINING HOURS REQUIREMENT.

12.4 PROPOSED LANGUAGE TO REDUCE EDUCATION HOURS REQUIREMENT.

12.5 PROPOSED LANGUAGE TO REDUCE BOTH TRAINING AND EDUCATION HOURS REQUIREMENT.

BUSINESS, CONSUMER SERVICES AND HOUSING AGENCY • GAVIN NEWSOM, GOVERNOR
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MEMORANDUM

DATE	May 21, 2025
TO	Board of Occupational Therapy Members
FROM	Austin Porter, Interim Executive Officer Board of Occupational Therapy
SUBJECT	**Agenda Item 12: Consideration and Possible Action to Initiate a Rulemaking Package to Amend CCR, Title 16, Division 39, Article 9 Section 4151, Hand Therapy, and Section 4155, Application for Approval in Advanced Practice Areas.**

Background

The Board's Practice Committee met on October 11, 2024, and on April 25, 2025, to discuss the requirements for advanced practice approval in hand therapy.

Currently, BPC 2570.3(e) states that an occupational therapist providing advanced practice services in hand therapy shall demonstrate to the satisfaction of the Board that the occupational therapist has completed education and training in six subject areas:

1. Anatomy of the upper extremity and how it is altered by pathology.
2. Histology as it relates to tissue healing and the effects of immobilization and mobilization on connective tissue.
3. Muscle, sensory, vascular, and connective tissue physiology.
4. Kinesiology of the upper extremity, such as biomechanical principles of pulleys, intrinsic and extrinsic muscle function, internal forces of muscles, and the effects of external forces.
5. The effects of temperature and electrical currents on nerve and connective tissue.
6. Surgical procedures of the upper extremity and their postoperative course.

Furthermore, CCR section 4151 requires that an occupational therapist seeking approval in the advanced practice area of hand therapy complete 45 contact hours of education in the subject areas outlined in 2570.3(e) and 480 hours of supervised, on-the-job training in hand therapy.

The committee found that, since the requirements for advanced practice in hand therapy were put in place, the Accreditation Council for Occupational Therapy Education (ACOTE) guidelines have evolved such that ACOTE-accredited schools now provide education that meets five of the six subject areas identified in BPC 2570.3(e). The committee did NOT find clear evidence that occupational therapists, while in the course of their qualifying degree programs, were receiving sufficient education and training in subject area six: surgical procedures of the upper extremity and their postoperative course.

The committee reasoned that, because 5 out of 6 content areas were already being met, it would be appropriate to reduce the number of required education hours for occupational therapists completing their qualifying degree program under the 2025 (effective) ACOTE guidelines by approximately five sixths, to 8 hours focused on the missing content area of surgical procedures.

In its discussion of the supervised, on-the-job training hours required by CCR Section 4151, the committee found that 480 hours presents an undue burden on the licensee and may unnecessarily limit the number of approved occupational therapists and create a barrier for consumer access to hand therapy services. The Committee drew on its previous discussion and recommendation to reduce required training hours for physical agent modalities (PAMs) approval from 240 to 40 hours when determining an appropriate number of hours for hand therapy. It was determined that a similar reduction by five sixths would be appropriate.

Action Requested

The Practice Committee has made two recommendations to the Board:

1. Reduce the required education hours for Advanced Practice approval in Hand Therapy for those licensed Occupational Therapists having started their qualifying degree program on or after August 1, 2025, from 45 hours contact hours in the 6 content areas listed in Code Section 2570.3(e) to 8 contact hours focused specifically on content area six.
2. Reduce the required on-the-job, supervised training hours for Advanced Practice approval in Hand Therapy for all licensed Occupational Therapists from 480 hours to 80 hours.

Board staff asks that the Board consider the findings of the Practice Committee and vote on proposed regulatory language that would enact the Committee's recommendations.

Items to Consider

CCR Section 4155(c) permits an applicant for advanced practice approval in hand therapy to use a maximum of 8 contact hours of education and 60 hours of supervised training completed for approval in PAMs to satisfy the requirements for approval in hand therapy.

- If education contact hours required for hand therapy approval are reduced from 45 hours to 8 hours in content area six for certain practitioners, it may be necessary and appropriate to reduce the number of accepted education hours completed in pursuit of PAMs approval from 8 hours to 0 hours, for those practitioners.
- If supervised training hours required for hand therapy approval are reduced from 480 to 80, it may be necessary and appropriate to reduce the number of accepted hours completed in pursuit of PAMs approval by a similar factor of five sixths, from 60 hours to 10 hours.

A reduction in either education contact hours, supervised training hours, or both would require modifications to the Application for Advanced Practice Approval, incorporated by reference in CCR Section 4155(a)(1).

Included Materials

- Business and Professions Code Division 2, Chapter 5.6, Section 2570.3. California Code of Regulations Title 16, Division 39, Article 9, Section 4151, Hand Therapy, and Section 4155, Application for Approval in Advanced Practice Areas.
- Proposed Language to reduce the required on-the-job, supervised training hours for Advanced Practice approval in Hand Therapy for all licensed Occupational Therapists from 480 hours to 80 hours.
- Proposed Language to reduce the required education hours for Advanced Practice approval in Hand Therapy for those licensed Occupational Therapists having started their qualifying degree program on or after August 1, 2025, from 45 hours contact hours in the 6 content areas listed in Code Section 2570.3(e) to 8 contact hours focused specifically on content area six.
- Proposed language to reduce both the supervised training hours and the education contact hours.

*Neither this memo nor the included materials have been reviewed by regulatory counsel.

Laws and Regulations Pertaining to Advanced Practice Approval in Hand Therapy

BUSINESS AND PROFESSIONS CODE, DIVISION 2, CHAPTER 5.6, SECTION 2570.3.

(a) A person shall not practice occupational therapy or hold themselves out as an occupational therapist or as being able to practice occupational therapy, or to render occupational therapy services in this state unless the person is licensed as an occupational therapist under the provisions of this chapter. A person shall not hold themselves out as an occupational therapy assistant or work as an occupational therapy assistant under the supervision of an occupational therapist unless the person is licensed as an occupational therapy assistant under this chapter.
(b) Only an individual may be licensed under this chapter.
(c) This chapter does not authorize an occupational therapist to practice physical therapy, as defined in Section 2620; speech-language pathology or audiology, as defined in Section 2530.2; nursing, as defined in Section 2725; psychology, as defined in Section 2903; marriage and family therapy, as defined in Section 4980.02; clinical social work, as defined in Section 4996.9; professional clinical counseling, as defined in Section 4999.20; educational psychology, as defined in Section 4989.14; or spinal manipulation or other forms of healing, except as authorized by this section.
(d) An occupational therapist may provide advanced practices if the occupational therapist has the knowledge, skill, and ability to do so and has demonstrated to the satisfaction of the board that the occupational therapist has met educational training and competency requirements. These advanced practices include the following:
(1) Hand therapy.
(2) The use of physical agent modalities.
(3) Swallowing assessment, evaluation, or intervention.
(e) An occupational therapist providing hand therapy services shall demonstrate to the satisfaction of the board that the occupational therapist has completed education and training in all of the following areas:
(1) Anatomy of the upper extremity and how it is altered by pathology.
(2) Histology as it relates to tissue healing and the effects of immobilization and mobilization on connective tissue.
(3) Muscle, sensory, vascular, and connective tissue physiology.
(4) Kinesiology of the upper extremity, such as biomechanical principles of pulleys, intrinsic and extrinsic muscle function, internal forces of muscles, and the effects of external forces.
(5) The effects of temperature and electrical currents on nerve and connective tissue.
(6) Surgical procedures of the upper extremity and their postoperative course.
(f) An occupational therapist using physical agent modalities shall demonstrate to the satisfaction of the board that the occupational therapist has completed education and training in all of the following areas:
(1) Anatomy and physiology of muscle, sensory, vascular, and connective tissue in response to the application of physical agent modalities.
(2) Principles of chemistry and physics related to the selected modality.

(3) Physiological, neurophysiological, and electrophysiological changes that occur as a result of the application of a modality.
(4) Guidelines for the preparation of the client, including education about the process and possible outcomes of treatment.
(5) Safety rules and precautions related to the selected modality.
(6) Methods for documenting immediate and long-term effects of treatment.
(7) Characteristics of the equipment, including safe operation, adjustment, indications of malfunction, and care.
(g) An occupational therapist in the process of achieving the education, training, and competency requirements established by the board for providing hand therapy or using physical agent modalities may practice these techniques under the supervision of an occupational therapist who has already met the requirements established by the board, a physical therapist, or a physician and surgeon.
(h) The board shall develop and adopt regulations regarding the educational training and competency requirements for advanced practices in collaboration with the Speech-Language Pathology and Audiology and Hearing Aid Dispensers Board, the Board of Registered Nursing, and the Physical Therapy Board of California.
(i) This chapter does not authorize an occupational therapist to seek reimbursement for services other than for the practice of occupational therapy as defined in this chapter.
(j) “Supervision of an occupational therapy assistant” means that the responsible occupational therapist shall at all times be responsible for all occupational therapy services provided to the client. The occupational therapist who is responsible for appropriate supervision shall formulate and document in each client’s record, with the occupational therapist’s signature, the goals and plan for that client, and shall make sure that the occupational therapy assistant assigned to that client functions under appropriate supervision. As part of the responsible occupational therapist’s appropriate supervision, the occupational therapist shall conduct at least weekly review and inspection of all aspects of occupational therapy services by the occupational therapy assistant.
(1) The supervising occupational therapist has the continuing responsibility to follow the progress of each client, provide direct care to the client, and to ensure that the occupational therapy assistant does not function autonomously.
(2) An occupational therapist shall not supervise more occupational therapy assistants, at any one time, than can be appropriately supervised in the opinion of the board. Three occupational therapy assistants shall be the maximum number of occupational therapy assistants supervised by an occupational therapist at any one time, but the board may permit the supervision of a greater number by an occupational therapist if, in the opinion of the board, there would be adequate supervision and the public’s health and safety would be served. In no case shall the total number of occupational therapy assistants exceed three times the number of occupational therapists regularly employed by a facility at any one time.

CALIFORNIA CODE OF REGULATIONS, TITLE 16, ARTICLE 9

§ 4151. Hand Therapy

(a) Hand therapy services may be performed only when an occupational therapist has demonstrated to the Board in an application filed pursuant to section 4155 that they have met the post professional education and training requirements established by this section as follows:
(1) Education: Completion of 45 contact hours in the subjects listed in Code section 2570.3(e), including 30 hours specifically relating to the hand, wrist, and forearm.
(2) Training: Completion of 480 hours of supervised on-the-job training, clinical internship or affiliation, which may be paid or voluntary, pertaining to hand therapy.
(b) An occupational therapist whose application pursuant to section 4155 provides proof of current certification as a Certified Hand Therapist, issued by the Hand Therapy Certification Commission, shall be deemed to have met the education and training requirements established by this section.
(c) An occupational therapist providing hand therapy services using physical agent modalities must also comply with the requirements of section 4152. A maximum of 8 contact hours and 60 hours of supervised on-the-job training, clinical internship or affiliation, paid or voluntary, completed under section 4152 will be credited toward the requirements of this section.
(d) An occupational therapist may provide only those hand therapy services the occupational therapist is competent to perform.
Note: Authority cited: Sections 2570.3 and 2570.20, Business and Professions Code. Reference: Sections 2570.2 and 2570.3, Business and Professions Code.

§ 4155. Application for Approval in Advanced Practice Areas

In order to provide any of the advanced practice services set forth in Code section 2570.3(d), an occupational therapist shall apply to the Board and receive approval in that advanced practice area.
(a) To apply for approval, an occupational therapist shall submit to the Board an application as specified in subsections (1), (2), or (3), along with the required documentation.
(1) Applicants seeking approval in the area of Hand Therapy shall submit the Application for Advanced Practice Approval in Hand Therapy (Form APH, Rev. 10/09), hereby incorporated by reference;.
(2) Applicants seeking approval in the use of physical agent modalities shall submit the Application for Advanced Practice Approval in Physical Agent Modalities (Form APP, Rev. 07/11), hereby incorporated by reference;
(3) Applicants seeking approval in the area of Swallowing Assessment, Evaluation, or Intervention shall submit the Application for Advanced Practice Approval in Swallowing (Form APS, Rev. 10/09), hereby incorporated by reference;
(b) The documentation must include the following:
(1) Documented proof of attendance and completion of each course (i.e., certificate of completion or transcript).
(2) Evidence of the number of contact hours completed for each course for courses that are not Board approved.
(3) Outline or syllabus of each course for courses that are not Board approved.

(4) Information describing, in detail, the depth and breadth of the content covered (e.g., a course syllabus and the goals and objectives of the course) as it relates to the advanced practice area.
(5) Resume or credentials of each instructor for courses that are not Board approved.
(6) Verification of completion of supervised on-the-job training, clinical internship or affiliation reflecting the nature of the training and the number of hours. Such verification must be signed by the supervisor(s) under penalty of perjury.
(c) An advanced practice application not completed within six months of receipt or notification of deficiency, whichever is later, shall be deemed abandoned.
(d) An application submitted subsequent to the abandonment of a previous application shall be treated as a new application.
Note: Authority cited: Sections 2570.3 and 2570.20, Business and Professions Code.
Reference: Sections 2570.2 and 2570.3, Business and Professions Code.

BOARD OF OCCUPATIONAL THERAPY

Title 16, Division 39, California Code of Regulations. California Board of Occupational Therapy

PROPOSED REGULATORY LANGUAGE

Advanced Practice – Hand Therapy

Legend:	Added text is indicated with an underline. Omitted text is indicated by (* * * *) Deleted text is indicated by ~~strikeout~~.

Amend sections 4151 and 4155 of Division 39, Title 16 of the California Code of Regulations to read as follows:

§ 4151. Hand Therapy

(a) Hand therapy services may be performed only when an occupational therapist has demonstrated to the Board in an application filed pursuant to section 4155 that they have met the post professional education and training requirements established by this section as follows:
(1) Education: Completion of 45 contact hours in the subjects listed in Code section 2570.3(e), including 30 hours specifically relating to the hand, wrist, and forearm.
(2) Training: Completion of ~~480~~80 hours of supervised on-the-job training, clinical internship or affiliation, which may be paid or voluntary, pertaining to hand therapy.
(b) An occupational therapist whose application pursuant to section 4155 provides proof of current certification as a Certified Hand Therapist, issued by the Hand Therapy Certification Commission, shall be deemed to have met the education and training requirements established by this section.
(c) An occupational therapist providing hand therapy services using physical agent modalities must also comply with the requirements of section 4152. A maximum of 8 contact hours and ~~60~~10 hours of supervised on-the-job training, clinical internship or affiliation, paid or voluntary, completed under section 4152 will be credited toward the requirements of this section.
(d) An occupational therapist may provide only those hand therapy services the occupational therapist is competent to perform.

Note: Authority cited: Sections 2570.3 and 2570.20, Business and Professions Code. Reference: Sections 2570.2 and 2570.3, Business and Professions Code.

§ 4155. Application for Approval in Advanced Practice Areas

In order to provide any of the advanced practice services set forth in Code section 2570.3(d), an occupational therapist shall apply to the Board and receive approval in that advanced practice area.

(a) To apply for approval, an occupational therapist shall submit to the Board an application as specified in subsections (1), (2), or (3), along with the required documentation.
(1) Applicants seeking approval in the area of Hand Therapy shall submit the Application for Advanced Practice Approval in Hand Therapy (Form APH, Rev. ~~10/09~~XX/XX), hereby incorporated by reference;.
(2) Applicants seeking approval in the use of physical agent modalities shall submit the Application for Advanced Practice Approval in Physical Agent Modalities (Form APP, Rev. 07/11), hereby incorporated by reference;
(3) Applicants seeking approval in the area of Swallowing Assessment, Evaluation, or Intervention shall submit the Application for Advanced Practice Approval in Swallowing (Form APS, Rev. 10/09), hereby incorporated by reference;
(b) The documentation must include the following:
(1) Documented proof of attendance and completion of each course (i.e., certificate of completion or transcript).
(2) Evidence of the number of contact hours completed for each course for courses that are not Board approved.
(3) Outline or syllabus of each course for courses that are not Board approved.
(4) Information describing, in detail, the depth and breadth of the content covered (e.g., a course syllabus and the goals and objectives of the course) as it relates to the advanced practice area.
(5) Resume or credentials of each instructor for courses that are not Board approved.
(6) Verification of completion of supervised on-the-job training, clinical internship or affiliation reflecting the nature of the training and the number of hours. Such verification must be signed by the supervisor(s) under penalty of perjury.
(c) An advanced practice application not completed within six months of receipt or notification of deficiency, whichever is later, shall be deemed abandoned.
(d) An application submitted subsequent to the abandonment of a previous application shall be treated as a new application.

Note: Authority cited: Sections 2570.3 and 2570.20, Business and Professions Code. Reference: Sections 2570.2 and 2570.3, Business and Professions Code

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APPLICATION FOR ADVANCED PRACTICE APPROVAL – *HAND THERAPY*

(Print clearly or type all information.)

Section I: Personal Data (Please Complete All Boxes)

A. Last Name		B. First Name		C. Middle Name
D. Residence Address (Street No., Apt No.)		City	State	Zip Code
E. OT License No.	F. Home Telephone No.	G. Business Telephone No.	H. E-Mail Address	
I. Current Employer		J. Supervisor First Name	K. Supervisor Last Name	

Section II: Affidavit

I hereby declare that I am the person named in this application and that I have read the complete application and know the contents thereof. **I declare, under penalty of perjury of the laws of the State of California, that all of the information contained herein, and evidence or other credentials submitted herewith are true and correct.** I understand that falsification or misrepresentation of any item or response on this application or any attachment hereto, is sufficient grounds for denial suspension or revocation of a license to practice as an occupational therapist in the State of California.

_____ _____

Signature of Applicant Date

Information Collection and Access – The Board's executive officer is the person responsible for information maintenance. Business and Professions Code section 2570.18 gives the Board authority to maintain information. All information is mandatory. Failure to provide any mandatory information will result in the application being rejected as incomplete. The information provided will be used to determine qualification for advanced practice approval. Each individual has the right to review his or her file maintained by the agency subject to the provisions of the California Public Records Act.

Approval in an advanced practice area demonstrates entry-level competency in the area approved. Approval does not represent expertise in this area and should not be misrepresented as such. Pursuant to Title 16, California Code of Regulations, Section 4170(f)(1) of the Ethical Standards of Practice, occupational therapists are required to accurately represent their credentials, qualifications, education, experience, training, and competency. Further, Section 4170(d) states that occupational therapists shall perform services only when they are qualified by education, training, and experience to do so.

Section III: EDUCATION AND TRAINING SUMMARY SHEET – HAND THERAPY:

HAND THERAPY EDUCATION (Minimum of 45 Contact Hours Required*)

# of Hours	Course Title:
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	Total Contact Hours

HAND THERAPY TRAINING (Minimum of ~~480~~80 Supervised Hours Required*):

# of Hours	Name of Facility:
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	Total Supervised Hours

*Eight (8) hours of education and sixty (~~60~~10) hours of supervised on the job training in physical agent modalities can be applied towards meeting the education and training requirements for hand therapy. No other courses or hours can count for advanced practice approval in both hand therapy and physical agent modalities.

Section IV: Education (Copy this form and use a separate form for *each* course.)

Name of Course: _____

Number of Contact Hours: _____

Name of Course Provider: _____

Date Completed: _____

Course(s) must have been completed within the past five (5) years.
(Courses older than 5 years will not be counted toward the educational requirement.)

Required content areas – Please indicate the areas covered by the above-named course:

☐ Anatomy of the upper extremity and how it is altered by pathology.

☐ Histology as it relates to tissue healing and the effects of immobilization and mobilization on connective tissue.

☐ Muscle, sensory, vascular, and connective tissue physiology.

☐ Kinesiology of the upper extremity, such as biomechanical principles of pulleys, intrinsic and extrinsic muscle function, internal forces of muscles, and the effects of external forces.

☐ The effects of temperature and electrical currents on nerve and connective tissue.

☐ Surgical procedures of the upper extremity and their postoperative course.

A Copy of Certificate of Completion must be attached for each course.

Section V: Training (Copy this form and use a separate form for each training and/or affiliation.)

NOTE TO SUPERVISOR: You are being asked to provide information for an OT seeking approval to provide hand therapy. Please complete this form and return it to the OT so that it can be included in his/her application packet.

This training represents _____ hours of experience in ***Hand Therapy*** acquired between _____(month/day/year) and _____ (month/day/year). *(Training hours must be completed within the five (5) years immediately preceding this application.)*

Supervisor's Name: _____
First Last

License Type/Number: _____ Supervisor's Phone #: _____
e.g., OT, PT, MD

Name and Address of Facility
Where Training Occurred: _____

_____

Is _____ competent in providing hand therapy?
OT applicant's name

☐ YES, competence has been demonstrated in the area of hand therapy.

☐ NO, competence has not been demonstrated in the area of hand therapy.

Please identify the knowledge, skills and abilities demonstrated by the OT:

_____

_____

_____

_____

_____

By signing below, YOU certify that you were the clinical supervisor for training hours noted above and that the timeframes and hours listed are true and correct.

Supervisor's Signature: _____ Date: _____

Note to Supervisor:

- **Until the Board approves this applicant, you have *continuing* supervisory responsibility *even if the "training" period has ended,* IF the OT is providing hand therapy and you are both employed at the location named above.**

BOARD OF OCCUPATIONAL THERAPY

Title 16, Division 39, California Code of Regulations. California Board of Occupational Therapy

PROPOSED REGULATORY LANGUAGE

Advanced Practice – Hand Therapy

Legend:	Added text is indicated with an underline. Omitted text is indicated by (* * * *) Deleted text is indicated by ~~strikeout~~.

Amend sections 4151 and 4155 of Division 39, Title 16 of the California Code of Regulations to read as follows:

§ 4151. Hand Therapy

(a) Hand therapy services may be performed only when an occupational therapist has demonstrated to the Board in an application filed pursuant to section 4155 that they have met the post professional education and training requirements established by this section as follows:
(1) Education: Completion of 45 contact hours in the subjects listed in Code section 2570.3(e), including 30 hours specifically relating to the hand, wrist, and forearm.
(A) Occupational Therapists having started their qualifying degree program on or after August

surgical procedures of the upper extremity and their postoperative course.

affiliation, which may be paid or voluntary, pertaining to hand therapy.
(b) An occupational therapist whose application pursuant to section 4155 provides proof of current certification as a Certified Hand Therapist, issued by the Hand Therapy Certification Commission, shall be deemed to have met the education and training requirements established by this section.
(c) An occupational therapist providing hand therapy services using physical agent modalities must also comply with the requirements of section 4152. A maximum of 8 contact hours and 60 hours of supervised on-the-job training, clinical internship or affiliation, paid or voluntary, completed under section 4152 will be credited toward the requirements of this section.
(1) Occupational Therapists having started their qualifying degree program on or after August

requirements of this section.

therapist is competent to perform.
Note: Authority cited: Sections 2570.3 and 2570.20, Business and Professions Code.
Reference: Sections 2570.2 and 2570.3, Business and Professions Code.

§ 4155. Application for Approval in Advanced Practice Areas

In order to provide any of the advanced practice services set forth in Code section 2570.3(d), an occupational therapist shall apply to the Board and receive approval in that advanced practice area.

(a) To apply for approval, an occupational therapist shall submit to the Board an application as specified in subsections (1), (2), or (3), along with the required documentation.

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(2) Applicants seeking approval in the use of physical agent modalities shall submit the Application for Advanced Practice Approval in Physical Agent Modalities (Form APP, Rev. 07/11), hereby incorporated by reference;

(3) Applicants seeking approval in the area of Swallowing Assessment, Evaluation, or Intervention shall submit the Application for Advanced Practice Approval in Swallowing (Form APS, Rev. 10/09), hereby incorporated by reference;

(b) The documentation must include the following:

(1) Documented proof of attendance and completion of each course (i.e., certificate of completion or transcript).

(2) Evidence of the number of contact hours completed for each course for courses that are not Board approved.

(3) Outline or syllabus of each course for courses that are not Board approved.

(4) Information describing, in detail, the depth and breadth of the content covered (e.g., a course syllabus and the goals and objectives of the course) as it relates to the advanced practice area.

(5) Resume or credentials of each instructor for courses that are not Board approved.

(6) Verification of completion of supervised on-the-job training, clinical internship or affiliation reflecting the nature of the training and the number of hours. Such verification must be signed by the supervisor(s) under penalty of perjury.

(c) An advanced practice application not completed within six months of receipt or notification of deficiency, whichever is later, shall be deemed abandoned.

(d) An application submitted subsequent to the abandonment of a previous application shall be treated as a new application.

Note: Authority cited: Sections 2570.3 and 2570.20, Business and Professions Code. Reference: Sections 2570.2 and 2570.3, Business and Professions Code

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APPLICATION FOR ADVANCED PRACTICE APPROVAL – *HAND THERAPY*

(Print clearly or type all information.)

Section I: Personal Data (Please Complete All Boxes)

A. Last Name		B. First Name		C. Middle Name
D. Residence Address (Street No., Apt No.)		City	State	Zip Code
E. OT License No.	F. Home Telephone No.	G. Business Telephone No.	H. E-Mail Address	
I. Current Employer		J. Supervisor First Name	K. Supervisor Last Name	

Section II: Affidavit

I hereby declare that I am the person named in this application and that I have read the complete application and know the contents thereof. **I declare, under penalty of perjury of the laws of the State of California, that all of the information contained herein, and evidence or other credentials submitted herewith are true and correct.** I understand that falsification or misrepresentation of any item or response on this application or any attachment hereto, is sufficient grounds for denial, suspension or revocation of a license to practice as an occupational therapist in the State of California.

_____ _____

Signature of Applicant Date

Information Collection and Access – The Board's executive officer is the person responsible for information maintenance. Business and Professions Code section 2570.18 gives the Board authority to maintain information. All information is mandatory. Failure to provide any mandatory information will result in the application being rejected as incomplete. The information provided will be used to determine qualification for advanced practice approval. Each individual has the right to review his or her file maintained by the agency subject to the provisions of the California Public Records Act.

Approval in an advanced practice area demonstrates entry-level competency in the area approved. Approval does not represent expertise in this area and should not be misrepresented as such. Pursuant to Title 16, California Code of Regulations, Section 4170(f)(1) of the Ethical Standards of Practice, occupational therapists are required to accurately represent their credentials, qualifications, education, experience, training, and competency. Further, Section 4170(d) states that occupational therapists shall perform services only when they are qualified by education, training, and experience to do so.

Section III: EDUCATION AND TRAINING SUMMARY SHEET – HAND THERAPY:

HAND THERAPY EDUCATION (Minimum of 45 Contact Hours Required/8 Contact Hours if Degree Program started on or after August 1, 2025*)

# of Hours	Course Title:
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	Total Contact Hours

HAND THERAPY TRAINING (Minimum of 480 Supervised Hours Required*):

# of Hours	Name of Facility:
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	Total Supervised Hours

*Eight (8) hours of education ~~and sixty (60) hours of supervised on the job training~~ in physical agent modalities can be applied towards meeting the education ~~and training~~ requirements for hand therapy, unless an applicant began their degree program on or after August 1, 2025. Sixty (60) hours of supervised on the job training in physical agent modalities can be applied towards meeting the training requirements for hand therapy. No other courses or hours can count for advanced practice approval in both hand therapy and physical agent modalities.

Section IV: Education (Copy this form and use a separate form for each course.)

Name of Course: _____

Number of Contact Hours: _____

Name of Course Provider: _____

Date Completed: _____

Course(s) must have been completed within the past five (5) years.
(Courses older than 5 years will not be counted toward the educational requirement.)

Required content areas – Please indicate the areas covered by the above-named course:

☐ Anatomy of the upper extremity and how it is altered by pathology.

☐ Histology as it relates to tissue healing and the effects of immobilization and mobilization on connective tissue.

☐ Muscle, sensory, vascular, and connective tissue physiology.

☐ Kinesiology of the upper extremity, such as biomechanical principles of pulleys, intrinsic and extrinsic muscle function, internal forces of muscles, and the effects of external forces.

☐ The effects of temperature and electrical currents on nerve and connective tissue.

☐ Surgical procedures of the upper extremity and their postoperative course.

A Copy of Certificate of Completion must be attached for *each* course.

Section V: Training (Copy this form and use a separate form for each training and/or affiliation.)

NOTE TO SUPERVISOR: You are being asked to provide information for an OT seeking approval to provide hand therapy. Please complete this form and return it to the OT so that it can be included in his/her application packet.

This training represents _____ hours of experience in ***Hand Therapy*** acquired between _____(month/day/year) and _____ (month/day/year). *(Training hours must be completed within the five (5) years immediately preceding this application.)*

Supervisor's Name: _____
First Last

License Type/Number: _____ Supervisor's Phone #: _____
e.g., OT, PT, MD

Name and Address of Facility
Where Training Occurred: _____

_____

Is _____ competent in providing hand therapy?
OT applicant's name

☐ YES, competence has been demonstrated in the area of hand therapy.

☐ NO, competence has not been demonstrated in the area of hand therapy.

Please identify the knowledge, skills and abilities demonstrated by the OT:

_____

_____

_____

_____

_____

By signing below, YOU certify that you were the clinical supervisor for training hours noted above and that the timeframes and hours listed are true and correct.

Supervisor's Signature: _____ Date: _____

Note to Supervisor:

- **Until the Board approves this applicant, you have *continuing* supervisory responsibility *even if the "training" period has ended,* IF the OT is providing hand therapy and you are both employed at the location named above.**

BOARD OF OCCUPATIONAL THERAPY

Title 16, Division 39, California Code of Regulations. California Board of Occupational Therapy

PROPOSED REGULATORY LANGUAGE

Advanced Practice – Hand Therapy

Legend:	Added text is indicated with an underline. Omitted text is indicated by (* * * *) Deleted text is indicated by ~~strikeout~~.

Amend sections 4151 and 4155 of Division 39, Title 16 of the California Code of Regulations to read as follows:

§ 4151. Hand Therapy

(a) Hand therapy services may be performed only when an occupational therapist has demonstrated to the Board in an application filed pursuant to section 4155 that they have met the post professional education and training requirements established by this section as follows:
(1) Education: Completion of 45 contact hours in the subjects listed in Code section 2570.3(e), including 30 hours specifically relating to the hand, wrist, and forearm.
(A) Occupational Therapists having started their qualifying degree program on or after August

(b) An occupational therapist whose application pursuant to section 4155 provides proof of current certification as a Certified Hand Therapist, issued by the Hand Therapy Certification Commission, shall be deemed to have met the education and training requirements established by this section.
(c) An occupational therapist providing hand therapy services using physical agent modalities must also comply with the requirements of section 4152. A maximum of 8 contact hours and ~~60~~10 hours of supervised on-the-job training, clinical internship or affiliation, paid or voluntary,

(1) Occupational Therapists having started their qualifying degree program on or after August 1, 2025, may not use any contact hours completed under section 4152 to satisfy the requirements of this section.

therapist is competent to perform.
Note: Authority cited: Sections 2570.3 and 2570.20, Business and Professions Code.
Reference: Sections 2570.2 and 2570.3, Business and Professions Code.

§ 4155. Application for Approval in Advanced Practice Areas

In order to provide any of the advanced practice services set forth in Code section 2570.3(d), an occupational therapist shall apply to the Board and receive approval in that advanced practice area.
(a) To apply for approval, an occupational therapist shall submit to the Board an application as specified in subsections (1), (2), or (3), along with the required documentation.
(1) Applicants seeking approval in the area of Hand Therapy shall submit the Application for Advanced Practice Approval in Hand Therapy (Form APH, Rev. ~~10/09~~XX/XX), hereby incorporated by reference;.
(2) Applicants seeking approval in the use of physical agent modalities shall submit the Application for Advanced Practice Approval in Physical Agent Modalities (Form APP, Rev. 07/11), hereby incorporated by reference;
(3) Applicants seeking approval in the area of Swallowing Assessment, Evaluation, or Intervention shall submit the Application for Advanced Practice Approval in Swallowing (Form APS, Rev. 10/09), hereby incorporated by reference;
(b) The documentation must include the following:
(1) Documented proof of attendance and completion of each course (i.e., certificate of completion or transcript).
(2) Evidence of the number of contact hours completed for each course for courses that are not Board approved.
(3) Outline or syllabus of each course for courses that are not Board approved.
(4) Information describing, in detail, the depth and breadth of the content covered (e.g., a course syllabus and the goals and objectives of the course) as it relates to the advanced practice area.
(5) Resume or credentials of each instructor for courses that are not Board approved.
(6) Verification of completion of supervised on-the-job training, clinical internship or affiliation reflecting the nature of the training and the number of hours. Such verification must be signed by the supervisor(s) under penalty of perjury.
(c) An advanced practice application not completed within six months of receipt or notification of deficiency, whichever is later, shall be deemed abandoned.
(d) An application submitted subsequent to the abandonment of a previous application shall be treated as a new application.
Note: Authority cited: Sections 2570.3 and 2570.20, Business and Professions Code.
Reference: Sections 2570.2 and 2570.3, Business and Professions Code

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APPLICATION FOR ADVANCED PRACTICE APPROVAL – *HAND THERAPY*

(Print clearly or type all information.)

Section I: Personal Data (Please Complete All Boxes)

A. Last Name		B. First Name		C. Middle Name
D. Residence Address (Street No., Apt No.)		City	State	Zip Code
E. OT License No.	F. Home Telephone No.	G. Business Telephone No.	H. E-Mail Address	
I. Current Employer		J. Supervisor First Name	K. Supervisor Last Name	

Section II: Affidavit

I hereby declare that I am the person named in this application and that I have read the complete application and know the contents thereof. **I declare, under penalty of perjury of the laws of the State of California, that all of the information contained herein, and evidence or other credentials submitted herewith are true and correct.** I understand that falsificationor misrepresentation of any item or response on this application or any attachment hereto, is sufficient grounds for denial, suspension or revocation of a license to practice as an occupational therapist in the State of California.

Signature of Applicant _____ Date _____

Information Collection and Access – The Board's executive officer is the person responsible for information maintenance. Business and Professions Code section 2570.18 gives the Board authority to maintain information. All information is mandatory. Failure to provide any mandatory information will result in the application being rejected as incomplete. The information provided will be used to determine qualification for advanced practice approval. Each individual has the right to review his or her file maintained by the agency subject to the provisions of the California Public Records Act.

Approval in an advanced practice area demonstrates entry-level competency in the area approved. Approval does not represent expertise in this area and should not be misrepresented as such. Pursuant to Title 16, California Code of Regulations, Section 4170(f)(1) of the Ethical Standards of Practice, occupational therapists are required to accurately represent their credentials, qualifications, education, experience, training, and competency. Further, Section 4170(d) states that occupational therapists shall perform services only when they are qualified by education, training, and experience to do so.

Section III: EDUCATION AND TRAINING SUMMARY SHEET – HAND THERAPY:

HAND THERAPY EDUCATION (Minimum of 45 Contact Hours Required/8 Contact Hours if Degree Program started on or after August 1, 2025*)

# of Hours	Course Title:
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	Total Contact Hours

HAND THERAPY TRAINING (Minimum of ~~480~~80 Supervised Hours Required*):

# of Hours	Name of Facility:
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	Total Supervised Hours

*Eight (8) hours of education ~~and sixty (60) hours of supervised on the job training~~ in physical agent modalities can be applied towards meeting the education ~~and training~~ requirements for hand therapy, unless an applicant began their degree program on or after August 1, 2025. Ten (10) hours of supervised on the job training in physical agent modalities can be applied towards meeting the training requirements for hand therapy. No other courses or hours can count for advanced practice approval in both hand therapy and physical agent modalities.

Section IV: Education (Copy this form and use a separate form for each course.)

Name of Course: _____

Number of Contact Hours: _____

Name of Course Provider: _____

Date Completed: _____

Course(s) must have been completed within the past five (5) years.
(Courses older than 5 years will not be counted toward the educational requirement.)

Required content areas – Please indicate the areas covered by the above-named course:

☐ Anatomy of the upper extremity and how it is altered by pathology.

☐ Histology as it relates to tissue healing and the effects of immobilization and mobilization on connective tissue.

☐ Muscle, sensory, vascular, and connective tissue physiology.

☐ Kinesiology of the upper extremity, such as biomechanical principles of pulleys, intrinsic and extrinsic muscle function, internal forces of muscles, and the effects of external forces.

☐ The effects of temperature and electrical currents on nerve and connective tissue.

☐ Surgical procedures of the upper extremity and their postoperative course.

A Copy of Certificate of Completion must be attached for *each* course.

Section V: Training (Copy this form and use a separate form for each training and/or affiliation.)

NOTE TO SUPERVISOR: You are being asked to provide information for an OT seeking approval to provide hand therapy. Please complete this form and return it to the OT so that it can be included in his/her application packet.

This training represents _____ hours of experience in ***Hand Therapy*** acquired between _____(month/day/year) and _____ (month/day/year). *(Training hours must be completed within the five (5) years immediately preceding this application.)*

Supervisor's Name: _____
First Last

License Type/Number: _____ Supervisor's Phone #: _____
e.g., OT, PT, MD

Name and Address of Facility
Where Training Occurred: _____

_____

Is _____ competent in providing hand therapy?
OT applicant's name

☐ YES, competence has been demonstrated in the area of hand therapy.

☐ NO, competence has not been demonstrated in the area of hand therapy.

Please identify the knowledge, skills and abilities demonstrated by the OT:

_____

_____

_____

_____

_____

By signing below, YOU certify that you were the clinical supervisor for training hours noted above and that the timeframes and hours listed are true and correct.

Supervisor's Signature: _____ Date: _____

Note to Supervisor:

- **Until the Board approves this applicant, you have *continuing* supervisory responsibility *even if the "training" period has ended,* IF the OT is providing hand therapy and you are both employed at the location named above.**

Agenda Item 13

Consideration and possible action to initiate a rulemaking package to amend California Code of Regulations, Title 16, Division 39, Article 6, Section 4152, Physical Agent Modalities, and Section 4155, Application for Approval in Advanced Practice Areas.

Includes the following:

13.1 Memorandum.

13.2 Business and Professions Code Section 2570.3, as approved by the Board vote on August 22, 2024.

13.3 Proposed language to reduce required training and education hours for advanced practice approval in Physical Agent Modalities.

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MEMORANDUM

DATE	May 27, 2025
TO	Board of Occupational Therapy Members
FROM	Austin Porter, Interim Executive Officer Board of Occupational Therapy
SUBJECT	**Agenda Item 13: Consideration and Possible Action to Initiate a Rulemaking Package to Amend CCR, Title 16, Division 39, Article 6, Section 4152, Physical Agent Modalities, and Section 4155, Application for Approval in Advanced Practice Areas.**

Background

During its August 2024 meeting, the Board moved to seek amendments to Business and Professions Code Section (BPC) 2570.3(d) and 2570.3(f) that would eliminate the need for Board approval to practice Physical Agent Modalities (PAMs) for those licensees having started their qualifying degree program on or after July 31, 2020. The Board also moved to reduce the required training hours for PAMs approval for all licensees.

Since that time, Board staff have been unsuccessful in finding an author for such a bill. In addition, staff have identified issues and consequences (outlined below) of the proposed change that require clarification of the Board's intent.

Furthermore, in drafting regulatory language for the previously discussed CCR sections pertaining to Hand Therapy approval, it was found that similar changes for PAMs approval could be affected through regulation, rather than statute.

An excerpt of the proposed changes to BPC Section 2570.3, as approved by the Board, are provided below:

> **BPC Section 2570.3** (Note: Subsections (a)–(c) and (e) not included)
>
> (d) An occupational therapist may provide advanced practices if the occupational therapist has the knowledge, skill, and ability to do so and has demonstrated to the satisfaction of the board that the occupational therapist has met educational, training and competency requirements. These advanced practices include the following:

(1) Hand therapy.
(2) The use of physical agent modalities. This provision only applies to occupational therapists who began their qualifying degree program prior to July 31, 2020.
(3) Swallowing assessment, evaluation, or intervention.
(f) An occupational therapist using physical agent modalities, who began their qualifying degree program prior to July 31, 2020, shall demonstrate to the satisfaction of the board that the occupational therapist has completed education and training in all of the following areas.:

Items to Consider

As shown above, the proposed changes to BPC Section 2570.3 would exempt an occupational therapist having started their qualifying degree program on or after July 31, 2020, from having to apply for PAMs approval altogether. They would not be required to demonstrate completion of education or training.

- Was it the intent of the Board that these occupational therapists need not show evidence of completion of training hours, in addition to being exempt from education requirements?
- Was it the intent of the Board that these licensees need not apply for approval in PAMs at all?

If certain licensees are exempt from the application and approval process, how will the Board communicate to the public that these individuals are able to provide PAMs?

Action Requested

Board staff asks that the Board consider making changes to the requirements for advanced practice approval in PAMs through a regulatory proposal, as shown in the materials that follow.

Included Materials

- Proposed amendments to BPC 2570.3 and CCR 4152 & 4155 as approved by the Board at the August 2024 meeting.
- Proposed language to reduce required supervised training hours from 240 contact hours to 40 hours and exempt certain occupational therapists from required education hours for PAMs approval.

*Neither this memo nor the included materials have been reviewed by regulatory counsel.

Previously Approved Amendments to BPC 2570.3 and CCR Sections 4152 and 4155

BPC Section 2570.3
(Note: Subsections (a)–(c) and (e) not included)

(d) An occupational therapist may provide advanced practices if the occupational therapist has the knowledge, skill, and ability to do so and has demonstrated to the satisfaction of the board that the occupational therapist has met educational, training and competency requirements. These advanced practices include the following:
(1) Hand therapy.
(2) The use of physical agent modalities. **This provision only applies to occupational therapists who began their qualifying degree program prior to July 31, 2020**.
(3) Swallowing assessment, evaluation, or intervention.
(f) An occupational therapist using physical agent modalities, **who began their qualifying degree program prior to July 31, 2020**, shall demonstrate to the satisfaction of the board that the occupational therapist has completed education and training in all of the following areas.:
(1) Anatomy and physiology of muscle, sensory, vascular, and connective tissue in response to the application of physical agent modalities.
(2) Principles of chemistry and physics related to the selected modality.
(3) Physiological, neurophysiological, and electrophysiological changes that occur as a result of the application of a modality.
(4) Guidelines for the preparation of the client, including education about the process and possible outcomes of treatment.
(5) Safety rules and precautions related to the selected modality.
(6) Methods for documenting immediate and long-term effects of treatment.
(7) Characteristics of the equipment, including safe operation, adjustment, indications of malfunction, and care.
~~(g)~~(h) An occupational therapist in the process of achieving the education, training, and competency requirements established by the board for providing hand therapy or using physical agent modalities may practice these techniques under the supervision of an occupational therapist who has already met the requirements established by the board, a physical therapist, or a physician and surgeon.
~~(h)~~(i) The board shall develop and adopt regulations regarding the educational training and competency requirements for advanced practices in collaboration with the Speech-Language Pathology and Audiology and Hearing Aid Dispensers Board, the Board of Registered Nursing, and the Physical Therapy Board of California.
~~(i)~~(j) This chapter does not authorize an occupational therapist to seek reimbursement for services other than for the practice of occupational therapy as defined in this chapter.
~~(j)~~(k) "Supervision of an occupational therapy assistant" means that the responsible occupational therapist shall at all times be responsible for all occupational therapy services provided to the client. The occupational therapist who is responsible for

appropriate supervision shall formulate and document in each client's record, with the occupational therapist's signature, the goals and plan for that client, and shall make sure that the occupational therapy assistant assigned to that client functions under appropriate supervision. As part of the responsible occupational therapist's appropriate supervision, the occupational therapist shall conduct at least weekly review and inspection of all aspects of occupational therapy services by the occupational therapy assistant.
(1) The supervising occupational therapist has the continuing responsibility to follow the progress of each client, provide direct care to the client, and to ensure that the occupational therapy assistant does not function autonomously.
(2) An occupational therapist shall not supervise more occupational therapy assistants, at any one time, than can be appropriately supervised in the opinion of the board. Three occupational therapy assistants shall be the maximum number of occupational therapy assistants supervised by an occupational therapist at any one time, but the board may permit the supervision of a greater number by an occupational therapist if, in the opinion of the board, there would be adequate supervision and the public's health and safety would be served. In no case shall the total number of occupational therapy assistants exceed three times the number of occupational therapists regularly employed by a facility at any one time.
(Amended by Stats. 2023, Ch. 131, Sec. 4. (AB 1754) Effective January 1, 2024.)

CCR § 4152. Physical Agent Modalities

(a) Physical agent modalities may be used only when an occupational therapist has demonstrated to the Board in an application filed pursuant to section 4155 that they have met the post professional education and training requirements established by this section as follows:
(1) Education: Completion of 30 contact hours in the subjects listed in Code section 2570.3(f).
(2) Training: Completion of ~~**240**~~ **40** hours of supervised on-the-job training, clinical internship or affiliation, which may be paid or voluntary, pertaining to physical agent modalities.
(b) An occupational therapist whose application pursuant to section 4155 provides proof of current certification as a Certified Hand Therapist, issued by the Hand Therapy Certification Commission, shall be deemed to have met the education and training requirements established by this section.
(c) An occupational therapist may use only those physical agent modalities the occupational therapist is competent to use.

CCR § 4155. Application for Approval in Advanced Practice Areas

In order to provide any of the advanced practice services set forth in Code section 2570.3(d), an occupational therapist shall apply to the Board and receive approval in that advanced practice area.
(a) To apply for approval, an occupational therapist shall submit to the Board an application as specified in subsections (1), (2), or (3), along with the required documentation.

(1) Applicants seeking approval in the area of Hand Therapy shall submit the Application for Advanced Practice Approval in Hand Therapy (Form APH, Rev. 10/09), hereby incorporated by reference;
(2) Applicants seeking approval in the use of physical agent modalities shall submit the Application for Advanced Practice Approval in Physical Agent Modalities (Form APP, ~~**Rev. 07/11**~~ **Rev. XX/XX)**, hereby incorporated by reference. **This requirement only applies to occupational therapists who began their qualifying degree program prior to July 31, 2020**;
(3) Applicants seeking approval in the area of Swallowing Assessment, Evaluation, or Intervention shall submit the Application for Advanced Practice Approval in Swallowing (Form APS, Rev. 10/09), hereby incorporated by reference;
(b) The documentation must include the following:
(1) Documented proof of attendance and completion of each course (i.e., certificate of completion or transcript).
(2) Evidence of the number of contact hours completed for each course for courses that are not Board approved.
(3) Outline or syllabus of each course for courses that are not Board approved.
(4) Information describing, in detail, the depth and breadth of the content covered (e.g., a course syllabus and the goals and objectives of the course) as it relates to the advanced practice area.
(5) Resume or credentials of each instructor for courses that are not Board approved.
(6) Verification of completion of supervised on-the-job training, clinical internship or affiliation reflecting the nature of the training and the number of hours. Such verification must be signed by the supervisor(s) under penalty of perjury.

DEPARTMENT OF CONSUMER AFFAIRS

Title 16, Division 39, California Code of Regulations. California Board of Occupational Therapy

PROPOSED REGULATORY LANGUAGE

Advanced Practice – Physical Agent Modalities

Legend:	Added text is indicated with an underline. Omitted text is indicated by (* * * *) Deleted text is indicated by ~~strikeout~~.

Amend sections 4152 and 4155 of Division 39, Title 16 of the California Code of Regulations to read as follows:

§ 4152. Physical Agent Modalities

(a) Physical agent modalities may be used only when an occupational therapist has demonstrated to the Board in an application filed pursuant to section 4155 that they have met the post professional education and training requirements established by this section as follows:
(1) Education: Completion of 30 contact hours in the subjects listed in Code section 2570.3(f).
(A) Occupational therapists having started their qualifying degree program on or after August 1, 2020, need not complete the additional education hours above.
(2) Training: Completion of ~~240~~40 hours of supervised on-the-job training, clinical internship or affiliation, which may be paid or voluntary, pertaining to physical agent modalities.
(b) An occupational therapist whose application pursuant to section 4155 provides proof of current certification as a Certified Hand Therapist, issued by the Hand Therapy Certification Commission, shall be deemed to have met the education and training requirements established by this section.
(c) An occupational therapist may use only those physical agent modalities the occupational therapist is competent to use.
Note: Authority Cited: Sections 2570.3 and 2570.20, Business and Professions Code.
Reference: Sections 2570.2 and 2570.3, Business and Professions Code.

§ 4155. Application for Approval in Advanced Practice Areas

In order to provide any of the advanced practice services set forth in Code section 2570.3(d), an occupational therapist shall apply to the Board and receive approval in that advanced practice area.
(a) To apply for approval, an occupational therapist shall submit to the Board an application as specified in subsections (1), (2), or (3), along with the required documentation.
(1) Applicants seeking approval in the area of Hand Therapy shall submit the Application for Advanced Practice Approval in Hand Therapy (Form APH, Rev. 10/09), hereby incorporated by reference;.
(2) Applicants seeking approval in the use of physical agent modalities shall submit

the Application for Advanced Practice Approval in Physical Agent Modalities (Form APP, Rev. ~~07/11~~XX/XX), hereby incorporated by reference;
(3) Applicants seeking approval in the area of Swallowing Assessment, Evaluation, or Intervention shall submit the Application for Advanced Practice Approval in Swallowing (Form APS, Rev. 10/09), hereby incorporated by reference;
(b) The documentation must include the following:
(1) Documented proof of attendance and completion of each course (i.e., certificate of completion or transcript).
(2) Evidence of the number of contact hours completed for each course for courses that are not Board approved.
(3) Outline or syllabus of each course for courses that are not Board approved.
(4) Information describing, in detail, the depth and breadth of the content covered (e.g., a course syllabus and the goals and objectives of the course) as it relates to the advanced practice area.
(5) Resume or credentials of each instructor for courses that are not Board approved.
(6) Verification of completion of supervised on-the-job training, clinical internship or affiliation reflecting the nature of the training and the number of hours. Such verification must be signed by the supervisor(s) under penalty of perjury.
(c) An advanced practice application not completed within six months of receipt or notification of deficiency, whichever is later, shall be deemed abandoned.
(d) An application submitted subsequent to the abandonment of a previous application shall be treated as a new application.
Note: Authority cited: Sections 2570.3 and 2570.20, Business and Professions Code. Reference: Sections 2570.2 and 2570.3, Business and Professions Code

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APPLICATION FOR ADVANCED PRACTICE APPROVAL – *PHYSICAL AGENT MODALITIES*

(Print clearly or type all information.)

Section I: Personal Data (Please Complete All Boxes)

A. Last Name		B. First Name		C. Middle Name
D. Residence Address (Street No., Apt No.)		City	State	Zip Code
E. OT License No.	F. Home Telephone No.	G. Business Telephone No.	H. E-Mail Address	
I. Current Employer		J. Supervisor First Name	K. Supervisor Last Name	

Section II: Affidavit

I hereby declare that I am the person named in this application and that I have read the complete application and know the contents thereof. **I declare, under penalty of perjury of the laws of the State of California, that all of the information contained herein, and evidence or other credentials submitted herewith are true and correct.** I understand that falsification or misrepresentation of any item or response on this application or any attachment hereto, is sufficient grounds for denial, suspension or revocation of a license to practice as an occupational therapist in the State of California.

Signature of Applicant _____ Date _____

Information Collection and Access – The Board's executive officer is the person responsible for information maintenance. Business and Professions Code section 2570.18 gives the Board authority to maintain information. All information is mandatory. Failure to provide any mandatory information will result in the application being rejected as incomplete. The information provided will be used to determine qualification for advanced practice approval. Each individual has the right to review his or her file maintained by the agency subject to the provisions of the California Public Records Act.

Approval in an advanced practice area demonstrates entry-level competency in the area approved. Approval does not represent expertise in this area and should not be misrepresented as such. Pursuant to Title 16, California Code of Regulations, Section 4170(f)(1) of the Ethical Standards of Practice, occupational therapists are required to accurately represent their credentials, qualifications, education, experience, training, and competency. Further, Section 4170(d) states that occupational therapists shall perform services only when they are qualified by education, training, and experience to do so.

Section III: EDUCATION AND TRAINING SUMMARY SHEET – PHYSICAL AGENT MODALITIES:

PHYSICAL AGENT MODALITIES EDUCATION (Minimum of 30 Contact Hours Required/ 0 Hours if Degree Program started on or after August 1, 2020*)

# of Hours	Course Title:
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	Total Contact Hours

PHYSICAL AGENT MODALITIES TRAINING (Minimum of ~~240~~40 Supervised Hours Required*):

# of Hours	Name of Facility:
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	Total Supervised Hours

*Eight (8) hours of education and sixty (~~60~~10) hours of supervised on the job training in physical agent modalities can be applied towards meeting the education and training requirements for hand therapy. No other courses or hours can count for advanced practice approval in both hand therapy and physical agent modalities.

Section IV: Education (Copy this form and use a separate form for each course.)

Name of Course: _____

Number of Contact Hours: _____

Name of Course Provider: _____

Date Completed: _____

(Course(s) must have been taken within the 5 years immediately preceding your application for approval. A Copy of Certificate of Completion must be attached for each course.)

Required content areas – Please indicate the areas covered by the above-named course:

☐ Anatomy and physiology of muscle, sensory, vascular, and connective tissue in response to the application of physical agent modalities.

☐ Principles of chemistry and physics related to the selected modality.

☐ Physiological, neurophysiological, and electrophysiological changes that occur as a result of the application of a modality.

☐ Guidelines for the preparation of the patient, including education about the process and possible outcomes of treatment.

☐ Safety rules and precautions related to the selected modality.

☐ Methods for documenting immediate and long-term effects of treatment.

☐ Characteristics of the equipment, including safe operation, adjustment, indications of malfunction, and care.

A Copy of Certificate of Completion must be attached for each course.

Section V: Training (Copy this form and use a separate form for each training and/or affiliation.)

NOTE TO SUPERVISOR: You are being asked to provide information for an OT seeking approval to provide physical agent modalities. Please complete this form and return it to the OT so that it can be included in his/her application packet.

This training represents _____ hours of experience in ***Physical Agent Modalities*** acquired between _____(month/day/year) and _____ (month/day/year). (Training hours must be completed within the five (5) years immediately preceding this application.)

Supervisor's Name: _____
First Last

License Type/Number: _____ Supervisor's Phone #: _____
e.g., OT, PT, MD

Name and Address of Facility
Where Training Occurred: _____

_____

Is _____ competent in providing physical agent modalities?
OT applicant's name

☐ YES, competence has been demonstrated in the area of physical agent modalities.

☐ NO, competence has not been demonstrated in the area of physical agent modalities.

Please identify the knowledge, skills and abilities demonstrated by the OT:

_____

_____

_____

_____

_____

By signing below, YOU certify that you were the clinical supervisor for training hours noted above and that the timeframes and hours listed are true and correct.

Supervisor's Signature: _____ Date: _____

Note to Supervisor:

- **Until the Board approves this applicant, you have continuing supervisory responsibility *even if the "training" period has ended,* IF the OT is providing ~~hand therapy~~physical agent modalities and you are both employed at the location named above.**

AGENDA ITEM 14

DISCUSSION OF THE AMERICAN OCCUPATIONAL THERAPY ASSOCIATION'S (AOTA) PRACTICE FRAMEWORK DOCUMENT.

Occupational Therapy Practice Framework: Domain and Process Fourth Edition

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Preface

The fourth edition of the *Occupational Therapy Practice Framework: Domain and Process* (hereinafter referred to as the *OTPF–4*), is an official document of the American Occupational Therapy Association (AOTA). Intended for occupational therapy practitioners and students, other health care professionals, educators, researchers, payers, policymakers, and consumers, the *OTPF–4* presents a summary of interrelated constructs that describe occupational therapy practice.

Definitions

Within the *OTPF–4, occupational therapy* is defined as the therapeutic use of everyday life occupations with persons, groups, or populations (i.e., the client) for the purpose of enhancing or enabling participation. Occupational therapy practitioners use their knowledge of the transactional relationship among the client, the client's 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. These services include acquisition and preservation of occupational identity for clients who have or are at risk for developing an illness, injury, disease, disorder, condition, impairment, disability, activity limitation, or participation restriction (AOTA, 2011; see the glossary in Appendix A for additional definitions).

When the term *occupational therapy practitioners* 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.

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Occupational therapy assistants deliver occupational therapy services under the supervision of and in partnership with an occupational therapist (AOTA, 2020a).

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). People may also consider themselves as part of a *community,* such as the Deaf community or the disability community; a *community* is a collection of populations that is changeable and diverse and includes various people, groups, networks, and organizations (Scaffa, 2019; World Federation of Occupational Therapists [WFOT], 2019). It is important to consider the community or communities with which a client identifies throughout the occupational therapy process.

Whether the client is a person, group, or population, information about the client's wants, needs, strengths, contexts, limitations, and occupational risks is gathered, synthesized, and framed from an occupational perspective. Throughout the *OTPF–4,* the term *client* is used broadly to refer to persons, groups, and populations unless otherwise specified. In the *OTPF–4*, "group" as a client is distinct from "group" as an intervention approach. For examples of clients, see Table 1 (all tables are placed together at the end of this document). The glossary in Appendix A provides definitions of other terms used in this document.

Evolution of This Document

The *Occupational Therapy Practice Framework* was originally developed to articulate occupational therapy's distinct perspective and contribution to promoting the health and participation of persons, groups, and populations through engagement in occupation. The first edition of the *OTPF* emerged from an examination of documents related to the *Occupational Therapy Product Output Reporting System and Uniform Terminology for Reporting Occupational Therapy Services* (AOTA, 1979). Originally a document that responded to a federal requirement to develop a uniform reporting system, this text gradually shifted to describing and outlining the domains of concern of occupational therapy.

The second edition of *Uniform Terminology for Occupational Therapy* (AOTA, 1989) was adopted by the AOTA Representative Assembly (RA) and published in 1989. The document focused on delineating and defining only the occupational performance areas and occupational performance components that are addressed in occupational therapy direct services. The third and final edition of *Uniform Terminology for Occupational Therapy* (*UT–III;* AOTA, 1994) was adopted by the RA in 1994 and was "expanded to reflect current practice and to incorporate contextual aspects of performance" (p. 1047). Each revision

reflected changes in practice and provided consistent terminology for use by the profession.

In fall 1998, the AOTA Commission on Practice (COP) embarked on the journey that culminated in the *Occupational Therapy Practice Framework: Domain and Process* (AOTA, 2002a). At that time, AOTA also published *The Guide to Occupational Therapy Practice* (Moyers, 1999), which outlined contemporary practice for the profession. Using this document and the feedback received during the review process for the *UT–III,* the COP proceeded to develop a document that more fully articulated occupational therapy.

The *OTPF* is an ever-evolving document. As an official AOTA document, it is reviewed on a 5-year cycle for usefulness and the potential need for further refinements or changes. During the review period, the COP collects feedback from AOTA members, scholars, authors, practitioners, AOTA volunteer leadership and staff, and other stakeholders. The revision process ensures that the *OTPF* maintains its integrity while responding to internal and external influences that should be reflected in emerging concepts and advances in occupational therapy.

The *OTPF* was first revised and approved by the RA in 2008. Changes to the document included refinement of the writing and the addition of emerging concepts and changes in occupational therapy. The rationale for specific changes can be found in Table 11 of the *OTPF–2* (AOTA, 2008, pp. 665–667).

In 2012, the process of review and revision of the *OTPF* was initiated again, and several changes were made. The rationale for specific changes can be found on page S2 of the *OTPF–3* (AOTA, 2014).

In 2018, the process to revise the *OTPF* began again. After member review and feedback, several modifications were made and are reflected in this document:

- The focus on group and population clients is increased, and examples are provided for both.
- Cornerstones of occupational therapy practice are identified and described as foundational to the success of occupational therapy practitioners.
- *Occupational science* is more explicitly described and defined.
- The terms *occupation* and *activity* are more clearly defined.
- For occupations, the definition of *sexual activity* as an activity of daily living is revised, *health management* is added as a general occupation category, and *intimate partner* is added in the social participation category (see Table 2).
- The *contexts and environments* aspect of the occupational therapy domain is changed to *context* on the basis of the World Health Organization (WHO; 2008) taxonomy from the *International Classification of Functioning, Disability and Health (ICF)* in an effort to adopt standard, well-accepted definitions (see Table 4).
- For the client factors category of body functions, *gender identity* is now included under "experience of self and time," the definition of *psychosocial* is expanded to match the *ICF* description, and *interoception* is added under sensory functions.
- For types of intervention, "preparatory methods and tasks" has been changed to "interventions to support occupations" (see Table 12).
- For outcomes, transitions and discontinuation are discussed as conclusions to occupational therapy services, and patient-reported outcomes are addressed (see Table 14).
- Five new tables are added to expand on and clarify concepts:
  - Table 1. Examples of Clients: Persons, Groups, and Populations
  - Table 3. Examples of Occupations for Persons, Groups, and Populations
  - Table 7. Performance Skills for Persons (includes examples of effective and ineffective performance skills)
  - Table 8. Performance Skills for Groups (includes examples of the impact of ineffective individual performance skills on group collective outcome)
  - Table 10. Occupational Therapy Process for Persons, Groups, and Populations.
- Throughout, the use of *OTPF* rather than *Framework* acknowledges the current requirements for a unique

identifier to maximize digital discoverability and to promote brevity in social media communications. It also reflects the longstanding use of the acronym in academic teaching and clinical practice.
- Figure 1 has been revised to provide a simplified visual depiction of the domain and process of occupational therapy.

Vision for This Work

Although this edition of the *OTPF* represents the latest in the profession's efforts to clearly articulate the occupational therapy domain and process, it builds on a set of values that the profession has held since its founding in 1917. The original vision had at its center a profound belief in the value of therapeutic occupations as a way to remediate illness and maintain health (Slagle, 1924). The founders emphasized the importance of establishing a therapeutic relationship with each client and designing a treatment plan based on knowledge about the client's environment, values, goals, and desires (Meyer, 1922). They advocated for scientific practice based on systematic observation and treatment (Dunton, 1934). Paraphrased using today's lexicon, the founders proposed a vision that was occupation based, client centered, contextual, and evidence based—the vision articulated in the *OTPF–4*.

Introduction

The purpose of a framework is to provide a structure or base on which to build a system or a concept ("Framework," 2020). The *OTPF* describes the central concepts that ground occupational therapy practice and builds a common understanding of the basic tenets and vision of the profession. The *OTPF–4* does not serve as a taxonomy, theory, or model of occupational therapy. By design, the *OTPF–4* must be used to guide occupational therapy practice in conjunction with the knowledge and evidence relevant to occupation and occupational therapy within the identified areas of practice and with the appropriate clients. In addition, the *OTPF–4* is intended to be a valuable tool in the academic preparation of students, communication with the public and policymakers, and provision of language that can shape and be shaped by research.

Occupation and Occupational Science

Embedded in this document is the occupational therapy profession's core belief in the positive relationship between occupation and health and its view of people as occupational beings. Occupational therapy practice emphasizes the occupational nature of humans and the importance of occupational identity (Unruh, 2004) to healthful, productive, and satisfying living. As Hooper and Wood (2019) stated,

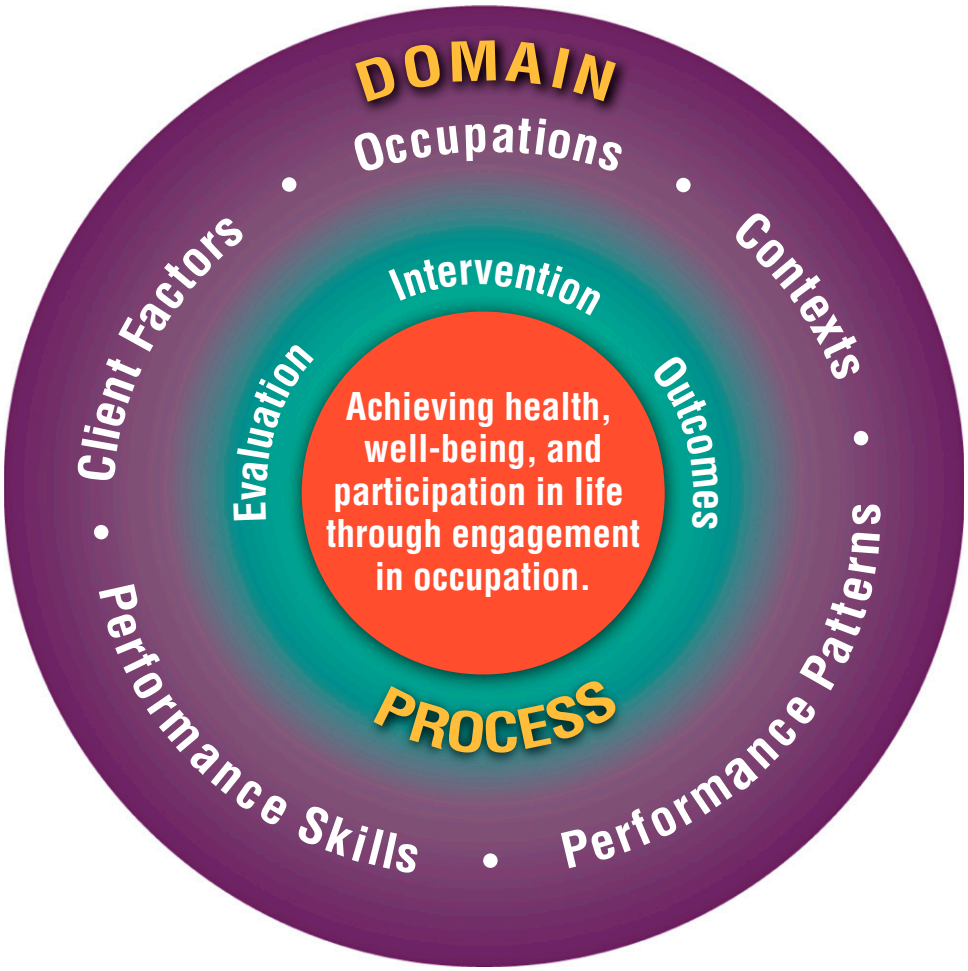
> A core philosophical assumption of the profession, therefore, is that by virtue of our biological endowment, people of all ages and abilities require occupation to grow and thrive; in pursuing occupation, humans express the totality of their being, a mind–body–spirit union. Because human existence could not otherwise be, humankind is, in essence, occupational by nature. (p. 46)

Occupational science is important to the practice of occupational therapy and "provides a way of thinking that enables an understanding of occupation, the occupational nature of humans, the relationship between occupation, health and well-being, and the influences that shape occupation" (WFOT, 2012b, p. 2). Many of its concepts are emphasized throughout the *OTPF–4,* including occupational justice and injustice, identity, time use, satisfaction, engagement, and performance.

OTPF *Organization*

The *OTPF–4* is divided into two major sections: (1) the *domain,* which outlines the profession's purview and the areas in which its members have an established body of knowledge and expertise, and (2) the *process,* which describes the actions practitioners take when providing services that are client centered and focused on engagement in occupations. The profession's understanding of the domain and process of occupational therapy guides practitioners as they seek to support clients' participation in daily living, which results from the dynamic intersection of clients, their desired engagements, and their contexts (including environmental and personal factors;

Figure 1. Occupational Therapy Domain and Process



Christiansen & Baum, 1997; Christiansen et al., 2005; Law et al., 2005).

"Achieving health, well-being, and participation in life through engagement in occupation" is the overarching statement that describes the domain and process of occupational therapy in its fullest sense. This statement acknowledges the profession's belief that active engagement in occupation promotes, facilitates, supports, and maintains health and participation. These interrelated concepts include

- *Health*—"a state of complete physical, mental, and social well-being, and not merely the absence of disease or infirmity" (WHO, 2006, p. 1).
- *Well-being*—"a general term encompassing the total universe of human life domains, including physical, mental, and social aspects, that make up what can be called a 'good life'" (WHO, 2006, p. 211).
- *Participation*—"involvement in a life situation" (WHO, 2008, p. 10). Participation occurs naturally when clients are actively involved in carrying out occupations or daily life activities they find purposeful and meaningful. More specific outcomes of occupational therapy intervention are multidimensional and support the end result of participation.
- *Engagement in occupation*—performance of occupations as the result of choice, motivation, and meaning within a supportive context (including

environmental and personal factors). Engagement includes objective and subjective aspects of clients' experiences and involves the transactional interaction of the mind, body, and spirit. Occupational therapy intervention focuses on creating or facilitating opportunities to engage in occupations that lead to participation in desired life situations (AOTA, 2008).

Although the domain and process are described separately, in actuality they are linked inextricably in a transactional relationship. The aspects that constitute the domain and those that constitute the process exist in constant interaction with one another during the delivery of occupational therapy services. Figure 1 represents aspects of the domain and process and the overarching goal of the profession as achieving health, well-being, and participation in life through engagement in occupation. Although the figure illustrates these two elements in distinct spaces, in reality the domain and process interact in complex and dynamic ways as described throughout this document. The nature of the interactions is impossible to capture in a static one-dimensional image.

Cornerstones of Occupational Therapy Practice

The transactional relationship between the domain and process is facilitated by the occupational therapy practitioner. Occupational therapy practitioners have distinct knowledge, skills, and qualities that contribute to the success of the occupational therapy process, described in this document as "cornerstones." A *cornerstone* can be defined as something of great importance on which everything else depends ("Cornerstone," n.d.), and the following cornerstones of occupational therapy help distinguish it from other professions:

- Core values and beliefs rooted in occupation (Cohn, 2019; Hinojosa et al., 2017)
- Knowledge of and expertise in the therapeutic use of occupation (Gillen, 2013; Gillen et al., 2019)
- Professional behaviors and dispositions (AOTA 2015a, 2015c)
- Therapeutic use of self (AOTA, 2015c; Taylor, 2020).

These cornerstones are not hierarchical; instead, each concept influences the others.

Occupational therapy cornerstones provide a fundamental foundation for practitioners from which to view clients and their occupations and facilitate the occupational therapy process. Practitioners develop the cornerstones over time through education, mentorship, and experience. In addition, the cornerstones are ever evolving, reflecting developments in occupational therapy practice and occupational science.

Many contributors influence each cornerstone. Like the cornerstones, the contributors are complementary and interact to provide a foundation for practitioners. The contributors include, but are not limited to, the following:

- Client-centered practice
- Clinical and professional reasoning
- Competencies for practice
- Cultural humility
- Ethics
- Evidence-informed practice
- Inter- and intraprofessional collaborations
- Leadership
- Lifelong learning
- Micro and macro systems knowledge
- Occupation-based practice
- Professionalism
- Professional advocacy
- Self-advocacy
- Self-reflection
- Theory-based practice.

Domain

Exhibit 1 identifies the aspects of the occupational therapy domain: occupations, contexts, performance patterns, performance skills, and client factors. All aspects of the domain have a dynamic interrelatedness. All aspects are of equal value and together interact to affect occupational identity, health, well-being, and participation in life.

Occupational therapists are skilled in evaluating all aspects of the domain, the interrelationships among the aspects, and the client within context. Occupational therapy practitioners recognize the importance and

Exhibit 1. Aspects of the Occupational Therapy Domain
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

impact of the mind–body–spirit connection on engagement and participation in daily life. Knowledge of the transactional relationship and the significance of meaningful and productive occupations forms the basis for the use of occupations as both the means and the ends of interventions (Trombly, 1995). This knowledge sets occupational therapy apart as a distinct and valuable service (Hildenbrand & Lamb, 2013) for which a focus on the whole is considered stronger than a focus on isolated aspects of human functioning.

The discussion that follows provides a brief explanation of each aspect of the domain. Tables included at the end of the document provide additional descriptions and definitions of terms.

Occupations

Occupations are central to a client's (person's, group's, or population's) health, identity, and sense of competence and have particular meaning and value to that client. "In occupational therapy, *occupations* refer to the everyday activities that people do as individuals, in families, and with communities to occupy time and bring meaning and purpose to life. Occupations include things people need to, want to and are expected to do" (WFOT, 2012a, para. 2).

In the *OTPF–4,* the term *occupation* denotes personalized and meaningful engagement in daily life events by a specific client. Conversely, the term *activity* denotes a form of action that is objective and not related to a specific client's engagement or context (Schell et al., 2019) and, therefore, can be selected and designed to enhance occupational engagement by supporting the development of performance skills and performance patterns. Both occupations and activities are used as interventions by practitioners. For example, a practitioner may use the activity of chopping vegetables during an intervention to address fine motor skills with the ultimate goal of improving motor skills for the occupation of preparing a favorite meal. Participation in occupations is considered both the means and the end in the occupational therapy process.

Occupations occur in contexts and are influenced by the interplay among performance patterns, performance skills, and client factors. Occupations occur over time; have purpose, meaning, and perceived utility to the client; and can be observed by others (e.g., preparing a meal) or be known only to the person involved (e.g., learning through reading a textbook). Occupations can involve the execution of multiple activities for completion and can result in various outcomes.

The *OTPF–4* identifies a broad range of occupations categorized as activities of daily living (ADLs), instrumental activities of daily living (IADLs), health management, rest and sleep, education, work, play, leisure, and social participation (Table 2). Within each of these nine broad categories of occupation are many specific occupations. For example, the broad category of IADLs has specific

occupations that include grocery shopping and money management.

When occupational therapy practitioners work with clients, they identify the types of occupations clients engage in individually or with others. Differences among clients and the occupations they engage in are complex and multidimensional. The client's perspective on how an occupation is categorized varies depending on that client's needs, interests, and contexts. Moreover, values attached to occupations are dependent on cultural and sociopolitical determinants (Wilcock & Townsend, 2019). For example, one person may perceive gardening as leisure, whereas another person, who relies on the food produced from that garden to feed their family or community, may perceive it as work. Additional examples of occupations for persons, groups, and populations can be found in Table 3.

The ways in which clients prioritize engagement in selected occupations may vary at different times. For example, clients in a community psychiatric rehabilitation setting may prioritize registering to vote during an election season and food preparation during holidays. The unique features of occupations are noted and analyzed by occupational therapy practitioners, who consider all components of the engagement and use them effectively as both a therapeutic tool and a way to achieve the targeted outcomes of intervention.

The extent to which a client is engaged in a particular occupation is also important. Occupational therapy practitioners assess the client's ability to engage in *occupational performance,* defined as the accomplishment of the selected occupation resulting from the dynamic transaction among the client, their contexts, and the occupation. Occupations can contribute to a well-balanced and fully functional lifestyle or to a lifestyle that is out of balance and characterized by occupational dysfunction. For example, excessive work without sufficient regard for other aspects of life, such as sleep or relationships, places clients at risk for health problems. External factors, including war, natural disasters, or extreme poverty, may hinder a client's ability to create balance or engage in certain occupations (AOTA, 2017b; McElroy et al., 2012).

Because occupational performance does not exist in a vacuum, context must always be considered. For example, for a client who lives in food desert, lack of access to a grocery store may limit their ability to have balance in their performance of IADLs such as cooking and grocery shopping or to follow medical advice from health care professionals on health management and preparation of nutritious meals. For this client, the limitation is not caused by impaired client factors or performance skills but rather is shaped by the context in which the client functions. This context may include policies that resulted in the decline of commercial properties in the area, a socioeconomic status that does not enable the client to live in an area with access to a grocery store, and a social environment in which lack of access to fresh food is weighed as less important than the social supports the community provides.

Occupational therapy practitioners recognize that health is supported and maintained when clients are able to engage in home, school, workplace, and community life. Thus, practitioners are concerned not only with occupations but also with the variety of factors that disrupt or empower those occupations and influence clients' engagement and participation in positive health-promoting occupations (Wilcock & Townsend, 2019).

Although engagement in occupations is generally considered a positive outcome of the occupational therapy process, it is important to consider that a client's history might include negative, traumatic, or unhealthy occupational participation (Robinson Johnson & Dickie, 2019). For example, a person who has experienced a traumatic sexual encounter might negatively perceive and react to engagement in sexual intimacy. A person with an eating disorder might engage in eating in a maladaptive way, deterring health management and physical health.

In addition, some occupations that are meaningful to a client might also hinder performance in other occupations or negatively affect health. For example, a person who spends a disproportionate amount of time playing video games may develop a repetitive stress injury and may have less balance in their time spent on IADLs and other forms of social participation. A client engaging in the recreational use of prescription pain medications may experience barriers to participation in previously

important occupations such as work or spending time with family.

Occupations have the capacity to support or promote other occupations. For example, children engage in play to develop the performance skills that later facilitate engagement in leisure and work. Adults may engage in social participation and leisure with an intimate partner that may improve satisfaction with sexual activity. The goal of engagement in sleep and health management includes maintaining or improving performance of work, leisure, social participation, and other occupations.

Occupations are often shared and done with others. Those that implicitly involve two or more individuals are termed *co-occupations* (Zemke & Clark, 1996). Co-occupations are the most interactive of all social occupations. Central to the concept of co-occupation is that two or more individuals share a high level of physicality, emotionality, and intentionality (Pickens & Pizur-Barnekow, 2009). In addition, co-occupations can be parallel (different occupations in close proximity to others; e.g., reading while others listen to music when relaxing at home) and shared (same occupation but different activities; e.g., preparing different dishes for a meal; Zemke & Clark, 1996).

Caregiving is a co-occupation that requires active participation by both the caregiver and the recipient of care. For the co-occupations required during parenting, the socially interactive routines of eating, feeding, and comforting may involve the parent, a partner, the child, and significant others (Olson, 2004). The specific occupations inherent in this social interaction are reciprocal, interactive, and nested (Dunlea, 1996; Esdaile & Olson, 2004). Consideration of co-occupations by practitioners supports an integrated view of the client's engagement in the context of relationship to significant others.

Occupational participation can be considered independent whether it occurs individually or with others. It is important to acknowledge that clients can be independent in living regardless of the amount of assistance they receive while completing occupations. Clients may be considered independent even when they direct others (e.g., caregivers) in performing the actions necessary to participate, regardless of the amount or kind of assistance required, if clients are satisfied with their performance. In contrast to definitions of independence that imply direct physical interaction with the environment or objects within the environment, occupational therapy practitioners consider clients to be independent whether they perform the specific occupations by themselves, in an adapted or modified environment, with the use of various devices or alternative strategies, or while overseeing activity completion by others (AOTA, 2002b). For example, a person with spinal cord injury who directs a personal care assistant to assist them with ADLs is demonstrating independence in this essential aspect of their life.

It is also important to acknowledge that not all clients view success as independence. *Interdependence,* or co-occupational performance, can also be an indicator of personal success. How a client views success may be influenced by their client factors, including their culture.

Contexts

Context is a broad construct defined as the environmental and personal factors specific to each client (person, group, population) that influence engagement and participation in occupations. Context affects clients' access to occupations and the quality of and satisfaction with performance (WHO, 2008). Practitioners recognize that for people to truly achieve full participation, meaning, and purpose, they must not only function but also engage comfortably within their own distinct combination of contexts.

In the literature, the terms *environment* and *context* often are used interchangeably, but this may result in confusion when describing aspects of situations in which occupational engagement takes place. Understanding the contexts in which occupations can and do occur provides practitioners with insights into the overarching, underlying, and embedded influences of environmental factors and personal factors on engagement in occupations.

Environmental Factors

Environmental factors are aspects of the physical, social, and attitudinal surroundings in which people live and

conduct their lives (Table 4). Environmental factors influence functioning and disability and have positive aspects (facilitators) or negative aspects (barriers or hindrances; WHO, 2008). Environmental factors include

- *Natural environment and human-made changes to the environment:* Animate and inanimate elements of the natural or physical environment and components of that environment that have been modified by people, as well as characteristics of human populations within that environment. Engagement in human occupation influences the sustainability of the natural environment, and changes to human behavior can have a positive impact on the environment (Dennis et al., 2015).
- *Products and technology:* Natural or human-made products or systems of products, equipment, and technology that are gathered, created, produced, or manufactured.
- *Support and relationships:* People or animals that provide practical physical or emotional support, nurturing, protection, assistance, and connections to other persons in the home, workplace, or school or at play or in other aspects of daily occupations.
- *Attitudes:* Observable evidence of customs, practices, ideologies, values, norms, factual beliefs, and religious beliefs held by people other than the client.
- *Services, systems, and policies:* Benefits, structured programs, and regulations for operations provided by institutions in various sectors of society designed to meet the needs of persons, groups, and populations.

When people interact with the world around them, environmental factors can either enable or restrict participation in meaningful occupations and can present barriers to or supports and resources for service delivery. Examples of environmental barriers that restrict participation include the following:

- For persons, doorway widths that do not allow for wheelchair passage
- For groups, absence of healthy social opportunities for those abstaining from alcohol use
- For populations, businesses that are not welcoming to people who identify as LGBTQ+. (*Note:* In this document, *LGBTQ+* is used to represent the large and diverse communities and individuals with nonmajority sexual orientations and gender identities.)

Addressing these barriers, such as by widening a doorway to allow access, results in environmental supports that enable participation. A client who has difficulty performing effectively in one context may be successful when the natural environment has human-made modifications or if the client uses applicable products and technology. In addition, occupational therapy practitioners must be aware of norms related to, for example, eating or deference to medical professionals when working with someone from a culture or socioeconomic status that differs from their own.

Personal Factors

Personal factors are the unique features of a person that are not part of a health condition or health state and that constitute the particular background of the person's life and living (Table 5). Personal factors are internal influences affecting functioning and disability and are not considered positive or negative but rather reflect the essence of the person—"who they are." When clients provide demographic information, they are typically describing personal factors. Personal factors also include customs, beliefs, activity patterns, behavioral standards, and expectations accepted by the society or cultural group of which a person is a member.

Personal factors are generally considered to be enduring, stable attributes of the person, although some personal factors change over time. They include, but are not limited to, the following:

- Chronological age
- Sexual orientation (sexual preference, sexual identity)
- Gender identity
- Race and ethnicity
- Cultural identification and attitudes

- Social background, social status, and socioeconomic status
- Upbringing and life experiences
- Habits and past and current behavioral patterns
- Psychological assets, temperament, unique character traits, and coping styles
- Education
- Profession and professional identity
- Lifestyle
- Health conditions and fitness status (that may affect the person's occupations but are not the primary concern of the occupational therapy encounter).

For example, siblings share personal factors of race and age, yet for those separated at birth, environmental differences may result in divergent personal factors in terms of cultural identification, upbringing, and life experiences, producing different contexts for their individual occupational engagement. Whether separated or raised together, as siblings move through life, they may develop differences in sexual orientation, life experience, habits, education, profession, and lifestyle.

Groups and populations are often formed or identified on the basis of shared or similar personal factors that make possible occupational therapy assessment and intervention. Of course, individual members of a group or population differ in other personal factors. For example, a group of fifth graders in a community public school are likely to share age and, perhaps, socioeconomic status. Yet race, fitness, habits, and coping styles make each group member unlike the others. Similarly, a population of older adults living in an urban low-income housing community may have few personal factors in common other than age and current socioeconomic status.

Application of Context to Occupational Justice

Interwoven throughout the concept of context is that of *occupational justice,* defined as "a justice that recognizes occupational rights to inclusive participation in everyday occupations for all persons in society, regardless of age, ability, gender, social class, or other differences" (Nilsson & Townsend, 2010, p. 58). Occupational therapy's focus on engagement in occupations and occupational justice complements WHO's (2008) perspective on health. To broaden the understanding of the effects of disease and disability on health, WHO emphasized that health can be affected by the inability to carry out occupations and activities and participate in life situations caused by contextual barriers and by problems that exist in body structures and body functions. The *OTPF–4* identifies occupational justice as both an aspect of contexts and an outcome of intervention.

Occupational justice involves the concern that occupational therapy practitioners have with respect, fairness, and impartiality and equitable opportunities when considering the contexts of persons, groups, and populations (AOTA, 2015a). As part of the occupational therapy domain, practitioners consider how these aspects can affect the implementation of occupational therapy and the target outcome of participation. Practitioners recognize that for individuals to truly achieve full participation, meaning, and purpose, they must not only function but also engage comfortably within their own distinct combination of contexts (both environmental factors and personal factors).

Examples of contexts that can present occupational justice issues include the following:

- An alternative school placement for children with mental health and behavioral disabilities that provides academic support and counseling but limited opportunities for participation in sports, music programs, and organized social activities
- A residential facility for older adults that offers safety and medical support but provides little opportunity for engagement in the role-related occupations that were once a source of meaning
- A community that lacks accessible and inclusive physical environments and provides limited services and supports, making participation difficult or even dangerous for people who have disabilities (e.g., lack of screening facilities and services resulting in higher rates of breast cancer among community members)
- A community that lacks financial and other necessary resources, resulting in an adverse and

disproportionate impact of natural disasters and severe weather events on vulnerable populations.

Occupational therapy practitioners recognize areas of occupational injustice and work to support policies, actions, and laws that allow people to engage in occupations that provide purpose and meaning in their lives. By understanding and addressing the specific justice issues in contexts such as an individual's home, a group's shared job site, or a population's community center, practitioners promote occupational therapy outcomes that address empowerment and self-advocacy.

Performance Patterns

Performance patterns are the acquired habits, routines, roles, and rituals used in the process of engaging consistently in occupations and can support or hinder occupational performance (Table 6). Performance patterns help establish lifestyles (Uyeshiro Simon & Collins, 2017) and occupational balance (e.g., proportion of time spent in productive, restorative, and leisure occupations; Eklund et al., 2017; Wagman et al., 2015) and are shaped, in part, by context (e.g., consistency, work hours, social calendars) and cultural norms (Eklund et al., 2017; Larson & Zemke, 2003).

Time provides an organizational structure or rhythm for performance patterns (Larson & Zemke, 2003); for example, an adult goes to work every morning, a child completes homework every day after school, or an organization hosts a fundraiser every spring. The manner in which people think about and use time is influenced by biological rhythms (e.g., sleep–wake cycles), family of origin (e.g., amount of time a person is socialized to believe should be spent in productive occupations), work and social schedules (e.g., religious services held on the same day each week), and cyclic cultural patterns (e.g., birthday celebration with cake every year, annual cultural festival; Larson & Zemke, 2003). Other temporal factors influencing performance patterns are time management and time use. *Time management* is the manner in which a person, group, or population organizes, schedules, and prioritizes certain activities (Uyeshiro Simon & Collins, 2017). *Time use* is the manner in which a person manages their activity levels; adapts to changes in routines; and organizes their days, weeks, and years (Edgelow & Krupa, 2011).

Habits are specific, automatic adaptive or maladaptive behaviors. Habits may be healthy or unhealthy (e.g., exercising on a daily basis vs. smoking during every lunch break), efficient or inefficient (e.g., completing homework after school vs. in the few minutes before the school bus arrives), and supportive or harmful (e.g., setting an alarm clock before going to bed vs. not doing so; Clark, 2000; Dunn, 2000; Matuska & Barrett, 2019).

Routines are established sequences of occupations or activities that provide a structure for daily life; they can also promote or damage health (Fiese, 2007; Koome et al., 2012; Segal, 2004). Shared routines involve two or more people and take place in a similar manner regardless of the individuals involved (e.g., routines shared by parents to promote the health of their children; routines shared by coworkers to sort the mail; Primeau, 2000). Shared routines can be nested in co-occupations. For example, a young child's occupation of completing oral hygiene with the assistance of an adult is a part of the child's daily routine, and the adult who provides the assistance may also view helping the young child with oral hygiene as a part of the adult's own daily routine.

Roles have historically been defined as sets of behaviors expected by society and shaped by culture and context; they may be further conceptualized and defined by a person, group, or population (Kielhofner, 2008; Taylor, 2017). Roles are an aspect of occupational identity—that is, they help define who a person, group, or population believes themselves to be on the basis of their occupational history and desires for the future. Certain roles are often associated with specific activities and occupations; for example, the role of parent is associated with feeding children (Kielhofner, 2008; Taylor, 2017). When exploring roles, occupational therapy practitioners consider the complexity of identity and the limitations associated with assigning stereotypical occupations to specific roles (e.g., on the basis of gender). Practitioners also consider how clients construct their occupations and establish efficient and supportive habits and routines to achieve health outcomes, fulfill their perceived roles and

identity, and determine whether their roles reinforce their values and beliefs.

Rituals are symbolic actions with spiritual, cultural, or social meaning. Rituals contribute to a client's identity and reinforce the client's values and beliefs (Fiese, 2007; Segal, 2004). Some rituals (e.g., those associated with certain holidays) are associated with different seasons or times of the year (e.g., New Year's Eve, Independence Day), whereas others are associated with times of the day or days of the week (e.g., daily prayers, weekly family dinners).

Performance patterns are influenced by all other aspects of the occupational therapy domain and develop over time. Occupational therapy practitioners who consider clients' past and present behavioral and performance patterns are better able to understand the frequency and manner in which performance skills and healthy and unhealthy occupations are, or have been, integrated into clients' lives. Although clients may have the ability to engage in skilled performance, if they do not embed essential skills in a productive set of engagement patterns, their health, well-being, and participation may be negatively affected. For example, a person may have skills associated with proficient health literacy but not embed them into consistent routines (e.g., a dietitian who consistently chooses to eat fast food rather than prepare a healthy meal) or struggle with modifying daily performance patterns to access health systems effectively (e.g., a nurse who struggles to modify work hours to get a routine mammogram).

Performance Skills

Performance skills are observable, goal-directed actions and consist of motor skills, process skills, and social interaction skills (Fisher & Griswold, 2019; Table 7). The occupational therapist evaluates and analyzes performance skills during actual performance to understand a client's ability to perform an activity (i.e., smaller aspect of the larger occupation) in natural contexts (Fisher & Marterella, 2019). This evaluation requires analysis of the quality of the individual actions (performance skills) during actual performance. Regardless of the client population, the performance skills defined in this document are universal and provide the foundation for understanding performance (Fisher & Marterella, 2019).

Performance skills can be analyzed for all occupations with clients of any age and level of ability, regardless of the setting in which occupational therapy services are provided (Fisher & Marterella, 2019). Motor and process skills are seen during performance of an activity that involves the use of tangible objects, and social interaction skills are seen in any situation in which a person is interacting with others:

- *Motor skills* refer to how effectively a person moves self or interacts with objects, including positioning the body, obtaining and holding objects, moving self and objects, and sustaining performance.
- *Process skills* refer to how effectively a person organizes objects, time, and space, including sustaining performance, applying knowledge, organizing timing, organizing space and objects, and adapting performance.
- *Social interaction skills* refer to how effectively a person uses both verbal and nonverbal skills to communicate, including initiating and terminating, producing, physically supporting, shaping content of, maintaining flow of, verbally supporting, and adapting social interaction.

For example, when a client catches a ball, the practitioner can analyze how effectively they bend and reach for and then grasp the ball (motor skills). When a client cooks a meal, the practitioner can analyze how effectively they initiate and sequence the steps to complete the recipe in a logical order to prepare the meal in a timely and well-organized manner (process skills). Or when a client interacts with a friend at work, the practitioner can analyze the manner in which the client smiles, gestures, turns toward the friend, and responds to questions (social interaction skills). In these examples, many other motor skills, process skills, and social interaction skills are also used by the client.

By analyzing the client's performance within an occupation at the level of performance skills, the occupational therapist identifies effective and ineffective use of skills (Fisher & Marterella, 2019). The result of this

analysis indicates not only whether the person is able to complete an activity safely and independently but also the amount of physical effort and efficiency the client demonstrates in activities.

After the quality of occupational performance skills has been analyzed, the practitioner speculates about the reasons for decreased quality of occupational performance and determines the need to evaluate potential underlying causes (e.g., occupational demands, environmental factors, client factors; Fisher & Griswold, 2019). Performance skills are different from client factors (see the "Client Factors" section that follows), which include values, beliefs, and spirituality and body structures and functions (e.g., memory, strength) that reside within the person. Occupational therapy practitioners analyze performance skills as a client performs an activity, whereas client factors cannot be directly viewed during the performance of occupations. For example, the occupational therapy practitioner cannot directly view the client factors of cognitive ability or memory when a client is engaged in cooking but rather notes ineffective use of performance skills when the person hesitates to start a step or performs steps in an illogical order. The practitioner may then infer that a possible reason for the client's hesitation may be diminished memory and elect to further assess the client factor of cognition.

Similarly, context influences the quality of a client's occupational performance. After analyzing the client's performance skills while completing an activity, the practitioner can hypothesize how the client factors and context might have influenced the client's performance. Thus, client factors and contexts converge and may support or limit a person's quality of occupational performance.

Application of Performance Skills With Persons

When completing the analysis of occupational performance (described in the "Evaluation" section later in this document), the practitioner analyzes the client's challenges in performance and generates a hypothesis about gaps between current performance and effective performance and the need for occupational therapy services. To plan appropriate interventions, the practitioner considers the underlying reasons for the gaps, which may involve performance skills, performance patterns, and client factors. The hypothesis is generated on the basis of what the practitioner analyzes when the client is actually performing occupations.

Regardless of the client population, the universal performance skills defined in this section provide the foundations for understanding performance (Fisher & Marterella, 2019). The following example crosses many client populations. The practitioner observes as a client rushes through the steps of an activity toward completion. On the basis of what the client does, the practitioner may interpret this rushing as resulting from a lack of impulse control. This limitation may be seen in clients living with anxiety, attention deficit hyperactivity disorder, dementia, traumatic brain injury, and other clinical conditions. The behavior of rushing may be captured in motor performance skills of *manipulates, coordinates,* or *calibrates;* in process performance skills of *paces, initiates, continues,* or *organizes;* or in social interaction performance skills of *takes turn, transitions, times response,* or *times duration*. Understanding the client's specific occupational challenges enables the practitioner to determine the suitable intervention to address impulsivity to facilitate greater occupational performance. Clinical interventions then address the skills required for the client's specific occupational demands on the basis of their alignment with the universal performance skills (Fisher & Marterella, 2019). Thus, the application of universal performance skills guides practitioners in developing the intervention plan for specific clients to address the specific concerns occurring in the specific practice setting.

Application of Performance Skills With Groups

Analysis of performance skills is always focused on individuals (Fisher & Marterella, 2019). Thus, when analyzing performance skills with a group client, the occupational therapist always focuses on one individual at a time (Table 8). The therapist may choose to analyze some or all members of the group engaging in relevant group occupations over time as the group members contribute to the collective actions of the group.

If all members demonstrate effective performance skills, then the group client may achieve its collective outcomes. If one or more group members demonstrate ineffective performance skills, the collective outcomes may be diminished. Only in cases in which group members demonstrate ongoing limitations in performance skills that hinder the collective outcomes of the group would the practitioner recommend interventions for individual group members. Interventions would then be directed at those members demonstrating diminished performance skills to facilitate their contributions to the collective group outcomes.

Application of Performance Skills With Populations

Using an occupation-based approach to population health, occupational therapy addresses the needs of populations by enhancing occupational performance and participation for communities of people (see "Service Delivery" in the "Process" section). Service delivery to populations focuses on aggregates of people rather than on intervention for persons or groups; thus, it is not relevant to analyze performance skills at the person level in service delivery to populations.

Client Factors

Client factors are specific capacities, characteristics, or beliefs that reside within the person, group, or population and influence performance in occupations (Table 9). Client factors are affected by the presence or absence of illness, disease, deprivation, and disability, as well as by life stages and experiences. These factors can affect performance skills (e.g., a client may have weakness in the right arm [a client factor], affecting their ability to manipulate a button [a motor and process skill] to button a shirt; a child in a classroom may be nearsighted [a client factor], affecting their ability to copy from a chalkboard [a motor and process skill]).

In addition, client factors are affected by occupations, contexts, performance patterns, and performance skills. For example, a client in a controlled and calm environment might be able to problem solve to complete an occupation or activity, but when they are in a louder, more chaotic environment, their ability to process and plan may be adversely affected. It is through this interactive relationship that occupations and interventions to support occupations can be used to address client factors and vice versa.

Values, beliefs, and spirituality influence clients' motivation to engage in occupations and give their life or existence meaning. *Values* are principles, standards, or qualities considered worthwhile by the client who holds them. A *belief* is "something that is accepted, considered to be true, or held as an opinion" ("Belief," 2020). *Spirituality* is "a deep experience of meaning brought about by engaging in occupations that involve the enacting of personal values and beliefs, reflection, and intention within a supportive contextual environment" (Billock, 2005, p. 887). It is important to recognize spirituality "as dynamic and often evolving" (Humbert, 2016, p. 12).

Body functions and *body structures* refer to the "physiological function of body systems (including psychological functions) and anatomical parts of the body such as organs, limbs, and their components," respectively (WHO, 2008, p. 10). Examples of body functions include sensory, musculoskeletal, mental (affective, cognitive, perceptual), cardiovascular, respiratory, and endocrine functions. Examples of body structures include the heart and blood vessels that support cardiovascular function. Body structures and body functions are interrelated, and occupational therapy practitioners consider them when seeking to promote clients' ability to engage in desired occupations.

Occupational therapy practitioners understand that the presence, absence, or limitation of specific body functions and body structures does not necessarily determine a client's success or difficulty with daily life occupations. Occupational performance and client factors may benefit from supports in the physical, social, or attitudinal contexts that enhance or allow participation. It is through the process of assessing clients as they engage in occupations that practitioners are able to determine the transaction between client factors and performance skills; to create adaptations, modifications, and remediation; and to select occupation-based interventions that best promote enhanced participation.

Exhibit 2. 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. • Consider potential discharge needs and plans. • Make recommendations or referrals to other professionals as needed.

(Continued)

Exhibit 2. Operationalizing the Occupational Therapy Process *(cont'd)*

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 their properties: ◦ 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).

Client factors can also be understood as pertaining to group and population clients and may be used to help define the group or population. Although client factors may be described differently when applied to a group or population, the underlying principles do not change substantively. Client factors of a group or population are explored by performing needs assessments, and interventions might include program development and strategic planning to help the members engage in occupations.

Process

This section operationalizes the process undertaken by occupational therapy practitioners when providing services to clients. Exhibit 2 summarizes the aspects of the occupational therapy process.

The *occupational therapy process* is the client-centered delivery of occupational therapy services. The three-part process includes (1) evaluation and (2) intervention to achieve (3) targeted outcomes and occurs within the purview of the occupational therapy domain (Table 10). The process is facilitated by the distinct perspective of occupational therapy practitioners engaging in professional reasoning, analyzing occupations and activities, and collaborating with clients. The cornerstones of occupational therapy practice underpin the process of service delivery.

Overview of the Occupational Therapy Process

Many professions use a similar process of evaluating, intervening, and targeting outcomes. However, only occupational therapy practitioners focus on the therapeutic use of occupations to promote health, well-

being, and participation in life. Practitioners use professional reasoning to select occupations as primary methods of intervention throughout the process. To help clients achieve desired outcomes, practitioners facilitate interactions among the clients, their contexts, and the occupations in which they engage. This perspective is based on the theories, knowledge, and skills generated and used by the profession and informed by available evidence.

Analyzing occupational performance requires an understanding of the complex and dynamic interaction among the demands of the occupation and the client's contexts, performance patterns, performance skills, and client factors. Occupational therapy practitioners fully consider each aspect of the domain and gauge the influence of each on the others, individually and collectively. By understanding how these aspects influence one another, practitioners can better evaluate how each aspect contributes to clients' participation and performance-related concerns and potentially to interventions that support occupational performance and participation.

The occupational therapy process is fluid and dynamic, allowing practitioners and clients to maintain their focus on the identified outcomes while continually reflecting on and changing the overall plan to accommodate new developments and insights along the way, including information gained from inter- and intraprofessional collaborations. The process may be influenced by the context of service delivery (e.g., setting, payer requirements); however, the primary focus is always on occupation.

Service Delivery Approaches

Various service delivery approaches are used when providing skilled occupational therapy services, of which intra- and interprofessional collaborations are a key component. It is imperative to communicate with all relevant providers and stakeholders to ensure a collaborative approach to the occupational therapy process. These providers and stakeholders can be within the profession (e.g., occupational therapist and occupational therapy assistant collaborating to work with a student in a school, a group of practitioners collaborating to develop community-based mental health programming in their region) or outside the profession (e.g., a team of rehabilitation and medical professionals on an inpatient hospital unit; a group of employees, human resources staff, and health and safety professionals in a large organization working with an occupational therapy practitioner on workplace wellness initiatives).

Regardless of the service delivery approach, the individual client may not be the exclusive focus of the occupational therapy process. For example, the needs of an at-risk infant may be the initial impetus for intervention, but the concerns and priorities of the parents, extended family, and funding agencies are also considered. Occupational therapy practitioners understand and focus intervention to include the issues and concerns surrounding the complex dynamics among the client, caregiver, family, and community. Similarly, services addressing independent living skills for adults coping with serious mental illness or chronic health conditions may also address the needs and expectations of state and local service agencies and of potential employers.

Direct Services. Services are provided directly to clients using a collaborative approach in settings such as hospitals, clinics, industry, schools, homes, and communities. Direct services include interventions completed when in direct contact with the client through various mechanisms such as meeting in person, leading a group session, and interacting with clients and families through telehealth systems (AOTA, 2018c).

Examples of person-level direct service delivery include working with an adult on an inpatient rehabilitation unit, working with a child in the classroom while collaborating with the teacher to address identified goals, and working with an adolescent in an outpatient setting. Direct group interventions include working with a cooking group in a skilled nursing facility, working with an outpatient feeding group, and working with a handwriting group in a school. Examples of population-level direct services include implementing a large-scale healthy lifestyle or safe driver initiative in the community and

delivering a training program for brain injury treatment facilities regarding safely accessing public transportation. An occupational therapy approach to population health focuses on aggregates or communities of people and the many factors that influence their health and well-being: "Occupational therapy practitioners develop and implement occupation-based health approaches to enhance occupational performance and participation, [quality of life], and occupational justice for populations" (AOTA, 2020b, p. 3).

Indirect Services. When providing services to clients indirectly on their behalf, occupational therapy practitioners provide consultation to entities such as teachers, multidisciplinary teams, and community planning agencies. For example, a practitioner may consult with a group of elementary school teachers and administrators about opportunities for play during recess to promote health and well-being. A practitioner may also provide consultation on inclusive design to a park district or civic organization to address how the built and natural environments can support occupational performance and engagement. In addition, a practitioner may consult with a business regarding the work environment, ergonomic modifications, and compliance with the Americans With Disabilities Act of 1990 (Pub. L. 101-336).

Occupational therapy practitioners can advocate indirectly on behalf of their clients at the person, group, and population levels to ensure their occupational needs are met. For example, an occupational therapy practitioner may advocate for funding to support the costs of training a service animal for an individual client. A practitioner working with a group client may advocate for meeting space in the community for a peer support group of transgender youth. Examples of population-level advocacy include talking with legislators about improving transportation for older adults, developing services for people with disabilities to support their living and working in the community of their choice, establishing meaningful civic engagement opportunities for underserved youth, and assisting in the development of policies that address inequities in access to health care.

Additional Approaches. Occupational therapy practitioners use additional approaches that may also be classified as direct or indirect for persons, groups, and populations. Examples include, but are not limited to, case management (AOTA, 2018b), telehealth (AOTA, 2018c), episodic care (Centers for Medicare & Medicaid Services, 2019), and family-centered care approaches (Hanna & Rodger, 2002).

Practice Within Organizations and Systems

Organization- or systems-level practice is a valid and important part of occupational therapy for several reasons. First, organizations serve as a mechanism through which occupational therapy practitioners provide interventions to support participation of people who are members of or served by the organization (e.g., falls prevention programming in a skilled nursing facility, ergonomic changes to an assembly line to reduce musculoskeletal disorders). Second, organizations support occupational therapy practice and practitioners as stakeholders in carrying out the mission of the organization. Practitioners have the responsibility to ensure that services provided to organizational stakeholders (e.g., third-party payers, employers) are of high quality and delivered in an ethical, efficient, and efficacious manner.

Finally, organizations employ occupational therapy practitioners in roles in which they use their knowledge of occupation and the profession of occupational therapy indirectly. For example, practitioners can serve in positions such as dean, administrator, and corporate leader (e.g., CEO, business owner). In these positions, practitioners support and enhance the organization but do not provide occupational therapy services in the traditional sense. Occupational therapy practitioners can also serve organizations in roles such as client advocate, program coordinator, transition manager, service or care coordinator, health and wellness coach, and community integration specialist.

Occupational and Activity Analysis

Occupational therapy practitioners are skilled in the analysis of occupations and activities and apply this important skill throughout the occupational therapy

process. Occupational analysis is performed with an understanding of "the specific situation of the client and therefore . . . the specific occupations the client wants or needs to do in the actual context in which these occupations are performed" (Schell et al., 2019, p. 322). In contrast, activity analysis is generic and decontextualized in its purpose and serves to develop an understanding of typical activity demands within a given culture. Many professions use activity analysis, whereas occupational analysis requires the understanding of occupation as distinct from activity and brings an occupational therapy perspective to the analysis process (Schell et al., 2019).

Occupational therapy practitioners analyze the demands of an occupation or activity to understand the performance patterns, performance skills, and client factors that are required to perform it (Table 11). Depending on the purpose of the analysis, the meaning ascribed to and the contexts for performance of and engagement in the occupation or activity are considered either from a client-specific subjective perspective (occupational analysis) or a general perspective within a given culture (activity analysis).

Therapeutic Use of Self

An integral part of the occupational therapy process is *therapeutic use of self,* in which occupational therapy practitioners develop and manage their therapeutic relationship with clients by using professional reasoning, empathy, and a client-centered, collaborative approach to service delivery (Taylor & Van Puymbrouck, 2013). Occupational therapy practitioners use professional reasoning to help clients make sense of the information they are receiving in the intervention process, discover meaning, and build hope (Taylor, 2019; Taylor & Van Puymbrouck, 2013). *Empathy* is the emotional exchange between occupational therapy practitioners and clients that allows more open communication, ensuring that practitioners connect with clients at an emotional level to assist them with their current life situation.

Practitioners develop a collaborative relationship with clients to understand their experiences and desires for intervention. The collaborative approach used throughout the process honors the contributions of clients along with practitioners. Through the use of interpersonal communication skills, practitioners shift the power of the relationship to allow clients more control in decision making and problem solving, which is essential to effective intervention. Clients have identified the therapeutic relationship as critical to the outcome of occupational therapy intervention (Cole & McLean, 2003).

Clients bring to the occupational therapy process their knowledge about their life experiences and their hopes and dreams for the future. They identify and share their needs and priorities. Occupational therapy practitioners must create an inclusive, supportive environment to enable clients to feel safe in expressing themselves authentically. To build an inclusive environment, practitioners can take actions such as pursuing education on gender-affirming care, acknowledging systemic issues affecting underrepresented groups, and using a lens of cultural humility throughout the occupational therapy process (AOTA, 2020c; Hammell, 2013).

Occupational therapy practitioners bring to the therapeutic relationship their knowledge about how engagement in occupation affects health, well-being, and participation; they use this information, coupled with theoretical perspectives and professional reasoning, to critically evaluate, analyze, describe, and interpret human performance. Practitioners and clients, together with caregivers, family members, community members, and other stakeholders (as appropriate), identify and prioritize the focus of the intervention plan.

Clinical and Professional Reasoning

Throughout the occupational therapy process, practitioners are continually engaged in clinical and professional reasoning about a client's occupational performance. The term *professional reasoning* is used throughout this document as a broad term to encompass reasoning that occurs in all settings (Schell, 2019). Professional reasoning enables practitioners to

- Identify the multiple demands, required skills, and potential meanings of the activities and occupations and
- Gain a deeper understanding of the interrelationships among aspects of the domain that affect performance and that support client-centered interventions and outcomes.

Occupational therapy practitioners use theoretical principles and models, knowledge about the effects of conditions on participation, and available evidence on the effectiveness of interventions to guide their reasoning. Professional reasoning ensures the accurate selection and application of client-centered evaluation methods, interventions, and outcome measures. Practitioners also apply their knowledge and skills to enhance clients' participation in occupations and promote their health and well-being regardless of the effects of disease, disability, and occupational disruption or deprivation.

Evaluation

The evaluation process is focused on finding out what the client wants and needs to do; determining what the client can do and has done; and identifying supports and barriers to health, well-being, and participation. Evaluation occurs during the initial and all subsequent interactions with a client. The type and focus of the evaluation differ depending on the practice setting; however, all evaluations should assess the complex and multifaceted needs of each client.

The evaluation consists of the occupational profile and the analysis of occupational performance, which are synthesized to inform the intervention plan (Hinojosa et al., 2014). Although it is the responsibility of the occupational therapist to initiate the evaluation process, both occupational therapists and occupational therapy assistants may contribute to the evaluation, following which the occupational therapist completes the analysis and synthesis of information for the development of the intervention plan (AOTA, 2020a). The occupational profile includes information about the client's needs, problems, and concerns about performance in occupations. The analysis of occupational performance focuses on collecting and interpreting information specifically to identify supports and barriers related to occupational performance and establish targeted outcomes.

Although the *OTPF–4* describes the components of the evaluation process separately and sequentially, the exact manner in which occupational therapy practitioners collect client information is influenced by client needs, practice settings, and frames of reference or practice models. The evaluation process for groups and populations mirrors that for individual clients.

In some settings, the occupational therapist first completes a screening or consultation to determine the appropriateness of a full occupational therapy evaluation (Hinojosa et al., 2014). This process may include

- Review of client history (e.g., medical, health, social, or academic records),
- Consultation with an interprofessional or referring team, and
- Use of standardized or structured screening instruments.

The screening or consultation process may result in the development of a brief occupational profile and recommendations for full occupational therapy evaluation and intervention (Hinojosa et al., 2014).

Occupational Profile

The *occupational profile* is a summary of a client's (person's, group's, or population's) occupational history and experiences, patterns of daily living, interests, values, needs, and relevant contexts (AOTA, 2017a). Developing the occupational profile provides the occupational therapy practitioner with an understanding of the client's perspective and background.

Using a client-centered approach, the occupational therapy practitioner gathers information to understand what is currently important and meaningful to the client (i.e., what the client wants and needs to do) and to identify past experiences and interests that may assist in the understanding of current issues and problems. During the process of collecting this information, the client, with the assistance of the practitioner, identifies priorities and desired

targeted outcomes that will lead to the client's engagement in occupations that support participation in daily life. Only clients can identify the occupations that give meaning to their lives and select the goals and priorities that are important to them. By valuing and respecting clients' input, practitioners help foster their involvement and can more effectively guide interventions.

Occupational therapy practitioners collect information for the occupational profile at the beginning of contact with clients to establish client-centered outcomes. Over time, practitioners collect additional information, refine the profile, and ensure that the additional information is reflected in changes subsequently made to targeted outcomes. The process of completing and refining the occupational profile varies by setting and client and may occur continuously throughout the occupational therapy process.

Information gathering for the occupational profile may be completed in one session or over a longer period while working with the client. For clients who are unable to participate in this process, their profile may be compiled through interaction with family members or other significant people in their lives. Information for the occupational profile may also be gathered from available and relevant records.

Obtaining information for the occupational profile through both formal and informal interview techniques and conversation is a way to establish a therapeutic relationship with clients and their support network. Techniques used should be appropriate and reflective of clients' preferred method and style of communication (e.g., use of a communication board, translation services). Practitioners may use AOTA's Occupational Profile Template as a guide to completing the occupational profile (AOTA, 2017a). The information obtained through the occupational profile contributes to an individualized approach in the evaluation, intervention planning, and intervention implementation stages. Information is collected in the following areas:

- 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?

After the practitioner collects profile data, the occupational therapist views the information and develops a working hypothesis regarding possible reasons for the identified problems and concerns. Reasons could include impairments in performance skills, performance patterns, or client factors or barriers within relevant contexts. In addition, the therapist notes the client's strengths and supports in all areas because these can inform the intervention plan and affect targeted outcomes.

Analysis of Occupational Performance

Occupational performance is the accomplishment of the selected occupation resulting from the dynamic transaction among the client, their contexts, and the occupation. In the *analysis of occupational performance,* the practitioner identifies the client's ability to effectively complete desired occupations. The client's assets and limitations or potential problems are more specifically determined through

assessment tools designed to analyze, measure, and inquire about factors that support or hinder occupational performance.

Multiple methods often are used during the evaluation process to assess the client, contexts, occupations, and occupational performance. Methods may include observation and analysis of the client's performance of specific occupations and assessment of specific aspects of the client or their performance. The approach to the analysis of occupational performance is determined by the information gathered through the occupational profile and influenced by models of practice and frames of reference appropriate to the client and setting. 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.

Occupational performance may be measured through standardized, formal, and structured assessment tools, and when necessary informal approaches may also be used (Asher, 2014). Standardized assessments are preferred, when available, to provide objective data about various aspects of the domain influencing engagement and performance. The use of valid and reliable assessments for obtaining trustworthy information can also help support and justify the need for occupational therapy services (Doucet & Gutman, 2013; Hinojosa & Kramer, 2014). In addition, the use of standardized outcome performance measures and outcome tools assists in establishing a baseline of occupational performance to allow for objective measurement of progress after intervention.

Synthesis of the Evaluation Process

The occupational therapist synthesizes the information gathered through the occupational profile and analysis of occupational performance. This process 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.

Any outcome assessment used by occupational therapy practitioners must be consistent with clients' belief systems and underlying assumptions regarding their desired occupational performance. Occupational therapy practitioners select outcome assessments pertinent to clients' needs and goals, congruent with the practitioner's theoretical model of practice. Assessment selection is also based on the practitioner's knowledge of and available evidence for the psychometric properties of standardized measures or the rationale and protocols for nonstandardized structured measures. In addition, clients' perception of success in engaging in desired occupations is a vital part of outcome assessment (Bandura, 1986). The occupational therapist uses the synthesis and summary of information from the

evaluation and established targeted outcomes to guide the intervention process.

Intervention

The intervention process consists of services provided by occupational therapy practitioners in collaboration with clients to facilitate engagement in occupation related to health, well-being, and achievement of established goals consistent with the various service delivery models. Practitioners use the information about clients gathered during the evaluation and theoretical principles to select and provide occupation-based interventions to assist clients in achieving physical, mental, and social well-being; identifying and realizing aspirations; satisfying needs; and changing or coping with contextual factors.

Types of occupational therapy interventions are categorized as occupations and activities, interventions to support occupations, education and training, advocacy, group interventions, and virtual interventions (Table 12). Approaches to intervention include create or promote, establish or restore, maintain, modify, and prevent (Table 13). Across all types of and approaches to interventions, it is imperative that occupational therapy practitioners maintain an understanding of the *Occupational Therapy Code of Ethics* (AOTA, 2015a) and the *Standards of Practice for Occupational Therapy* (AOTA, 2015c).

Intervention is intended to promote health, well-being, and participation. *Health promotion* is "the process of enabling people to increase control over, and to improve, their health" (WHO, 1986). Wilcock (2006) stated,

> Following an occupation-based health promotion approach to well-being embraces a belief that the potential range of what people can do, be, and strive to become is the primary concern, and that health is a by-product. A varied and full occupational lifestyle will coincidentally maintain and improve health and well-being if it enables people to be creative and adventurous physically, mentally, and socially. (p. 315)

Interventions vary depending on the client—person, group, or population—and the context of service delivery. The actual term used for clients or groups of clients receiving occupational therapy varies among practice settings and delivery models. For example, when working in a hospital, the person or group might be referred to as a *patient* or *patients,* and in a school, the clients might be *students.* Early intervention requires practitioners to work with the family system as their clients. When practitioners provide consultation to an organization, clients may be called *consumers* or *members.* Terms used for others who may help or be served indirectly include, but are not limited to, *caregiver, teacher, parent, employer,* or *spouse*.

Intervention can also be in the form of collective services to groups and populations. Such intervention can occur as direct service provision or consultation. When consulting with an organization, occupational therapy practitioners may use strategic planning, change agent plans, and other program development approaches. Practitioners addressing the needs of a population direct their interventions toward current or potential diseases or conditions with the goal of enhancing the health, well-being, and participation of all members collectively. With groups and populations, the intervention focus is often on health promotion, prevention, and screening. Interventions may include (but are not limited to) self-management training, educational services, and environmental modification. For instance, occupational therapy practitioners may provide education on falls prevention and the impact of fear of falling to residents in an assisted living center or training to people facing a mental health challenge in use of the internet to identify and coordinate community resources that meet their needs.

Occupational therapy practitioners work with a wide variety of populations experiencing difficulty in accessing and engaging in healthy occupations because of factors such as poverty, homelessness, displacement, and discrimination. For example, practitioners can work with organizations providing services to refugees and asylum seekers to identify opportunities to reestablish occupational roles and enhance well-being and quality of life.

The intervention process is divided into three components: (1) intervention plan, (2) intervention implementation, and (3) intervention review. During the intervention process, the occupational therapy practitioner integrates information from the evaluation with theory,

practice models, frames of reference, and research evidence on interventions, including those that support occupations. This information guides the practitioner's professional reasoning in intervention planning, implementation, and review. Because evaluation is ongoing, revision may occur at any point during the intervention process.

Intervention Plan

The *intervention plan,* which directs the actions of occupational therapy practitioners, describes the occupational therapy approaches and types of interventions selected for use in reaching clients' targeted outcomes. The intervention plan is developed collaboratively with clients or their proxies and is directed by

- Client goals, values, beliefs, and occupational needs and
- Client health and well-being,

as well as by the practitioners' evaluation of

- Client occupational performance needs;
- Collective influence of the contexts, occupational or activity demands, and client factors on the client;
- Client performance skills and performance patterns;
- Context of service delivery in which the intervention is provided; and
- Best available evidence.

The occupational therapist designs the intervention plan on the basis of established treatment goals, addressing the client's current and potential situation related to engagement in occupations or activities. The intervention plan should reflect the priorities of the client, information on occupational performance gathered through the evaluation process, and targeted outcomes of the intervention. Intervention planning includes the following steps:

1. Developing the plan, which involves selecting
   - Objective and measurable occupation-based goals and related time frames;
   - Occupational therapy intervention approach or approaches; and
   - Methods for service delivery, including what types of interventions will be provided, who will provide the interventions, and which service delivery approaches will be used;
2. Considering potential discharge needs and plans; and
3. Making recommendations or referrals to other professionals as needed.

Steps 2 and 3 are discussed in the Outcomes section.

Intervention Implementation

Intervention implementation is the process of putting the intervention plan into action and occurs after the initial evaluation process and development of the intervention plan. Interventions may focus on a single aspect of the occupational therapy domain, such as a specific occupation, or on several aspects of the domain, such as contexts, performance patterns, and performance skills, as components of one or more occupations. Intervention implementation must always reflect the occupational therapy scope of practice; occupational practitioners should not perform interventions that do not use purposeful and occupation-based approaches (Gillen et al., 2019).

Intervention implementation includes the following steps (see Table 12):

- 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.

Given that aspects of the domain are interrelated and influence one another in a continuous, dynamic process, occupational therapy practitioners expect that a client's ability to adapt, change, and develop in one area will affect other areas. Because of this dynamic interrelationship, evaluation, including analysis of occupational performance, and intervention planning continue throughout the implementation process. In addition, intervention implementation includes monitoring of the client's response to specific interventions and progress toward goals.

Intervention Review

Intervention review is the continuous process of reevaluating and reviewing the intervention plan, the effectiveness of its delivery, and progress toward outcomes. As during intervention planning, this process includes collaboration with the client to identify progress toward goals and outcomes. Reevaluation and review may lead to change in the intervention plan. Practitioners should review best practices for using process indicators and, as appropriate, modify the intervention plan and monitor progress using outcome performance measures and outcome tools. Intervention review includes the following steps:

1. Reevaluating the plan and how it is implemented relative to achieving outcomes
2. Modifying the plan as needed
3. Determining the need for continuation or discontinuation of occupational therapy services and for referral to other services.

Outcomes

Outcomes emerge from the occupational therapy process and describe the results clients can achieve through occupational therapy intervention (Table 14). The outcomes of occupational therapy are multifaceted and may occur in all aspects of the domain of concern. Outcomes should be measured with the same methods used at evaluation and determined through comparison of the client's status at evaluation with the client's status at discharge or transition. Results of occupational therapy services are established using outcome performance measures and outcome tools.

Outcomes are directly related to the interventions provided and to the targeted occupations, performance patterns, performance skills, client factors, and contexts. Outcomes may be traced to improvement in areas of the domain, such as performance skills and client factors, but should ultimately be reflected in clients' ability to engage in their desired occupations. Outcomes targeted in occupational therapy can be summarized as

- Occupational performance,
- Prevention,
- Health and wellness,
- Quality of life,
- Participation,
- Role competence,
- Well-being, and
- Occupational justice.

Occupational adaptation, or the client's effective and efficient response to occupational and contextual demands (Grajo, 2019), is interwoven through all of these outcomes.

The impact of outcomes and the way they are defined are specific to clients (persons, groups, or populations) and to other stakeholders such as payers and regulators. Outcomes and their documentation vary by practice setting and are influenced by the stakeholders in each setting (AOTA, 2018a).

The focus on outcomes is woven throughout the process of occupational therapy. During evaluation, occupational therapy practitioners and clients (and often others, such as parents and caregivers) collaborate to identify targeted outcomes related to engagement in valued occupations or daily life activities. These outcomes are the basis for development of the intervention plan. During intervention implementation and review, clients and practitioners may modify targeted outcomes to accommodate changing needs, contexts, and performance abilities. Ultimately, the intervention process should result in the achievement of outcomes related to

health, well-being, and participation in life through engagement in occupation.

Outcome Measurement

Objective outcomes are measurable and tangible aspects of improved performance. Outcome measurement is sometimes derived from standardized assessments, with results reflected in numerical data following specific scoring instructions. These data quantify a client's response to intervention in a way that can be used by all relevant stakeholders. Objective outcome measures are selected early in the occupational therapy process on the basis of properties showing that they are

- Valid, reliable, and appropriately sensitive to change in the client's occupational performance,
- Consistent with targeted outcomes,
- Congruent with the client's goals, and
- Able to predict future outcomes.

Practitioners use objective outcome measures to measure progress and adjust goals and interventions by

- Comparing progress toward goal achievement with outcomes throughout the intervention process and
- Measuring and assessing results to make decisions about the future direction of intervention (e.g., continue, modify, transition, discontinue, provide follow-up, refer for other service).

In some settings, the focus is on *patient-reported outcomes* (PROs), which have been defined as "any report of the status of a patient's health condition that comes directly from the patient, without interpretation of the patient's response by a clinician or anyone else" (National Quality Forum, n.d., para. 1). PROs can be used as subjective measures of improved outlook, confidence, hope, playfulness, self-efficacy, sustainability of valued occupations, pain reduction, resilience, and perceived well-being. An example of a PRO is parents' greater perceived efficacy in parenting through a new understanding of their child's behavior (Cohn, 2001; Cohn et al., 2000; Graham et al., 2013). Another example is a report by an outpatient client with a hand injury of a reduction in pain during the IADL of doing laundry. "PRO tools measure what patients are able to do and how they feel by asking questions. These tools enable assessment of patient-reported health status for physical, mental, and social well-being" (National Quality Forum, n.d., para. 1).

Outcomes can also be designed for caregivers—for example, improved quality of life for both care recipient and caregiver. Studies of caregivers of people with dementia who received a home environmental intervention found fewer declines in occupational performance, enhanced mastery and skill, improved sense of self-efficacy and well-being, and less need for help with care recipients (Gitlin & Corcoran, 2005; Gitlin et al., 2001, 2003, 2008; Graff et al., 2007; Piersol et al., 2017).

Outcomes for groups that receive an educational intervention may include improved social interaction, increased self-awareness through peer support, a larger social network, or improved employee health and productivity. For example, education interventions for groups of employees on safety and workplace wellness have been shown to decrease work injuries and increase workplace productivity and satisfaction (Snodgrass & Amini, 2017).

Outcomes for populations may address health promotion, occupational justice and self-advocacy, health literacy, community integration, community living, and access to services. As with other occupational therapy clients, outcomes for populations are focused on occupational performance, engagement, and participation. For example, outcomes at the population level as a result of advocacy interventions include construction of accessible playground facilities, improved accessibility for polling places, and reconstruction of a school after a natural disaster.

Transition and Discontinuation

Transition is movement from one life role or experience to another. Transitions in services, like all life transitions, may require preparation, new knowledge, and time to accommodate to the new situation (Orentlicher et al., 2015). Transition planning may be needed, for example, when a client moves from one setting to another along the care continuum (e.g., acute hospital to skilled nursing

facility) or ages out of one program and into a new one (e.g., early intervention to elementary school). Collaboration among practitioners is necessary to ensure safety, well-being, and optimal outcomes for clients (Joint Commission, 2012, 2013).

Transition planning may include a referral to a provider within occupational therapy with advanced knowledge and skill (e.g., vestibular rehabilitation, driver evaluation, hand therapy) or outside the profession (e.g., psychologist, optometrist). Transition planning for groups and populations may be needed for a transition from one stage to another (e.g., middle school students in a life skills program who transition to high school) or from one set of needs to another (e.g., older adults in a community falls prevention program who transition to a community exercise program).

Planning for discontinuation of occupational therapy services begins at initial evaluation. Discontinuation of care occurs when the client ends services after meeting short- and long-term goals or chooses to discontinue receiving services (consistent with client-centered care). Safe and effective discharge planning for a person may include education on the use of new equipment, adaptation of an occupation, caregiver training, environmental modification, or determination of the appropriate setting for transition of care. A key goal of discharge planning for individual clients is prevention of readmission (Rogers et al., 2017). Discontinuation of services for groups and populations occurs when goals are met and sustainability plans are implemented for long-term success.

Conclusion

The *OTPF–4* describes the central concepts that ground occupational therapy practice and builds a common understanding of the basic tenets and distinct contribution of the profession. The occupational therapy domain and process are linked inextricably in a transactional relationship. An understanding of this relationship supports and guides the complex decision making required in the daily practice of occupational therapy and enhances practitioners' ability to define the reasons for and justify the provision of services when communicating with clients, family members, team members, employers, payers, and policymakers.

This edition of the *OTPF* provides a broader view than previous editions of occupational therapy as related to groups and populations and current and future occupational needs of clients. It also presents and describes the cornerstones of occupational therapy practice, which are discrete and critical qualities of occupational therapy practitioners that provide them with a foundation for success in the occupational therapy process. The *OTPF–4* highlights the distinct value of occupation and occupational therapy in contributing to health, well-being, and participation in life for persons, groups, and populations. This document can be used to advocate for the importance of occupational therapy in meeting society's current and future needs, ultimately advancing the profession to ensure a sustainable future.

Table 1. Examples of Clients: Persons, Groups, and Populations

Person	Group	Population
Health Management		
Middle-school student with diabetes interested in developing self-management skills to test blood sugar levels	Group of students with diabetes interested in problem solving the school setting's support for management of their condition	All students in the school provided with access to food choices to meet varying dietary needs and desires
Feeding		
Family of an infant with a history of prematurity and difficulty accepting nutrition orally	Families with infants experiencing feeding challenges advocating for the local hospital's rehabilitation services to develop infant feeding classes	Families of infants advocating for research and development of alternative nipple and bottle designs to address feeding challenges
Community Mobility		
Person with stroke who wants to return to driving	Stroke support group talking with elected leaders about developing community mobility resources	Stroke survivors advocating for increased access to community mobility options for all persons living with mobility limitations
Social Participation		
Young adult with IDD interested in increasing social participation	Young adults with IDD in a transition program sponsoring leisure activities in which all may participate in valued social relationships	Young adults with IDD educating their community about their need for inclusion in community-based social and leisure activities
Home Establishment and Management		
Person living with SMI interested in developing skills for independent living	Support group for people living with SMI developing resources to foster independent living	People living with SMI in the same region advocating for increased housing options for independent living
Work Participation		
Older worker with difficulty performing some work tasks	Group of older workers in a factory advocating for modification of equipment to address discomfort when operating the same set of machines	Older workers in a national corporation advocating for company-wide wellness support programs

Note. IDD = intellectual and developmental disabilities; SMI = serious mental illness.

Table 2. Occupations

Occupations are "the everyday activities that people do as individuals, in families, and with communities to occupy time and bring meaning and purpose to life. Occupations include things people need to, want to and are expected to do" (World Federation of Occupational Therapists, 2012a, para. 2). Occupations are categorized as activities of daily living, instrumental activities of daily living, health management, rest and sleep, education, work, play, leisure, and social participation.

Occupation	Description
Activities of Daily Living (ADLs)—Activities oriented toward taking care of one's own body and completed on a routine basis (adapted from Rogers & Holm, 1994).	
Bathing, showering	Obtaining and using supplies; soaping, rinsing, and drying body parts; maintaining bathing position; transferring to and from bathing positions
Toileting and toilet hygiene	Obtaining and using toileting supplies, managing clothing, maintaining toileting position, transferring to and from toileting position, cleaning body, caring for menstrual and continence needs (including catheter, colostomy, and suppository management), maintaining intentional control of bowel movements and urination and, if necessary, using equipment or agents for bladder control (Uniform Data System for Medical Rehabilitation, 1996, pp. III-20, III-24)
Dressing	Selecting clothing and accessories with consideration of time of day, weather, and desired presentation; obtaining clothing from storage area; dressing and undressing in a sequential fashion; fastening and adjusting clothing and shoes; applying and removing personal devices, prosthetic devices, or splints
Eating and swallowing	Keeping and manipulating food or fluid in the mouth, swallowing it (i.e., moving it from the mouth to the stomach)
Feeding	Setting up, arranging, and bringing food or fluid from the vessel to the mouth (includes self-feeding and feeding others)
Functional mobility	Moving from one position or place to another (during performance of everyday activities), such as in-bed mobility, wheelchair mobility, and transfers (e.g., wheelchair, bed, car, shower, tub, toilet, chair, floor); includes functional ambulation and transportation of objects
Personal hygiene and grooming	Obtaining and using supplies; removing body hair (e.g., using a razor or tweezers); applying and removing cosmetics; washing, drying, combing, styling, brushing, and trimming hair; caring for nails (hands and feet); caring for skin, ears, eyes, and nose; applying deodorant; cleaning mouth; brushing and flossing teeth; removing, cleaning, and reinserting dental orthotics and prosthetics
Sexual activity	Engaging in the broad possibilities for sexual expression and experiences with self or others (e.g., hugging, kissing, foreplay, masturbation, oral sex, intercourse)
Instrumental Activities of Daily Living (IADLs)—Activities to support daily life within the home and community.	
Care of others (including selection and supervision of caregivers)	Providing care for others, arranging or supervising formal care (by paid caregivers) or informal care (by family or friends) for others

(Continued)

Table 2. Occupations *(cont'd)*

Occupation	Description
Care of pets and animals	Providing care for pets and service animals, arranging or supervising care for pets and service animals
Child rearing	Providing care and supervision to support the developmental and physiological needs of a child
Communication management	Sending, receiving, and interpreting information using systems and equipment such as writing tools, telephones (including smartphones), keyboards, audiovisual recorders, computers or tablets, communication boards, call lights, emergency systems, Braille writers, telecommunication devices for deaf people, augmentative communication systems, and personal digital assistants
Driving and community mobility	Planning and moving around in the community using public or private transportation, such as driving, walking, bicycling, or accessing and riding in buses, taxi cabs, ride shares, or other transportation systems
Financial management	Using fiscal resources, including financial transaction methods (e.g., credit card, digital banking); planning and using finances with long-term and short-term goals
Home establishment and management	Obtaining and maintaining personal and household possessions and environments (e.g., home, yard, garden, houseplants, appliances, vehicles), including maintaining and repairing personal possessions (e.g., clothing, household items) and knowing how to seek help or whom to contact
Meal preparation and cleanup	Planning, preparing, and serving meals and cleaning up food and tools (e.g., utensils, pots, plates) after meals
Religious and spiritual expression	Engaging in religious or spiritual activities, organizations, and practices for self-fulfillment; finding meaning or religious or spiritual value; establishing connection with a divine power, such as is involved in attending a church, temple, mosque, or synagogue; praying or chanting for a religious purpose; engaging in spiritual contemplation (World Health Organization, 2008); may also include giving back to others, contributing to society or a cause, and contributing to a greater purpose
Safety and emergency maintenance	Evaluating situations in advance for potential safety risks; recognizing sudden, unexpected hazardous situations and initiating emergency action; reducing potential threats to health and safety, including ensuring safety when entering and exiting the home, identifying emergency contact numbers, and replacing items such as batteries in smoke alarms and light bulbs
Shopping	Preparing shopping lists (grocery and other); selecting, purchasing, and transporting items; selecting method of payment and completing payment transactions; managing internet shopping and related use of electronic devices such as computers, cell phones, and tablets

(Continued)

Table 2. Occupations *(cont'd)*

Occupation	Description
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.	
Social and emotional health promotion and maintenance	Identifying personal strengths and assets, managing emotions, expressing needs effectively, seeking occupations and social engagement to support health and wellness, developing self-identity, making choices to improve quality of life in participation
Symptom and condition management	Managing physical and mental health needs, including using coping strategies for illness, trauma history, or societal stigma; managing pain; managing chronic disease; recognizing symptom changes and fluctuations; developing and using strategies for managing and regulating emotions; planning time and establishing behavioral patterns for restorative activities (e.g., meditation); using community and social supports; navigating and accessing the health care system
Communication with the health care system	Expressing and receiving verbal, written, and digital communication with health care and insurance providers, including understanding and advocating for self or others
Medication management	Communicating with the physician about prescriptions, filling prescriptions at the pharmacy, interpreting medication instructions, taking medications on a routine basis, refilling prescriptions in a timely manner (American Occupational Therapy Association, 2017c; Schwartz & Smith, 2017)
Physical activity	Completing cardiovascular exercise, strength training, and balance training to improve or maintain health and decrease risk of health episodes, such as by incorporating walks into daily routine
Nutrition management	Implementing and adhering to nutrition and hydration recommendations from the medical team, preparing meals to support health goals, participating in health-promoting diet routines
Personal care device management	Procuring, using, cleaning, and maintaining personal care devices, including hearing aids, contact lenses, glasses, orthotics, prosthetics, adaptive equipment, pessaries, glucometers, and contraceptive and sexual devices
Rest and Sleep—Activities related to obtaining restorative rest and sleep to support healthy, active engagement in other occupations.	
Rest	Identifying the need to relax and engaging in quiet and effortless actions that interrupt physical and mental activity (Nurit & Michal, 2003, p. 227); reducing involvement in taxing physical, mental, or social activities, resulting in a relaxed state; engaging in relaxation or other endeavors that restore energy and calm and renew interest in engagement
Sleep preparation	Engaging in routines that prepare the self for a comfortable rest, such as grooming and undressing, reading or listening to music, saying goodnight to others, and engaging in meditation or prayers; determining the time of day and length of time

(Continued)

Table 2. Occupations *(cont'd)*

Occupation	Description
	desired for sleeping and the time needed to wake; establishing sleep patterns that support growth and health (patterns are often personally and culturally determined); preparing the physical environment for periods of sleep, such as making the bed or space on which to sleep, ensuring warmth or coolness and protection, setting an alarm clock, securing the home (e.g., by locking doors or closing windows or curtains), setting up sleep-supporting equipment (e.g., CPAP machine), and turning off electronics and lights
Sleep participation	Taking care of personal needs for sleep, such as ceasing activities to ensure onset of sleep, napping, and dreaming; sustaining a sleep state without disruption; meeting nighttime toileting and hydration needs, including negotiating the needs of and interacting with others (e.g., children, partner) within the social environment, such as providing nighttime caregiving (e.g., breastfeeding) and monitoring comfort and safety of others who are sleeping
Education—Activities needed for learning and participating in the educational environment.	
Formal educational participation	Participating in academic (e.g., math, reading, degree coursework), nonacademic (e.g., recess, lunchroom, hallway), extracurricular (e.g., sports, band, cheerleading, dances), technological (e.g., online assignment completion, distance learning), and vocational (including prevocational) educational activities
Informal personal educational needs or interests exploration (beyond formal education)	Identifying topics and methods for obtaining topic-related information or skills
Informal educational participation	Participating in classes, programs, and activities that provide instruction or training outside of a structured curriculum in identified areas of interest
Work—Labor or exertion related to the development, production, delivery, or management of objects or services; benefits may be financial or nonfinancial (e.g., social connectedness, contributions to society, structure and routine to daily life; Christiansen & Townsend, 2010; Dorsey et al., 2019).	
Employment interests and pursuits	Identifying and selecting work opportunities consistent with personal assets, limitations, goals, and interests (adapted from Mosey, 1996, p. 342)
Employment seeking and acquisition	Advocating for oneself; completing, submitting, and reviewing application materials; preparing for interviews; participating in interviews and following up afterward; discussing job benefits; finalizing negotiations
Job performance and maintenance	Creating, producing, and distributing products and services; maintaining required work skills and patterns; managing time use; managing relationships with coworkers, managers, and customers; following and providing leadership and supervision; initiating, sustaining, and completing work; complying with work norms and procedures; seeking and responding to feedback on performance

(Continued)

Table 2. Occupations *(cont'd)*

Occupation	Description
Retirement preparation and adjustment	Determining aptitudes, developing interests and skills, selecting vocational pursuits, securing required resources, adjusting lifestyle in the absence of the worker role
Volunteer exploration	Identifying and learning about community causes, organizations, and opportunities for unpaid work consistent with personal skills, interests, location, and time available
Volunteer participation	Performing unpaid work activities for the benefit of selected people, causes, or organizations
Play—Activities that are intrinsically motivated, internally controlled, and freely chosen and that may include suspension of reality (e.g., fantasy; Skard & Bundy, 2008), exploration, humor, risk taking, contests, and celebrations (Eberle, 2014; Sutton-Smith, 2009). Play is a complex and multidimensional phenomenon that is shaped by sociocultural factors (Lynch et al., 2016).	
Play exploration	Identifying play activities, including exploration play, practice play, pretend play, games with rules, constructive play, and symbolic play (adapted from Bergen, 1988, pp. 64–65)
Play participation	Participating in play; maintaining a balance of play with other occupations; obtaining, using, and maintaining toys, equipment, and supplies
Leisure—"Nonobligatory activity that is intrinsically motivated and engaged in during discretionary time, that is, time not committed to obligatory occupations such as work, self-care, or sleep" (Parham & Fazio, 1997, p. 250).	
Leisure exploration	Identifying interests, skills, opportunities, and leisure activities
Leisure participation	Planning and participating in leisure activities; maintaining a balance of leisure activities with other occupations; obtaining, using, and maintaining equipment and supplies
Social Participation—Activities that involve social interaction with others, including family, friends, peers, and community members, and that support social interdependence (Bedell, 2012; Khetani & Coster, 2019; Magasi & Hammel, 2004).	
Community participation	Engaging in activities that result in successful interaction at the community level (e.g., neighborhood, organization, workplace, school, digital social network, religious or spiritual group)
Family participation	Engaging in activities that result in "interaction in specific required and/or desired familial roles" (Mosey, 1996, p. 340)
Friendships	Engaging in activities that support "a relationship between two people based on mutual liking in which partners provide support to each other in times of need" (Hall, 2017, para. 2)
Intimate partner relationships	Engaging in activities to initiate and maintain a close relationship, including giving and receiving affection and interacting in desired roles; intimate partners may or may not engage in sexual activity
Peer group participation	Engaging in activities with others who have similar interests, age, background, or social status

Note. CPAP = continuous positive airway pressure.

Table 3. Examples of Occupations for Persons, Groups, and Populations
Persons engage in occupations, and groups engage in shared occupations; populations as a whole do not engage in shared occupations, which happen at the person or group level. Occupational therapy practitioners provide interventions for persons, groups, and populations.

Occupation Category	Client Type	Example
Activities of daily living	Person	Older adult completing bathing with assistance from an adult child
	Group	Students eating lunch during a lunch break
Instrumental activities of daily living	Person	Parent using a phone app to pay a babysitter electronically
	Group	Club members using public transportation to arrive at a musical performance
Health management	Person	Patient scheduling an appointment with a specialist after referral by the primary care doctor
	Group	Parent association sharing preparation of healthy foods to serve at a school-sponsored festival
Rest and sleep	Person	Person turning off lights and adjusting the room temperature to 68° before sleep
	Group	Children engaging in nap time at a day care center
Education	Person	College student taking an African-American history class online
	Group	Students working on a collaborative science project on robotics
Work	Person	Electrician turning off power before working on a power line
	Group	Peers volunteering for a day of action at an animal shelter
Play	Person	Child playing superhero dress up
	Group	Class playing freeze tag during recess
Leisure	Person	Family member knitting a sweater for a new baby
	Group	Friends meeting for a craft circle
Social participation	Person	New mother going to lunch with friends
	Group	Older adults gathering at a community center to wrap holiday presents for charity distribution

Table 4. Context: Environmental Factors

Context is the broad construct that encompasses environmental factors and personal factors. *Environmental factors* are aspects of the physical, social, and attitudinal surroundings in which people live and conduct their lives.

Environmental Factor	Components	Examples
Natural environment and human-made changes to the environment: Animate and inanimate elements of the natural or physical environment and components of that environment that have been modified by people, as well as characteristics of human populations within the environment	Physical geography	• Raised flower beds in a backyard • Local stream cleanup by Boy Scouts during a community service day project • Highway expansion cutting through an established neighborhood
	Population: Groups of people living in a given environment who share the same pattern of environmental adaptation	• Universal access playground where children with mobility impairment can play • Hearing loop installed in a synagogue for congregation members with hearing aids • Tree-shaded, solid-surface walking path enjoyed by older adults in a senior living community
	Flora (plants) and fauna (animals)	• Nonshedding service dog • Family-owned herd of cattle • Community garden
	Climate: Meteorological features and events, such as weather	• Sunny day requiring use of sunglasses • Rain shower prompting a crew of road workers to don rain gear • Unusually high temperatures turning a community ice skating pond to slush
	Natural events: Regular or irregular geographic and atmospheric changes that cause disruption in the physical environment	• Barometric pressure causing a headache • Flood of a local creek damaging neighborhood homes • Hurricane devastating a low-lying region
	Human-caused events: Alterations or disturbances in the natural environment caused by humans that result in the disruption of day-to-day life	• High air pollution forcing a person with lung disease to stay indoors • Accessible dock at a local river park demolished to make way for a new bridge construction project • Derailment of a train loaded with highly combustible chemicals leading to the emergency total evacuation of a small town
	Light: Light intensity and quality	• Darkness requiring use of a reading lamp • Office with ample natural light • Street lamps
	Time-related changes: Natural, regularly occurring, or predictable change; rhythm and duration of activity; time of day, week, month, season, or year; day–night cycles; lunar cycles	• Jet lag • Quitting time at the end of a work shift • Summer solstice

(Continued)

Table 4. Context: Environmental Factors *(cont'd)*

Environmental Factor	Components	Examples
	Sound and vibration: Heard or felt phenomena that may provide useful or distracting information about the world	• Vibration of a cell phone indicating a text message • Bell signaling the start of the school day • Outdoor emergency warning system on a college campus
	Air quality: Characteristics of the atmosphere (outside buildings) or enclosed areas of air (inside buildings)	• Heavy perfume use by a family member causing an asthmatic reaction • Smoking area outside an office building • High incidence of respiratory diseases near an industrial district
Products and technology: Natural or human-made products or systems of products, equipment, and technology that are gathered, created, produced, or manufactured	Food, drugs, and other products or substances for personal consumption	• Preferred snack • Injectable hormones for a transgender man • Grade-school cafeteria lunch
	General products and technology for personal use in daily living (including assistive technology and products)	• Toothbrush • Household refrigerator • Shower in a fitness or exercise facility
	Personal indoor and outdoor mobility and transportation equipment used by people in activities requiring movement inside and outside of buildings	• Four-wheeled walker • Family car • Elevator in a multistory apartment building
	Communication: Activities involving sending and receiving information	• Hearing aid • Text chain via personal cell phones • Use of emergency response system to warn region of impending dangerous storms
	Education: Processes and methods for acquiring knowledge, expertise, or skill	• Textbook • Online course • Curriculum for workplace sexual harassment program
	Employment: Paid work activities	• Home office for remote work • Assembly factory • Internet connection for health care workers to access electronic medical records
	Cultural, recreational, and sporting activities	• Gaming console • Instruments for a university marching band • Soccer stadium
	Practice of religion and spirituality	• Prayer rug • Temple • Sunday church service television broadcast
	Indoor and outdoor human-made environments that are planned, designed, and constructed for public and private use	• Home bathroom with grab bars and raised toilet seat • Accessible playground at a city park • Zero-grade entry to a shopping mall

(Continued)

Table 4. Context: Environmental Factors *(cont'd)*

Environmental Factor	Components	Examples
	Assets for economic exchange, such as money, goods, property, and other valuables that an individual owns or has rights to use	• Pocket change • Household budget • Condominium association tax bill
	Virtual environments occurring in simulated, real-time, and near-time situations, absent of physical contact	• Personal cell phone • Synchronous video meeting of coworkers in distant locations • Open-source video gaming community
Support and relationships: People or animals that provide practical physical or emotional support, nurturing, protection, assistance, and relationships to other persons in the home, workplace, or school or at play or in other aspects of their daily activities	Immediate and extended family	• Spouses, partners, parents, siblings, foster parents, and adoptive grandparents • Biological families and found or constructed families
	Friends, acquaintances, peers, colleagues, neighbors, and community members	• Trusted best friend • Coworkers • Helpful next-door neighbor • Substance abuse recovery support group sponsor
	People in positions of authority and those in subordinate positions	• Teacher who offers extra tutoring • Legal guardian for a parentless minor • Female religious reporting to a sister superior • New employee being oriented to the job tasks by an assigned mentor
	Personal care providers and personal assistants providing support to individuals	Health care professionals and other professionals serving a community
	Domesticated animals	• Therapy dog program in a senior living community • Horse kept to draw a buggy for an Amish family's transportation
Attitudes: Observable evidence of customs, practices, ideologies, values, norms, factual beliefs, and religious beliefs held by people other than the client	Individual attitudes of immediate and extended family, friends and acquaintances, peers and colleagues, neighbors and community members, people in positions of authority and subordinate positions, personal care providers and personal assistants, strangers, and health care and other professionals	• Shared grief over the untimely death of a sibling • Automatic trust from a patient who knows one's father • Reliance among members of a faith community
	Societal attitudes, including discriminatory practices	• Failure to acknowledge a young person who wants to vote for the first time • Racial discrimination in job hiring processes
	Social norms, practices, and ideologies that marginalize specific populations	No time off work allowed to observe a religion's holy day
Services, systems, and policies: Benefits, structured programs, and regulations for operations, provided by institutions in	Services designed to meet the needs of persons, groups, and populations	• Economic services, including Social Security income and public assistance

(Continued)

Table 4. Context: Environmental Factors *(cont'd)*

Environmental Factor	Components	Examples
various sectors of society, designed to meet the needs of persons, groups, and populations		• Health services for preventing and treating health problems, providing medical rehabilitation, and promoting healthy lifestyles
	Systems established by governments at the local, regional, national, and international levels or by other recognized authorities	• Public utilities (e.g., water, electricity, sanitation) • Communications (transmission and exchange of information) • Transportation systems • Political systems related to voting, elections, and governance
	Policies constituted by rules, regulations, conventions, and standards established by governments at the local, regional, national, and international levels or by other recognized authorities	• Architecture, construction, open space use, and housing policies • Civil protection and legal services • Labor and employment policies related to finding suitable work, looking for different work, or seeking promotion

Table 5. Context: Personal Factors

Context is the broad construct that encompasses environmental factors and personal factors. *Personal factors* are the particular background of a person's life and living and consist of the unique features of the person that are not part of a health condition or health state.

Personal Factor	Person A	Person B
Age (chronological)	• 48 years old	• 14 years old
Sexual orientation	• Attracted to men	• Attracted to all genders
Gender identity	• Female	• Male
Race and ethnicity	• Black French Caribbean	• Southeast Asian Hmong
Cultural identification and cultural attitudes	• Urban Black • Feminist • Caribbean island identification	• Traditional clan structure • Elders who are decision makers for community
Social background, social status, and socioeconomic status	• Urban, upscale neighborhood • Friends in the professional workforce • Income that allows for luxury	• Family owns small home • Father with a stable job in light manufacturing • Mother who is a child care provider for neighborhood children
Upbringing and life experiences	• No siblings • Raised in household with grandmother as caregiver • Moved from California to Boston while an adolescent	• Traditional • Born in a refugee camp before parents emigrated • Youngest of five siblings • Lives in a small city in the Upper Midwest
Habits and past and current behavioral patterns	• Coffee before anything else • Meticulous about dress	• Organized and attentive to family • Never misses a family meal
Individual psychological assets, including temperament, character traits, and coping styles, for handling responsibilities, stress, crises, and other psychological demands (e.g., extroversion, agreeableness, conscientiousness, psychic stability, openness to experience, optimism, confidence)	• Anxious when not working • Extroverted • High level of confidence • Readily adapts approach to and interactions with those who are culturally different	• Known for being calm • Not outgoing but friendly to all • Does not speak up or complain at school during conflict
Education	• Master's degree in political science • Law degree	• High school freshman • Advanced skills in the sciences
Profession and professional identity	• Public interest lawyer	• Public high school student
Lifestyle	• High-rise apartment • Likes urban nightlife and casual dating • Works long hours	• Engaged in clan and community • Four older siblings who live nearby
Other health conditions and fitness	• Treated for anorexia nervosa while an adolescent • Occasional runner	• Wears eyeglasses for astigmatism • Sedentary at home except for assigned chores

Table 6. Performance Patterns

Performance patterns are the habits, routines, roles, and rituals that may be associated with different lifestyles and used in the process of engaging in occupations or activities. These patterns are influenced by context and time use and can support or hinder occupational performance.

Category	Description	Examples
Person		
Habits	"Specific, automatic behaviors performed repeatedly, relatively automatically, and with little variation" (Matuska & Barrett, 2019, p. 214). Habits can be healthy or unhealthy, efficient or inefficient, and supportive or harmful (Dunn, 2000).	• Automatically puts car keys in the same place • Spontaneously looks both ways before crossing the street • Always turns off the stove burner before removing a cooking pot • Activates the alarm system before leaving the home • Always checks smartphone for emails or text messages on waking • Snacks when watching television
Routines	Patterns of behavior that are observable, regular, and repetitive and that provide structure for daily life. They can be satisfying, promoting, or damaging. Routines require delimited time commitment and are embedded in cultural and ecological contexts (Fiese, 2007; Segal, 2004).	• Follows a morning sequence to complete toileting, bathing, hygiene, and dressing • Follows the sequence of steps involved in meal preparation • Manages morning routine to drop children off at school and arrive at work on time
Roles	Aspects of identity shaped by culture and context that may be further conceptualized and defined by the client and the activities and occupations one engages in.	• Sibling in a family with three children • Retired military personnel • Volunteer at a local park district • Mother of an adolescent with developmental disabilities • Student with a learning disability studying computer technology • Corporate executive returning to part-time work after a stroke
Rituals	Symbolic actions with spiritual, cultural, or social meaning contributing to the client's identity and reinforcing values and beliefs. Rituals have a strong affective component and consist of a collection of events (Fiese, 2007; Fiese et al., 2002; Segal, 2004).	• Shares a highlight from the day during evening meals with family • Kisses a sacred book before opening the pages to read • Recites the Pledge of Allegiance before the start of the school day
Group and Population		
Routines	Patterns of behavior that are observable, regular, and repetitive and that provide structure for daily life. They can be satisfying, promoting, or damaging. Time provides an organizational structure or rhythm for routines (Larson & Zemke, 2003). Routines are embedded in cultural and ecological contexts (Segal, 2004).	*Group* • Workers attending weekly staff meetings • Students turning in homework assignments as they enter the classroom • Exercise class attendees setting up their mats and towels before class *Population* • Parents of young children following health practices such as yearly checkups and scheduled immunizations

(Continued)

Table 6. Performance Patterns *(cont'd)*

Category	Description	Examples
		• Corporations following business practices such as providing services for disadvantaged populations (e.g., loans to underrepresented groups) • School districts following legislative procedures such as those associated with the Individuals With Disabilities Education Improvement Act of 2004 (Pub. L. 108-446) or Medicare
Roles	Sets of behaviors by the group or population expected by society and shaped by culture and context that may be further conceptualized and defined by the group or population.	*Group* • Nonprofit civic group providing housing for people living with mental illness • Humanitarian group distributing food and clothing donations to refugees • Student organization in a university educating elementary school children about preventing bullying *Population* • Parents providing care for children until they become adults • Grandparents or older community members being consulted before decisions are made
Rituals	Shared social actions with traditional, emotional, purposive, and technological meaning contributing to values and beliefs within the group or population.	*Group* • Employees of a company attending an annual holiday celebration • Members of a community agency hosting a fundraiser every spring *Population* • Citizens of a country suspending work activities in observance of a national holiday

Table 7. Performance Skills for Persons

Performance skills are observable, goal-directed actions that result in a client's quality of performing desired occupations. Skills are supported by the context in which the performance occurs, including environmental and client factors (Fisher & Marterella, 2019). Effective use of motor and process performance skills is demonstrated when the client carries out an activity efficiently, safely, with ease, or without assistance. Effective use of social interaction performance skills is demonstrated when the client completes interactions in a manner that matches the demands of the social situation. Ineffective use of performance skills is demonstrated when the client routinely requires assistance or support to perform activities or engage in social interactions.

The examples in this table are limited to descriptions of the client's ability to use each performance skill in an effective or ineffective manner. A client who demonstrates ineffective use of performance skills may be able to successfully complete the entire occupation with the use of occupational or environmental adaptations. Successful occupational performance by the client may be achieved when such adaptions are used.

Specific Skill Definitions	Examples	
	Effective Performance[a]	Ineffective Performance[b]
Motor Skills—*"Motor skills* are the group of performance skills that represent small, observable actions related to moving oneself or moving and interacting with tangible task objects (e.g., tools, utensils, clothing, food or other supplies, digital devices, plant life) in the context of performing a personally and ecologically relevant daily life task" (Fisher & Marterella, 2019, p. 331).		
Positioning the body	**Washing dishes at the kitchen sink**	
Stabilizes—Moves through task environment and interacts with task objects without momentary propping or loss of balance	Person moves through the kitchen without propping or loss of balance.	Person momentarily props on the counter to stabilize body while standing at the sink and washing dishes.
Aligns—Interacts with task objects without evidence of persistent propping or leaning	Person washes dishes without using the counter for support.	Person persistently leans on the counter, resulting in ineffective performance when washing dishes.
Positions—Positions self an effective distance from task objects and without evidence of awkward arm or body positions	Person places body or wheelchair at an effective distance for washing dishes.	Person positions body or wheelchair too far from the sink, resulting in difficulty reaching for dishes in the sink.
Obtaining and holding objects	**Acquiring a game from a cabinet in preparation for a family activity**	
Reaches—Effectively extends arm and, when appropriate, bends trunk to effectively grasp or place task objects that are out of reach	Person reaches without effort for the game box.	Person reaches with excessive physical effort for the game box.
Bends—Flexes or rotates trunk as appropriate when sitting down or when bending to grasp or place task objects that are out of reach	Person bends without effort when reaching for the game box.	Person demonstrates excessive stiffness when bending to reach for the game box.
Grips—Effectively pinches or grasps task objects such that the objects do not slip (e.g., from between fingers, from between teeth, from between hand and supporting surface)	Person grips the game box and game pieces, and they do not slip from the hand.	Person grips the game box ineffectively, and the box slips from the hand so that game pieces spill.
Manipulates—Uses dexterous finger movements, without evidence of fumbling, when manipulating task objects	Person readily manipulates the game pieces with fingers while setting up and playing the game.	Person fumbles the game pieces so that some pieces fall off the game board.

(Continued)

Table 7. Performance Skills for Persons *(cont'd)*

Specific Skill Definitions	Examples	
	Effective Performance[a]	Ineffective Performance[b]
Performance Skills: Motor Skills *(cont'd)*		
Moving self and objects	**Completing janitorial tasks at a factory site**	
Coordinates—Uses two or more body parts together to manipulate and hold task objects without evidence of fumbling or task objects slipping from the grasp	Person uses both hands to shuffle the game cards without fumbling them, and the cards do not slip from the hands.	Person uses both hands to shuffle the cards but fumbles the deck, and the cards slip out of the hands.
Moves—Effectively pushes or pulls task objects along a supporting surface, pulls to open or pushes to close doors and drawers, or pushes on wheels to propel a wheelchair	Person moves the broom easily, pushing and pulling it across the floor.	Person demonstrates excessive effort to move the broom across the floor when sweeping.
Lifts—Effectively raises or lifts task objects without evidence of excessive physical effort	Person easily lifts cleaning supplies out of the cart.	Person needs to use both hands to lift small lightweight containers of cleaning supplies out of the cart.
Walks—During task performance, ambulates on level surfaces without shuffling feet, becoming unstable, propping, or using assistive devices	Person walks steadily through the factory.	Person demonstrates unstable walking while performing janitorial duties or walks while supporting self on the cart.
Transports—Carries task objects from one place to another while walking or moving in a wheelchair	Person carries cleaning supplies from one factory location to another, either by walking or using a wheelchair, without effort.	Person is unstable when transporting cleaning supplies throughout the factory.
Calibrates—Uses movements of appropriate force, speed, or extent when interacting with task objects (e.g., does not crush task objects, pushes a door with enough force to close it without a bang)	Person uses an appropriate amount of force to squeeze liquid soap onto a cleaning cloth.	Person applies too little force to squeeze soap out of the container onto the cleaning cloth.
Flows—Uses smooth and fluid arm and wrist movements when interacting with task objects	Person demonstrates fluid arm and wrist movements when wiping tables.	Person demonstrates stiff and jerky arm and wrist movements when wiping tables.
Sustaining performance	**Bathing an older parent as caregiver**	
Endures—Persists and completes the task without demonstrating physical fatigue, pausing to rest, or stopping to catch breath	Person completes bathing of parent without evidence of physical fatigue.	Person stops to rest, interrupting the task of bathing the parent.
Paces—Maintains a consistent and effective rate or tempo of performance throughout the entire task performance	Person uses an appropriate tempo when bathing the parent.	Person sometimes rushes or delays actions when bathing the parent.
Process Skills—*"Process skills* are the group of performance skills that represent small, observable actions related to selecting, interacting with, and using tangible task objects (e.g., tools, utensils, clothing, food or other supplies, digital devices, plant life); carrying out individual actions and steps; and preventing problems of occupational performance from occurring or reoccurring in the context of performing a personally and ecologically relevant daily life task" (Fisher & Marterella, 2019, pp. 336–337).		

(Continued)

Table 7. Performance Skills for Persons *(cont'd)*

Specific Skill Definitions	Examples	
	Effective Performance[a]	Ineffective Performance[b]
Performance Skills: Process Skills *(cont'd)*		
Sustaining performance	**Writing sentences for a school assignment**	
Paces—Maintains a consistent and effective rate or tempo of performance throughout the entire task performance	Person uses a consistent and even tempo when writing sentences.	Person rushes writing sentences, resulting in incorrectly formed letters or misspelled words.
Attends—Does not look away from task performance, maintaining the ongoing task progression	Person maintains gaze on the assignment and continues writing sentences without pause.	Person looks toward another student and pauses when writing sentences.
Heeds—Carries out and completes the task originally agreed on or specified by another person	Person completes the assignment, writing the number of sentences required.	Person writes fewer sentences than required, not completing the assignment.
Applying knowledge	**Taking prescribed medications**	
Chooses—Selects necessary and appropriate type and number of objects for the task, including the task objects that one chooses or is directed to use (e.g., by a teacher)	Person chooses specified medicine bottles appropriate for the specific timed dose.	Person chooses an incorrect medicine bottle for the specific timed dose.
Uses—Applies task objects as they are intended (e.g., using a pencil sharpener to sharpen a pencil but not a crayon) and in a hygienic fashion	Person uses a medicine spoon to take a dose of liquid medicine.	Person uses a tablespoon to take a 1-teaspoon dose of liquid medicine.
Handles—Supports or stabilizes task objects appropriately, protecting them from being damaged, slipping, moving, or falling	Person supports the medicine bottle, keeping it upright without the bottle tipping or falling.	Person allows the medicine bottle to tip, and pills spill from the bottle.
Inquires—(1) Seeks needed verbal or written information by asking questions or reading directions or labels and (2) does not ask for information when fully oriented to the task and environment and recently aware of the answer	Person reads the label on the medicine bottle before taking the medication.	Person asks the care provider what dose to take having already read the dose on the label.
Organizing timing	**Using an ATM to get cash to pay a babysitter**	
Initiates—Starts or begins the next task action or task step without any hesitation	Person begins each step of ATM use without hesitation.	Person pauses before entering the PIN into the ATM.
Continues—Performs single actions or steps without any interruptions so that once an action or task step is initiated, performance continues without pauses or delays until the action or step is completed	Person completes each step of ATM use without delays.	Person starts to enter the PIN, pauses, and then continues entering the PIN.

(Continued)

Table 7. Performance Skills for Persons *(cont'd)*

Specific Skill Definitions	Examples	
	Effective Performance[a]	Ineffective Performance[b]
Performance Skills: Process Skills *(cont'd)*		
Sequences—Performs steps in an effective or logical order and with an absence of randomness in the ordering or inappropriate repetition of steps	Person completes each step of ATM use in logical order.	Person attempts to enter the PIN before inserting the bank card into the card reader.
Terminates—Brings to completion single actions or single steps without inappropriate persistence or premature cessation	Person completes each step of ATM use in the appropriate length of time.	Person persists in entering numbers after completing the four-digit PIN.
Organizing space and objects	**Managing clerical duties for a large company**	
Searches/locates—Looks for and locates task objects in a logical manner	Person readily locates needed office supplies from shelves and drawers.	Person searches a shelf a second time to locate needed clerical supplies.
Gathers—Collects related task objects into the same work space and regathers task objects that have spilled, fallen, or been misplaced	Person gathers required clerical tools and supplies in the assigned work space.	Person places required paper and pen in different work spaces and then must move them to the same work space.
Organizes—Logically positions or spatially arranges task objects in an orderly fashion within a single work space or between multiple appropriate work spaces such that the work space is not too spread out or too crowded	Person organizes required clerical tools and supplies within the work space so all are within reach.	Person places books on top of papers, resulting in a crowded work space.
Restores—Puts away task objects in appropriate places and ensures that the immediate work space is restored to its original condition	Person returns clerical tools and supplies to their original storage location.	Person puts pens and extra paper in a different storage closet from where originally found.
Navigates—Moves body or wheelchair without bumping into obstacles when moving through the task environment or interacting with task objects	Person moves through the office space without bumping into office furniture or machines.	Person bumps hand into the edge of the desk when reaching for a pen from the pen holder.
Adapting performance	**Preparing a green salad for a family meal**	
Notices/responds—Responds appropriately to (1) nonverbal task-related cues (e.g., heat, movement), (2) the spatial arrangement and alignment of task objects to one another, and (3) cupboard doors or drawers that have been left open during task performance	Person notices the carrot rolling off the cutting board and catches it before it rolls onto the floor.	Person delays noticing a rolling carrot, and it rolls off the cutting board onto the floor.
Adjusts—Overcomes problems with ongoing task performance effectively by (1) going to a new workspace; (2) moving task objects out of the current workspace; or (3) adjusting knobs, dials, switches, or water taps	Person readily adjusts the flow of water from the tap when washing vegetables.	Person delays turning off the water tap after washing the vegetables.

(Continued)

Table 7. Performance Skills for Persons *(cont'd)*

Specific Skill Definitions	Examples	
	Effective Performance[a]	**Ineffective Performance[b]**
Performance Skills: Process Skills *(cont'd)*		
Accommodates—Prevents ineffective performance of all other motor and process skills and asks for assistance only when appropriate or needed	Person prevents problems from occurring during the salad preparation.	Person does not prevent problems from occurring, such as carrots rolling off the cutting board and onto the floor.
Benefits—Prevents ineffective performance of all other motor and process skills from recurring or persisting	Person prevents problems from continuing or reoccurring during the salad preparation.	Person retrieves the carrot from the floor and puts it back on the cutting board, and the carrot rolls off the board again.
Social Interaction Skills—*"Social interaction skills* are the group of performance skills that represent small, observable actions related to communicating and interacting with others in the context of engaging in a personally and ecologically relevant daily life task performance that involves social interaction with others" (Fisher & Marterella, 2019, p. 342).		
Initiating and terminating social interaction	**Participating in a community support group**	
Approaches/starts—Approaches or initiates interaction with the social partner in a manner that is socially appropriate	Person politely begins interactions with support group members.	Person begins interactions with support group members by yelling at them from across the room.
Concludes/disengages—Effectively terminates the conversation or social interaction, brings to closure the topic under discussion, and disengages or says goodbye	Person politely ends a conversation with a support group member.	Person abruptly ends interaction with the support group by walking out of the room.
Producing social interaction	**Child playing in the sandbox with others to build roads for cars and trucks**	
Produces speech—Produces spoken, signed, or augmentative (i.e., computer-generated) messages that are audible and clearly articulated	Person produces clear verbal, signed, or augmentative messages to communicate with other children playing in the sandbox.	Person mumbles when interacting with other children playing in the sandbox, and the other children do not understand the message.
Gesticulates—Uses socially appropriate gestures to communicate or support a message	Person gestures by waving or pointing while communicating with other children playing in the sandbox.	Person uses aggressive gestures when interacting with other children playing in the sandbox.
Speaks fluently—Speaks in a fluent and continuous manner, with an even pace (not too fast, not too slow) and without pauses or delays, while sending a message	Person speaks, without pausing, stuttering, or hesitating, when engaging with other children playing in the sandbox.	Person hesitates or pauses when talking with other children playing in the sandbox.
Physically supporting social interaction	**Older adult in a senior residence talking with other residents during a shared mealtime**	
Turns toward—Actively positions or turns body and face toward the social partner or the person who is speaking	Person turns body and face toward other residents while interacting during the meal.	Person turns face away from other residents while interacting during the meal.
Looks—Makes eye contact with the social partner	Person makes eye contact with other residents while interacting during the meal.	Person looks down at own plate while interacting during the meal.

(Continued)

Table 7. Performance Skills for Persons *(cont'd)*

Specific Skill Definitions	Examples	
	Effective Performance[a]	Ineffective Performance[b]
Performance Skills: Social Interaction Skills *(cont'd)*		
Places self—Positions self at an appropriate distance from the social partner	Person sits an appropriate distance from other residents at the table.	Person sits too far from other residents, interfering with interactions.
Touches—Responds to and uses touch or bodily contact with the social partner in a socially appropriate manner	Person touches other residents appropriately during the meal.	Person reaches out, grasps another resident's shirt, and abruptly pulls on it during the meal.
Regulates—Does not demonstrate irrelevant, repetitive, or impulsive behaviors during social interaction	Person avoids demonstrating irrelevant, repetitive, or impulsive behaviors while interacting during the meal.	Person repeatedly taps the fork on the plate while interacting during the meal.
Shaping content of social interaction	**Serving ice cream to customers in an ice cream shop**	
Questions—Requests relevant facts and information and asks questions that support the intended purpose of the social interaction	Person asks customers for their choice of ice cream flavor.	Person asks customers for their choice of ice cream flavor and then repeats the question after they respond.
Replies—Keeps conversation going by replying appropriately to suggestions, opinions, questions, and comments	Person readily replies with relevant answers to customers' questions about ice cream products.	Person delays in replying to customers' questions or provides irrelevant information.
Discloses—Reveals opinions, feelings, and private information about self or others in a socially appropriate manner	Person discloses no personal information about self or others to customers.	Person reveals socially inappropriate details about own family.
Expresses emotions—Displays affect and emotions in a socially appropriate manner	Person displays socially appropriate emotions when sending messages to customers.	Person uses a sarcastic tone of voice when describing ice cream flavor options.
Disagrees—Expresses differences of opinion in a socially appropriate manner	Person expresses a difference of opinion about ice cream products in a polite way.	Person becomes argumentative when a customer requests a flavor that is not available.
Thanks—Uses appropriate words and gestures to acknowledge receipt of services, gifts, or compliments	Person thanks the customers for purchasing ice cream.	Person fails to say thank you after customers purchase ice cream.
Maintaining flow of social interaction	**Sharing suggestions with others in a support group for persons experiencing mental health challenges**	
Transitions—Handles transitions in the conversation or changes the topic without disrupting the ongoing conversation	Person offers comments or suggestions that relate to the topic of mental health challenges, smoothly moving the topic in a relevant direction.	Person abruptly changes the topic of conversation to planning social activities during a discussion of mental health challenges.
Times response—Replies to social messages without delay or hesitation and without interrupting the social partner	Person replies to another group member's question about community supports for mental health challenges after briefly considering how best to respond.	Person replies to another group member's question about community supports for mental health challenges before the other person finishes asking the question.

(Continued)

Table 7. Performance Skills for Persons *(cont'd)*

Specific Skill Definitions	Examples	
	Effective Performance[a]	Ineffective Performance[b]
Performance Skills: Social Interaction Skills *(cont'd)*		
Times duration—Speaks for a reasonable length of time given the complexity of the message	Person sends messages about mental health challenges of an appropriate length.	Person sends prolonged messages containing extraneous details.
Takes turns—Speaks in turn and gives the social partner the freedom to take their turn	Person engages in back-and-forth conversation with others in the group.	Person does not respond to comments from others during the group discussion.
Verbally supporting social interaction	**Visiting a Social Security office to obtain information relative to potential benefits**	
Matches language—Uses a tone of voice, dialect, and level of language that are socially appropriate and matched to the social partner's abilities and level of understanding	Person uses a tone of voice and vocabulary that match those of the Social Security agent.	Person uses a loud voice and slang when interacting with the Social Security agent.
Clarifies—Responds to gestures or verbal messages from the social partner signaling that the social partner does not comprehend or understand a message and ensures that the social partner is following the conversation	Person rephrases the initial question when the Social Security agent requests clarification.	Person asks an unrelated question when the Social Security agent requests clarification of the initial question.
Acknowledges and encourages—Acknowledges receipt of messages, encourages the social partner to continue the social interaction, and encourages all social partners to participate in the interaction	Person nods to indicate understanding of the information shared by the Social Security agent.	Person does not nod or use words to acknowledge receipt of messages sent by the Social Security agent.
Empathizes—Expresses a supportive attitude toward the social partner by agreeing with, empathizing with, or expressing understanding of the social partner's feelings and experiences	Person shows empathy when the Social Security agent expresses frustration with the slow computer system.	Person shows impatience when the Social Security agent expresses frustration with the slow computer system.
Adapting social interaction	**Deciding which restaurant to go to with a group of friends**	
Heeds—Uses goal-directed social interactions focused on carrying out and completing the intended purpose of the social interaction	Person maintains focus on deciding which restaurant to go to.	Person makes comments unrelated to choosing a restaurant, disrupting the group decision making.
Accommodates—Prevents ineffective or socially inappropriate social interaction	Person avoids making ineffective responses to others about restaurant choice.	Person asks a question that is irrelevant to choosing a restaurant.
Benefits—Prevents problems with ineffective or socially inappropriate social interaction from recurring or persisting	Person avoids making reoccurring ineffective comments during the decision making.	Person persists in asking questions irrelevant to choosing a restaurant.

Note. ATM = automated teller machine; PIN = personal identification number.

[a]Effective use of motor and process performance skills is demonstrated when the client carries out an activity efficiently, safely, with ease, or without assistance. Effective use of social interaction performance skills is demonstrated when the client completes interactions in a manner that matches the demands of the social situation. [b]Ineffective performance skills are demonstrated when the client routinely requires assistance or support to perform activities or engage in social interaction. Ineffective use of social interaction performance skills is demonstrated when the client engages in social interactions in a manner that does not appropriately meet the demands of the social situation.

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Table 8. Performance Skills for Groups

To address performance skills for a group client, occupational therapy practitioners analyze the motor, process, and social interaction skills of individual group members to identify whether ineffective performance skills may limit the group's collective outcome. Italicized words in the middle column are specific performance skills defined in Table 7.

Performance Skill Category	Ineffective Performance by an Individual Group Member	Impact on Group Collective Outcome
Group collective outcome: Religious organization committee furnishing spaces for a preschool for member families		
Motor—Obtaining and holding objects	• Member *reaches* with excessive effort for chairs stored in closet. • Member *bends* with stiffness or excessive effort when reaching for the chairs. • Member fumbles when *gripping* writing materials in preparation for recording committee decisions for planning. • Member demonstrates limited finger dexterity to *manipulate* tools for assembling storage units for toys. • Member is unable to *coordinate* one hand and trunk to stabilize self while gripping and loading toys onto shelves.	Other members may need to take responsibility for obtaining and holding objects to accommodate the member's ineffective motor performance skills during the process of furnishing preschool spaces.
Process—Organizing space and objects	• Member repeatedly asks for help when *searching* for needed furniture or *locating* play equipment that is organized logically in near and distant places within the building. • Member does not effectively *gather* required play activity materials in the designated play spaces. • Member has difficulty *organizing* toys or play equipment within the various play spaces in a logical and orderly fashion. • Member does not *restore* toys or play equipment to storage spaces to return the preschool space to an effective order. • Member bumps into play furniture when *navigating* spaces to set up furniture to meet the needs of families or groups.	The group may need to accommodate the member's limitations in effectively organizing space and objects by adjusting the timing of the outcome to allow greater time to complete furnishing the preschool spaces.
Social interaction—Producing social interaction	• Member communicates in whispers when *producing speech* to communicate with other members about decisions for placing play equipment. • Member delays in *gesticulating* so other members do not receive effective messages while arranging toys and play equipment. • Member *speaks fluently* but too quickly when communicating to friends, resulting in challenges for other members in decision making for furnishing the preschool.	The group decision-making process may be hindered by the member's difficulty in producing social interactions. Limited communication during the tasks of placing furniture in preschool spaces may cause confusion among group members.

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Table 9. Client Factors

Client factors include (1) values, beliefs, and spirituality; (2) body functions; and (3) body structures. Client factors reside within the client and influence the client's performance in occupations.

Category	Examples Relevant to Occupational Therapy Practice
Values, Beliefs, and Spirituality—Client's (person's, group's, or population's) perceptions, motivations, and related meaning that influence or are influenced by engagement in occupations.	
Values—Acquired beliefs and commitments, derived from culture, about what is good, right, and important to do (Kielhofner, 2008)	*Person* • Honesty with self and others • Commitment to family *Group* • Obligation to provide a service • Fairness • Inclusion *Population* • Freedom of speech • Equal opportunities for all • Tolerance toward others
Beliefs—"Something that is accepted, considered to be true, or held as an opinion" ("Belief," 2020).	*Person* • One is powerless to influence others. • Hard work pays off. *Group* • Teaching others how to garden decreases their reliance on grocery stores. • Writing letters as part of a neighborhood group can support the creation of a community park. *Population* • Some personal rights are worth fighting for. • A new health care policy, as yet untried, will positively affect society.
Spirituality—"A deep experience of meaning brought about by engaging in occupations that involve the enacting of personal values and beliefs, reflection, and intention within a supportive contextual environment" (Billock, 2005, p. 887). It is important to recognize spirituality "as dynamic and often evolving" (Humbert, 2016, p. 12).	*Person* • Personal search for purpose and meaning in life • Guidance of actions by a sense of value beyond the acquisition of wealth or fame *Group* • Study of religious texts together • Attendance at a religious service *Population* • Common search for purpose and meaning in life • Guidance of actions by values agreed on by the collective
Body Functions—"The physiological functions of body systems (including psychological functions)" (WHO, 2001, p. 10). This section of the table is organized according to the classifications of the *ICF;* for fuller descriptions and definitions, refer to WHO (2001). This list is not all inclusive.	

(Continued)

Table 9. Client Factors *(cont'd)*

Category	Examples Relevant to Occupational Therapy Practice
Body Functions *(cont'd)*	
Mental functions	
Specific mental functions	
Higher level cognitive	Judgment, concept formation, metacognition, executive functions, praxis, cognitive flexibility, insight
Attention	Sustained shifting and divided attention, concentration, distractibility
Memory	Short-term, long-term, and working memory
Perception	Discrimination of sensations (e.g., auditory, tactile, visual, olfactory, gustatory, vestibular, proprioceptive)
Thought	Control and content of thought, awareness of reality vs. delusions, logical and coherent thought
Mental functions of sequencing complex movement	Mental functions that regulate the speed, response, quality, and time of motor production, such as restlessness, toe tapping, or hand wringing, in response to inner tension
Emotional	Regulation and range of emotions; appropriateness of emotions, including anger, love, tension, and anxiety; lability of emotions
Experience of self and time	Awareness of one's identity (including gender identity), body, and position in the reality of one's environment and of time
Global mental functions	
Consciousness	State of awareness and alertness, including the clarity and continuity of the wakeful state
Orientation	Orientation to person, place, time, self, and others
Psychosocial	General mental functions, as they develop over the life span, required to understand and constructively integrate the mental functions that lead to the formation of the personal and interpersonal skills needed to establish reciprocal social interactions, in terms of both meaning and purpose
Temperament and personality	Extroversion, introversion, agreeableness, conscientiousness, emotional stability, openness to experience, self-control, self-expression, confidence, motivation, impulse control, appetite
Energy	Energy level, motivation, appetite, craving, impulse
Sleep	Physiological process, quality of sleep
Sensory functions	
Visual functions	Quality of vision, visual acuity, visual stability, and visual field functions to promote visual awareness of environment at various distances for functioning
Hearing functions	Sound detection and discrimination; awareness of location and distance of sounds
Vestibular functions	Sensation related to position, balance, and secure movement against gravity
Taste functions	Association of taste qualities of bitterness, sweetness, sourness, and saltiness
Smell functions	Sensing of odors and smells
Proprioceptive functions	Awareness of body position and space

(Continued)

Table 9. Client Factors *(cont'd)*

Category	Examples Relevant to Occupational Therapy Practice
Body Functions *(cont'd)*	
Touch functions	Feeling of being touched by others or touching various textures, such as those of food; presence of numbness, paresthesia, hyperesthesia
Interoception	Internal detection of changes in one's internal organs through specific sensory receptors (e.g., awareness of hunger, thirst, digestion, state of alertness)
Pain	Unpleasant feeling indicating potential or actual damage to some body structure; sensations of generalized or localized pain (e.g., diffuse, dull, sharp, phantom)
Sensitivity to temperature and pressure	Thermal awareness (hot and cold), sense of force applied to skin (thermoreception)
Neuromusculoskeletal and movement-related functions	
Functions of joints and bones	
Joint mobility	Joint range of motion
Joint stability	Maintenance of structural integrity of joints throughout the body; physiological stability of joints related to structural integrity
Muscle functions	
Muscle power	Strength
Muscle tone	Degree of muscle tension (e.g., flaccidity, spasticity, fluctuation)
Muscle endurance	Sustainability of muscle contraction
Movement functions	
Motor reflexes	Involuntary contraction of muscles automatically induced by specific stimuli (e.g., stretch, asymmetrical tonic neck, symmetrical tonic neck)
Involuntary movement reactions	Postural reactions, body adjustment reactions, supporting reactions
Control of voluntary movement	Eye–hand and eye–foot coordination, bilateral integration, crossing of the midline, fine and gross motor control, oculomotor function (e.g., saccades, pursuits, accommodation, binocularity)
Gait patterns	Gait and mobility in relation to engagement in daily life activities (e.g., walking patterns and impairments, asymmetric gait, stiff gait)
Cardiovascular, hematological, immune, and respiratory system functions (*Note.* Occupational therapy practitioners have knowledge of these body functions and understand broadly the interaction that occurs among these functions to support health, well-being, and participation in life through engagement in occupation.)	
Cardiovascular system functions	Maintenance of blood pressure functions (hypertension, hypotension, postural hypotension), heart rate and rhythm
Hematological and immune system functions	Protection against foreign substances, including infection, allergic reactions
Respiratory system functions	Rate, rhythm, and depth of respiration
Additional functions and sensations of the cardiovascular and respiratory systems	Physical endurance, aerobic capacity, stamina, fatigability

(Continued)

Table 9. Client Factors *(cont'd)*

Category	Examples Relevant to Occupational Therapy Practice
Voice and speech functions; digestive, metabolic, and endocrine system functions; genitourinary and reproductive functions (*Note.* Occupational therapy practitioners have knowledge of these body functions and understand broadly the interaction that occurs among these functions to support health, well-being, and participation in life through engagement in occupation.)	
Voice and speech functions	Fluency and rhythm, alternative vocalization functions
Digestive, metabolic, and endocrine system functions	Digestive system functions, metabolic system, and endocrine system functions
Genitourinary and reproductive functions	Genitourinary and reproductive functions
Skin and related structure functions (*Note.* Occupational therapy practitioners have knowledge of these body functions and understand broadly the interaction that occurs among these functions to support health, well-being, and participation in life through engagement in occupation.)	
Skin functions Hair and nail functions	Protection (presence or absence of wounds, cuts, or abrasions), repair (wound healing)
Body Structures—"Anatomical parts of the body, such as organs, limbs, and their components" that support body function (WHO, 2001, p. 10). This section of the table is organized according to the *ICF* classifications; for fuller descriptions and definitions, refer to WHO (2001).	
Structure of the nervous system Structures related to the eyes and ears Structures involved in voice and speech Structures of the cardiovascular, immunological, and respiratory systems Structures related to the digestive, metabolic, and endocrine systems Structures related to the genitourinary and reproductive systems Structures related to movement	Occupational therapy practitioners have knowledge of body structures and understand broadly the interaction that occurs between these structures to support health, well-being, and participation in life through engagement in occupation.

Note. The categorization of body functions and body structures is based on the *ICF* (WHO, 2001). The classification was selected because it has received wide exposure and presents a language that is understood by external audiences. *ICF* = *International Classification of Function, Disability and Health;* WHO = World Health Organization.

Table 10. Occupational Therapy Process for Persons, Groups, and Populations
The occupational therapy process applies to work with persons, groups, and populations. The process for groups and populations mirrors that for persons. The process for populations includes public health approaches, and the process for groups may include both person and population methods to address occupational performance (Scaffa & Reitz, 2014).

Process Component	Process Step		
	Person	**Group**	**Population**
Evaluation	*Consultation and screening:* • Review client history • Consult with interprofessional team • Administer standardized screening tools	*Consultation and screening, environmental scan:* • Identify collective need on the basis of available data • For each individual in the group, ◦ Review history ◦ Administer standardized screening tools ◦ Consult with interprofessional team	*Environmental scan, trend analysis, preplanning:* • Collect data to inform design of intervention program by identifying information needs • Identify health trends in targeted population and potential positive and negative impacts on occupational performance
	Occupational profile: • Interview client and caregiver	*Occupational profile or community profile:* • Interview persons who make up the group • Engage with persons in the group to determine their interests, needs, and priorities	*Needs assessment, community profile:* • Engage with persons within the population to determine their interests and needs and opportunities for collaboration • Identify priorities through ◦ Surveys ◦ Interviews ◦ Group discussions or forums
	Analysis of occupational performance: • Assess occupational performance • Conduct occupational and activity analysis • Assess contexts • Assess performance skills and patterns • Assess client factors	*Analysis of occupational performance:* • Conduct occupational and activity analysis • Assess group context • Assess the following for individual group members: ◦ Occupational performance ◦ Performance skills and patterns ◦ Client factors • Analyze impact of individual performance on the group	*Needs assessment, review of secondary data:* • Evaluate existing quantitative data, which may include ◦ Public health records ◦ Prevalence of disease or disability ◦ Demographic data ◦ Economic data
	Synthesis of evaluation process: • Review and consolidate information to select occupational outcomes and determine impact of performance patterns and client factors on occupation	*Synthesis of evaluation process:* • Review and consolidate information to select collective occupational outcomes • Review and consolidate information regarding each member's performance and its impact on the group and the group's occupational performance as a whole	*Data analysis and interpretation:* • Review and consolidate information to support need for the program and identify any missing data
Intervention	*Development of the intervention plan:* • Identify client goals • Identify intervention outcomes • Select outcome measures	*Development of the intervention plan or program:* • Identify collective group goals	*Program planning:* • Identify short-term program objectives • Identify long-term program goals

(Continued)

Table 10. Occupational Therapy Process for Persons, Groups, and Populations *(cont'd)*

Process Component	Process Step		
	Person	**Group**	**Population**
	• Select methods for service delivery, including theoretical framework	• Identify intervention outcomes for the group • Select outcome measures • Select methods for service delivery, including theoretical framework	• Select outcome measures to be used in program evaluation • Select strategies for service delivery, including theoretical framework
	Intervention implementation: • Carry out occupational therapy intervention to address specific occupations, contexts, and performance patterns and skills affecting performance	*Intervention or program implementation:* • Carry out occupational therapy intervention or program to address the group's specific occupations, contexts, and performance patterns and skills affecting group performance	*Program implementation:* • Carry out program or advocacy action to address identified occupational needs
	Intervention review: • Reevaluate and review client's response to intervention • Review progress toward goals and outcomes • Modify plan as needed	*Intervention review or program evaluation:* • Reevaluate and review individual members' and the group's response to intervention • Review progress toward goals and outcomes • Modify plan as needed • Evaluate efficiency of program • Evaluate achievement of determined objectives	*Program evaluation:* • Gather information on program implementation • Measure the impact of the program • Evaluate efficiency of program • Evaluate achievement of determined objectives
Outcomes	*Outcomes:* • Use measures to assess progress toward outcomes • Identify change in occupational participation	*Outcomes:* • Use measures to assess progress toward outcomes • Identify change in occupational performance of individual members and the group as a whole	*Outcomes:* • Use measures to assess progress toward long-term program goals • Identify change in occupational performance of targeted population
	Transition: • Facilitate client's move from one life role or experience to another, such as ◦ Moving to a new level of care ◦ Transitioning between providers ◦ Moving into a new setting or program	*Transition:* • Facilitate group members' move from one life role or experience to another, such as ◦ Moving to a new level of care ◦ Transitioning between providers ◦ Moving into a new setting or program	*Sustainability plan:* • Develop action plan to maintain program • Identify sources of funding • Build community capacity and support relationships to continue program
	Discontinuation: • Discontinue care after short- and long-term goals have been achieved or client chooses to no longer participate • Implement discharge plan to support performance after discontinuation of services	*Discontinuation:* • Discontinue care after the group's short- and long-term goals have been achieved • Implement discharge plan to support performance after discontinuation of services	*Dissemination plan:* • Share results with participants, stakeholders, and community members • Implement sustainability plan

Table 11. Occupation and Activity Demands

Occupation and activity demands are the components of occupations and activities that occupational therapy practitioners consider in their professional and clinical reasoning process. *Activity demands* are what is typically required to carry out the activity regardless of client and context. *Occupation demands* are what is required by the specific client (person, group, or population) to carry out an occupation. Depending on the context and needs of the client, occupation and activity demands can act as barriers to or supports for participation. Specific knowledge about activity demands assists practitioners in selecting occupations for therapeutic purposes.

Type of Demand	Activity Demands: Typically Required to Carry Out the Activity	Occupational Demands: Required by the Client (Person, Group, or Population) to Carry Out the Occupation
Relevance and importance	General meaning of the activity within the given culture	Meaning the client derives from the occupation, which may be subjective and personally constructed; symbolic, unconscious, and metaphorical; and aligned with the client's goals, values, beliefs, and needs and perceived utility
	Person: Knitting clothing items for personal use, for income from sale, or as a leisure activity	*Person:* Knitting as a way to practice mindfulness strategies for coping with anxiety
	Group: Cooking to provide nutrition, fulfill a family role, or engage in a leisure activity	*Group:* Preparation of a holiday meal with family to connect members to each other and to their culture and traditions
	Population: Presence of accessible restrooms in public spaces in compliance with federal law	*Population:* Creation of new accessible and all-gender restrooms to symbolize a community's commitment to safety and inclusion of members with disabilities and LGBTQ+ members
Objects used and their properties: Tools (e.g., scissors, dishes, shoes, volleyball), supplies (e.g., paints, milk, lipstick), equipment (e.g., workbench, stove, basketball hoop), and resources (e.g., money, transportation) required in the process of carrying out the activity or occupation and their inherent properties (e.g., heavy, rough, sharp, colorful, loud, bitter tasting)	*Person:* Computer workstation that includes a computer, keyboard, mouse, desk, and chair	
	Group: Financial and transportation resources for a group of friends to attend a concert	
	Population: Tools, supplies, and equipment for flood relief efforts to ensure safety of people with disabilities	
Space demands: Physical environment requirements of the occupation or activity (e.g., size, arrangement, surface, lighting, temperature, noise, humidity, ventilation)	*Person:* Desk arrangement in an elementary school classroom	
	Group: Accessible meeting space to run a fall prevention workshop	
	Population: Noise, lighting, arrangement, and temperature controls for a sensory-friendly museum	
Social demands: Elements of the social and attitudinal environments required for the occupation or activity	*Person:* Rules of engagement for a child at recess	
	Group: Expectations of travelers in an airport (e.g., waiting in line, following cues from staff and others, asking questions when needed)	
	Population: Understanding of the social and political climate of the geographic region	

(Continued)

Table 11. Occupation and Activity Demands *(cont'd)*

Type of Demand	Activity Demands: Typically Required to Carry Out the Activity	Occupational Demands: Required by the Client (Person, Group, or Population) to Carry Out the Occupation
Sequencing and timing demands: Temporal process required to carry out the activity or occupation (e.g., specific steps, sequence of steps, timing requirements)	*Person:* Preferred sequence and timing of a client's morning routine to affirm social, cultural, and gender identity	
	Group: Steps a class of students takes in preparation to start the school day	
	Population: Public train schedules	
Required actions and performance skills: Actions and performance skills (motor, process, and social interaction) that are an inherent part of the activity or occupation	*Person:* Body movements required to drive a car	
	Group and population: See "Performance Skills" section for discussion related to groups and population	
Required body functions: "Physiological functions of body systems (including psychological functions)" (WHO, 2001, p. 10) required to support the actions used to perform the activity or occupation	*Person:* Cognitive level required for a child to play a game	
	Group and population: See "Client Factors" section for discussion of required body functions related to groups and populations	
Required body structures: "Anatomical parts of the body such as organs, limbs, and their components" that support body functions (WHO, 2001, p. 10) and are required to perform the activity or occupation	*Person:* Presence of upper limbs to play catch	
	Group and population: See "Client Factors" section for discussion of required body structures related to groups and populations	

Note. WHO = World Health Organization.

Table 12. Types of Occupational Therapy Interventions
Occupational therapy intervention types include occupations and activities, interventions to support occupations, education and training, advocacy, group interventions, and virtual interventions. Occupational therapy interventions facilitate engagement in occupation to enable persons, groups, and populations to achieve health, well-being, and participation in life. The examples provided illustrate the types of interventions that clients engage in (denoted as "client") and that occupational therapy practitioners provide (denoted as "practitioner") and are not intended to be all-inclusive.

Intervention Type	Description	Examples
Occupations and Activities—Occupations and activities selected as interventions for specific clients are designed to meet therapeutic goals and address the underlying needs of the client's mind, body, and spirit. To use occupations and activities therapeutically, the practitioner considers activity demands and client factors in relation to the client's therapeutic goals and contexts.		
Occupations	Broad and specific daily life events that are personalized and meaningful to the client	*Person* Client completes morning dressing and hygiene using adaptive devices. *Group* Client plays a group game of tag on the playground to improve social participation. *Population* Practitioner creates an app to improve access for people with autism spectrum disorder using metropolitan paratransit systems.
Activities	Components of occupations that are objective and separate from the client's engagement or contexts. Activities as interventions are selected and designed to support the development of performance skills and performance patterns to enhance occupational engagement.	*Person* Client selects clothing and manipulates clothing fasteners in advance of dressing. *Group* Group members separate into two teams for a game of tag. *Population* Client establishes parent volunteer committees at their children's school.
Interventions to Support Occupations—Methods and tasks that prepare the client for occupational performance are used as part of a treatment session in preparation for or concurrently with occupations and activities or provided to a client as a home-based engagement to support daily occupational performance.		
PAMs and mechanical modalities	Modalities, devices, and techniques to prepare the client for occupational performance. Such approaches should be part of a broader plan and not used exclusively.	*Person* Practitioner administers PAMs to decrease pain, assist with wound healing or edema control, or prepare muscles for movement to enhance occupational performance. *Group* Practitioner develops a reference manual on postmastectomy manual lymphatic drainage techniques for implementation at an outpatient facility.

(Continued)

Table 12. Types of Occupational Therapy Interventions *(cont'd)*

Intervention Type	Description	Examples
Orthotics and prosthetics	Construction of devices to mobilize, immobilize, or support body structures to enhance participation in occupations	*Person* Practitioner fabricates and issues a wrist orthosis to facilitate movement and enhance participation in household activities. *Group* Group members participate in a basketball game with veterans using prosthetics after amputation.
Assistive technology and environmental modifications	Assessment, selection, provision, and education and training in use of high- and low-tech assistive technology; application of universal design principles; and recommendations for changes to the environment or activity to support the client's ability to engage in occupations	*Person* Practitioner recommends using a visual support (e.g., social story) to guide behavior. *Group* Practitioner uses a smart board with speaker system during a social skills group session to improve participants' attention. *Population* Practitioner recommends that a large health care organization paint exits in their facilities to resemble bookshelves to deter patients with dementia from eloping.
Wheeled mobility	Products and technologies that facilitate a client's ability to maneuver through space, including seating and positioning; improve mobility to enhance participation in desired daily occupations; and reduce risk for complications such as skin breakdown or limb contractures	*Person* Practitioner recommends, in conjunction with the wheelchair team, a sip-and-puff switch to allow the client to maneuver the power wheelchair independently and interface with an environmental control unit in the home. *Group* Group of wheelchair users in the same town host an educational peer support event.
Self-regulation	Actions the client performs to target specific client factors or performance skills. Intervention approaches may address sensory processing to promote emotional stability in preparation for social participation or work or leisure activities or executive functioning to support engagement in occupation and meaningful activities. Such approaches involve active participation of the client and sometimes use of materials to simulate components of occupations.	*Person* Client participates in a fabricated sensory environment (e.g., through movement, tactile sensations, scents) to promote alertness before engaging in a school-based activity. *Group* Practitioner instructs a classroom teacher to implement mindfulness techniques, visual imagery, and rhythmic breathing after recess to enhance students' success in classroom activities. *Population* Practitioner consults with businesses and community sites to establish sensory-friendly environments for people with sensory processing deficits.

(Continued)

Table 12. Types of Occupational Therapy Interventions *(cont'd)*

Intervention Type	Description	Examples
Education and Training		
Education	Imparting of knowledge and information about occupation, health, well-being, and participation to enable the client to acquire helpful behaviors, habits, and routines	*Person* Practitioner provides education regarding home and activity modifications to the spouse or family member of a person with dementia to support maximum independence. *Group* Practitioner participates in a team care planning meeting to educate the family and team members on a patient's condition and level of function and establish a plan of care. *Population* Practitioner educates town officials about the value of and strategies for constructing walking and biking paths accessible to people who use mobility devices.
Training	Facilitation of the acquisition of concrete skills for meeting specific goals in a real-life, applied situation. In this case, *skills* refers to measurable components of function that enable mastery. Training is differentiated from education by its goal of enhanced performance as opposed to enhanced understanding, although these goals often go hand in hand (Collins & O'Brien, 2003).	*Person* Practitioner instructs the client in the use of coping skills such as deep breathing to address anxiety symptoms before engaging in social interaction. *Group* Practitioner provides an in-service on applying new reimbursement and practice standards adopted by a facility. *Population* Practitioner develops a training program to support practice guidelines addressing occupational deprivation and cultural competence for practitioners working with refugees.
Advocacy—Efforts directed toward promoting occupational justice and empowering clients to seek and obtain resources to support health, well-being, and occupational participation.		
Advocacy	Advocacy efforts undertaken by the practitioner	*Person* Practitioner collaborates with a client to procure reasonable accommodations at a work site. *Group* Practitioner collaborates with and educates teachers in an elementary school about inclusive classroom design. *Population* Practitioner serves on the policy board of an organization to procure supportive housing accommodations for people with disabilities.

(Continued)

Table 12. Types of Occupational Therapy Interventions *(cont'd)*

Intervention Type	Description	Examples
Self-advocacy	Advocacy efforts undertaken by the client with support by the practitioner	*Person* Client requests reasonable accommodations, such as audio textbooks, to support their learning disability. *Group* Client participates in an employee meeting to request and procure adjustable chairs to improve comfort at computer workstations. *Population* Client participates on a student committee partnering with school administration to develop cyberbullying prevention programs in their district.
Group Interventions—Use of distinct knowledge of the dynamics of group and social interaction and leadership techniques to facilitate learning and skill acquisition across the lifespan. Groups are used as a method of service delivery.		
Functional groups, activity groups, task groups, social groups, and other groups	Groups used in health care settings, within the community, or within organizations that allow clients to explore and develop skills for participation, including basic social interaction skills and tools for self-regulation, goal setting, and positive choice making	*Person* Client participates in a group for adults with traumatic brain injury focused on individual goals for reentering the community after inpatient treatment. *Group* Group of older adults participates in volunteer days to maintain participation in the community through shared goals. *Population* Practitioner works with middle school teachers in a district on approaches to address issues of self-efficacy and self-esteem as the basis for creating resiliency in children at risk for being bullied.
Virtual Interventions—Use of simulated, real-time, and near-time technologies for service delivery absent of physical contact, such as telehealth or mHealth.		
Telehealth (telecommunication and information technology) and mHealth (mobile telephone application technology)	Use of technology such as video conferencing, teleconferencing, or mobile telephone application technology to plan, implement, and evaluate occupational therapy intervention, education, and consultation	*Person* Practitioner performs a telehealth therapy session with a client living in a rural area. *Group* Client participates in an initial online support group session to establish group protocols, procedures, and roles. *Population* Practitioner develops methods and standards for mHealth in community occupational therapy practice.

Note. mHealth = mobile health; PAMs = physical agent modalities.

Table 13. Approaches to Intervention
Approaches to intervention are specific strategies selected to direct the evaluation and intervention processes on the basis of the client's desired outcomes, evaluation data, and research evidence. Approaches inform the selection of practice models, frames of references, and treatment theories.

Approach	Description	Examples
Create, promote (health promotion)	An intervention approach that does not assume a disability is present or that any aspect would interfere with performance. This approach is designed to provide enriched contextual and activity experiences that will enhance performance for all people in the natural contexts of life (adapted from Dunn et al., 1998, p. 534).	*Person* Develop a fatigue management program for a client recently diagnosed with multiple sclerosis *Group* Create a resource list of developmentally appropriate toys to be distributed by staff at a day care program *Population* Develop a falls prevention curriculum for older adults for trainings at senior centers and day centers
Establish, restore (remediation, restoration)	Approach designed to change client variables to establish a skill or ability that has not yet developed or to restore a skill or ability that has been impaired (adapted from Dunn et al., 1998, p. 533)	*Person* Restore a client's upper extremity movement to enable transfer of dishes from the dishwasher into the upper kitchen cabinets Collaborate with a client to help establish morning routines needed to arrive at school or work on time *Group* Educate staff of a group home for clients with serious mental illness to develop a structured schedule, chunking tasks to decrease residents' risk of being overwhelmed by the many responsibilities of daily life roles *Population* Restore access ramps to a church entrance after a hurricane
Maintain	Approach designed to provide supports that will allow clients to preserve the performance capabilities that they have regained and that continue to meet their occupational needs. The assumption is that without continued maintenance intervention, performance would decrease and occupational needs would not be met, thereby affecting health, well-being, and quality of life.	*Person* Provide ongoing intervention for a client with amyotrophic lateral sclerosis to address participation in desired occupations through provision of assistive technology *Group* Maintain environmental modifications at a group home for young adults with physical disabilities for continued safety and engagement with housemates

(Continued)

Table 13. Approaches to Intervention *(cont'd)*

Approach	Description	Examples
		Population Maintain safe and independent access for people with low vision by increasing hallway lighting in a community center
Modify (compensation, adaptation)	Approach directed at "finding ways to revise the current context or activity demands to support performance in the natural setting, [including] compensatory techniques . . . [such as] enhancing some features to provide cues or reducing other features to reduce distractibility" (Dunn et al., 1998, p. 533)	*Person* Simplify task sequence to help a person with cognitive impairments complete a morning self-care routine *Group* Modify a college campus housing building to accommodate a group of students with mobility impairments *Population* Consult with architects and builders to design homes that will support aging in place and use universal design principles
Prevent (disability prevention)	Approach designed to address the needs of clients with or without a disability who are at risk for occupational performance problems. This approach is designed to prevent the occurrence or evolution of barriers to performance in context. Interventions may be directed at client, context, or activity variables (adapted from Dunn et al., 1998, p. 534).	*Person* Aid in the prevention of illicit substance use by introducing self-initiated routine strategies that support drug-free behavior *Group* Prevent social isolation of employees by promoting participation in after-work group activities *Population* Consult with a hotel chain to provide an ergonomics educational program designed to prevent back injuries in housekeeping staff

Table 14. Outcomes

Outcomes are the end result of the occupational therapy process; they describe what clients can achieve through occupational therapy intervention. Some outcomes are measurable and are used for intervention planning and review and discharge planning. These outcomes reflect the attainment of treatment goals that relate to engagement in occupation. Other outcomes are experienced by clients when they have realized the effects of engagement in occupation and are able to return to desired habits, routines, roles, and rituals.

Adaptation is embedded in all categories of outcomes. The examples listed specify how the broad outcome of health and participation in life may be operationalized.

Outcome Category	Description	Examples
Occupational performance	Act of doing and accomplishing a selected action (performance skill), activity, or occupation (Fisher, 2009; Fisher & Griswold, 2019; Kielhofner, 2008) that results from the dynamic transaction among the client, the context, and the activity. Improving or enhancing skills and patterns in occupational performance leads to engagement in occupations or activities (adapted in part from Law et al., 1996, p. 16).	*Person* A patient with hip precautions showers safely with modified independence using a tub transfer bench and a long-handled sponge. *Group* A group of older adults cooks a holiday meal during their stay in a skilled nursing facility with minimal assistance from staff. *Population* A community welcomes children with spina bifida in public settings after a news story featuring occupational therapy practitioners.
Improvement	Increased occupational performance through adaptation when a performance limitation is present	*Person* A child with autism plays interactively with a peer. An older adult returns home from a skilled nursing facility as desired. *Group* Back strain in nursing personnel decreases as a result of an in-service education program on body mechanics for job duties that require bending and lifting. *Population* Accessible playground facilities for all children are constructed in city parks.
Enhancement	Development of performance skills and performance patterns that augment existing performance of life occupations when a performance limitation is not present	*Person* A teenage mother experiences increased confidence and competence in parenting as a result of structured social groups and child development classes. *Group* Membership in the local senior citizen center increases as a result of expanded social wellness and exercise programs. School staff have increased ability to address and manage school-age youth violence as a result of conflict resolution training to address bullying. *Population* Older adults have increased opportunities to participate in community activities through ride-share programs.

(Continued)

Table 14. Outcomes *(cont'd)*

Outcome Category	Description	Examples
Prevention	Education or health promotion efforts designed to identify, reduce, or stop the onset and reduce the incidence of unhealthy conditions, risk factors, diseases, or injuries. Occupational therapy promotes a healthy lifestyle at the individual, group, population (societal), and government or policy level (adapted from AOTA, 2020b).	*Person* A child with orthopedic impairments is provided with appropriate seating and a play area. *Group* A program of leisure and educational activities is implemented at a drop-in center for adults with serious mental illness. *Population* Access to occupational therapy services is provided in underserved areas where residents typically receive other services.
Health and wellness	*Health:* State of physical, mental, and social well-being, as well as a positive concept emphasizing social and personal resources and physical capacities (WHO, 1986). Health for groups and populations also includes social responsibility of members to the group or population as a whole. *Wellness:* "Active process through which individuals [or groups or populations] become aware of and make choices toward a more successful existence" (Hettler, 1984, p. 1117). Wellness is more than a lack of disease symptoms; it is a state of mental and physical balance and fitness (adapted from "Wellness," 1997, p. 2110)	*Person* A person with a mental health challenge participates in an empowerment and advocacy group to improve services in the community. A person with attention deficit hyperactivity disorder demonstrates self-management through the ability to manage the various aspects of their life. *Group* A company-wide program for employees is implemented to identify problems and solutions regarding the balance among work, leisure, and family life. *Population* The incidence of childhood obesity decreases.
Quality of life	Dynamic appraisal of the client's life satisfaction (perceptions of progress toward goals), hope (real or perceived belief that one can move toward a goal through selected pathways), self-concept (composite of beliefs and feelings about oneself), health and functioning (e.g., health status, self-care capabilities), and socioeconomic factors (e.g., vocation, education, income; adapted from Radomski, 1995)	*Person* A deaf child from a hearing family participates fully and actively during a recreational activity. *Group* A facility experiences increased participation of residents during outings and independent travel as a result of independent living skills training for care providers. *Population* A lobby is formed to support opportunities for social networking, advocacy activities, and sharing of scientific information for stroke survivors and their families.

(Continued)

Table 14. Outcomes *(cont'd)*

Outcome Category	Description	Examples
Participation	Engagement in desired occupations in ways that are personally satisfying and congruent with expectations within the culture	*Person* A person recovers the ability to perform the essential duties of his or her job after a flexor tendon laceration. *Group* A family enjoys a vacation spent traveling cross-country in their adapted van. *Population* All children within a state have access to school sports programs.
Role competence	Ability to effectively meet the demands of the roles in which one engages	*Person* A person with cerebral palsy is able to take notes and type papers to meet the demands of the student role. *Group* A factory implements job rotation to allow sharing of higher demand tasks so employees can meet the demands of the worker role. *Population* Accessibility of polling places is improved, enabling all people with disabilities in the community to meet the demands of the citizen role.
Well-being	Contentment with one's health, self-esteem, sense of belonging, security, and opportunities for self-determination, meaning, roles, and helping others (Hammell, 2009). *Well-being* is "a general term encompassing the total universe of human life domains, including physical, mental, and social aspects, that make up what can be called a 'good life'" (WHO, 2006, p. 211).	*Person* A person with amyotrophic lateral sclerosis achieves contentment with their ability to find meaning in fulfilling the role of parent through compensatory strategies and environmental modifications. *Group* Members of an outpatient depression and anxiety support group feel secure in their sense of group belonging and ability to help other members. *Population* Residents of a town celebrate the groundbreaking for a school being reconstructed after a natural disaster.

(Continued)

Table 14. Outcomes *(cont'd)*

Outcome Category	Description	Examples
Occupational justice	Access to and participation in the full range of meaningful and enriching occupations afforded to others, including opportunities for social inclusion and resources to participate in occupations to satisfy personal, health, and societal needs (adapted from Townsend & Wilcock, 2004)	*Person* An individual with intellectual and developmental disabilities serves on an advisory board to establish programs to be offered by a community recreation center. *Group* Workers have enough break time to eat lunch with their young children in the day care center. *Group and Population* People with persistent mental illness experience an increased sense of empowerment and self-advocacy skills, enabling them to develop an antistigma campaign promoting engagement in the civic arena (group) and alternative adapted housing options for older adults to age in place (population).

Note. AOTA = American Occupational Therapy Association; WHO = World Health Organization.

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Appendix A. Glossary

A

Activities
Actions designed and selected to support the development of performance skills and performance patterns to enhance occupational engagement.

Activities of daily living (ADLs)
Activities that are oriented toward taking care of one's own body (adapted from Rogers & Holm, 1994) and are completed on a daily basis. These activities are "fundamental to living in a social world; they enable basic survival and well-being" (Christiansen & Hammecker, 2001, p. 156; see Table 2).

Activity analysis
Generic and decontextualized analysis that seeks to develop an understanding of typical activity demands within a given culture.

Activity demands
Aspects of an activity needed to carry it out, including relevance and importance to the client, objects used and their properties, space demands, social demands, sequencing and timing, required actions and performance skills, and required underlying body functions and body structures (see Table 11).

Adaptation
Effective and efficient response by the client to occupational and contextual demands (Grajo, 2019).

Advocacy
Efforts directed toward promoting occupational justice and empowering clients to seek and obtain resources to fully participate in their daily life occupations. Efforts undertaken by the practitioner are considered advocacy, and those undertaken by the client are considered self-advocacy and can be promoted and supported by the practitioner (see Table 12).

Analysis of occupational performance
The step in the evaluation process in which the client's assets and limitations or potential problems are more specifically determined through assessment tools designed to analyze, measure, and inquire about factors that support or hinder occupational performance (see Exhibit 2).

Assessment
"A specific tool, instrument, or systematic interaction . . . used to understand a client's occupational profile, client factors, performance skills, performance patterns, and contextual and environmental factors, as well as activity demands that influence occupational performance" (Hinojosa et al., 2014, pp. 3–4).

B

Belief

Something that is accepted, considered to be true, or held as an opinion ("Belief," 2020).

Body functions

"Physiological functions of body systems (including psychological functions)" (World Health Organization, 2001, p. 10; see Table 9).

Body structures

"Anatomical parts of the body, such as organs, limbs, and their components" that support body functions (World Health Organization, 2001, p. 10; see Table 9).

C

Client

Person (including one involved in the care of a client), *group* (collection of individuals having shared characteristics or common or shared purpose, e.g., family members, workers, students, and those with similar interests or occupational challenges), or *population* (aggregate of people with common attributes such as contexts, characteristics, or concerns, including health risks; Scaffa & Reitz, 2014).

Client-centered care (client-centered practice)

Approach to service that incorporates respect for and partnership with clients as active participants in the therapy process. This approach emphasizes clients' knowledge and experience, strengths, capacity for choice, and overall autonomy (Schell & Gillen, 2019, p. 1194).

Client factors

Specific capacities, characteristics, or beliefs that reside within the person and that influence performance in occupations. Client factors include values, beliefs, and spirituality; body functions; and body structures (see Table 9).

Clinical reasoning

See *Professional reasoning*

Collaboration

"The complex interpretative acts in which the practitioners must understand the meanings of the interventions, the meanings of illness or disability in a person and family's life, and the feelings that accompany these experiences" (Lawlor & Mattingly, 2019, p. 201).

Community

Collection of populations that is changeable and diverse and includes various people, groups, networks, and organizations (Scaffa, 2019; World Federation of Occupational Therapists, 2019).

Context

Construct that constitutes the complete makeup of a person's life as well as the common and divergent factors that characterize groups and populations. Context includes environmental factors and personal factors (see Tables 4 and 5).

Co-occupation

Occupation that implicitly involves two or more individuals (Schell & Gillen, 2019, p. 1195) and includes aspects of physicality, emotionality, and intentionality (Pickens & Pizur-Barnekow, 2009).

Cornerstone

Something of significance on which everything else depends.

D

Domain

Profession's purview and areas in which its members have an established body of knowledge and expertise.

E

Education

As an occupation: Activities involved in learning and participating in the educational environment (see Table 2).
As an environmental factor of context: Processes and methods for acquisition of knowledge, expertise, or skills (see Table 4).
As an intervention: Activities that impart knowledge and information about occupation, health, well-being, and participation, resulting in acquisition by the client of helpful behaviors, habits, and routines that may or may not require application at the time of the intervention session (see Table 12).

Empathy

Emotional exchange between occupational therapy practitioners and clients that allows more open communication, ensuring that practitioners connect with clients at an emotional level to assist them with their current life situation.

Engagement in occupation

Performance of occupations as the result of choice, motivation, and meaning within a supportive context.

Environmental factors

Aspects of the physical, social, and attitudinal surroundings in which people live and conduct their lives.

Evaluation

"The comprehensive process of obtaining and interpreting the data necessary to understand the person, system, or situation. . . . Evaluation requires synthesis of all data obtained, analytic interpretation of that data, reflective clinical reasoning, and consideration of occupational performance and contextual factors" (Hinojosa et al., 2014, p. 3).

G

Goal

Measurable and meaningful, occupation-based, long-term or short-term aim directly related to the client's ability and need to engage in desired occupations (AOTA, 2018a, p. 4).

Group

Collection of individuals having shared characteristics or a common or shared purpose (e.g., family members, workers, students, others with similar occupational interests or occupational challenges).

Group intervention

Use of distinct knowledge and leadership techniques to facilitate learning and skill acquisition across the lifespan through the dynamics of group and social interaction. Groups may be used as a method of service delivery (see Table 12).

H

Habilitation

Health care services that help a person keep, learn, or improve skills and functioning for daily living (e.g., therapy for a child who does not walk or talk at the expected age). These services may include physical and occupational therapy, speech-language pathology, and other services for people with disabilities in a variety of inpatient and outpatient settings ("Provision of EHB," 2015).

Habits

"Specific, automatic behaviors performed repeatedly, relatively automatically, and with little variation" (Matuska & Barrett, 2019, p. 214). Habits can be healthy or unhealthy, efficient or inefficient, and supportive or harmful (Dunn, 2000).

Health

"State of complete physical, mental, and social well-being, and not merely the absence of disease or infirmity" (World Health Organization, 2006, p. 1).

Health management

Occupation focused on developing, managing, and maintaining routines for health and wellness by engaging in self-care with the goal of improving or maintaining health, including self-management, to allow for participation in other occupations (see Table 2).

Health promotion

"Process of enabling people to increase control over, and to improve, their health. To reach a state of complete physical, mental, and social well-being, an individual or group must be able to identify and realize aspirations, to satisfy needs, and to change or cope with the environment" (World Health Organization, 1986).

Hope

Real or perceived belief that one can move toward a goal through selected pathways.

I

Independence

"Self-directed state of being characterized by an individual's ability to participate in necessary and preferred occupations in a satisfying manner irrespective of the amount or kind of external assistance desired or required" (AOTA, 2002a, p. 660).

Instrumental activities of daily living (IADLs)

Activities that support daily life within the home and community and that often require more complex interactions than those used in ADLs (see Table 2).

Interdependence

"Reliance that people have on one another as a natural consequence of group living" (Christiansen & Townsend, 2010, p. 419). "Interdependence engenders a spirit of social inclusion, mutual aid, and a moral commitment and responsibility to recognize and support difference" (Christiansen & Townsend, 2010, p. 187).

Interests

"What one finds enjoyable or satisfying to do" (Kielhofner, 2008, p. 42).

Intervention

"Process and skilled actions taken by occupational therapy practitioners in collaboration with the client to facilitate engagement in occupation related to health and participation. The intervention process includes the plan, implementation, and review" (AOTA, 2015c, p. 2).

Intervention approaches

Specific strategies selected to direct the process of interventions on the basis of the client's desired outcomes, evaluation data, and evidence (see Table 13).

Interventions to support occupations

Methods and tasks that prepare the client for occupational performance, used as part of a treatment session in preparation for or concurrently with occupations and activities or provided to a client as a home-based engagement to support daily occupational performance (see Table 12).

L

Leisure

"Nonobligatory activity that is intrinsically motivated and engaged in during discretionary time, that is, time not committed to obligatory occupations such as work, self-care, or sleep" (Parham & Fazio, 1997, p. 250; see Table 2).

M

Motor skills

The "group of performance skills that represent small, observable actions related to moving oneself or moving and interacting with tangible task objects (e.g., tools, utensils, clothing, food or other supplies, digital devices, plant life) in the context of performing a personally and ecologically relevant daily life task. They are commonly named in terms of type of task being performed (e.g., [activity of daily living] motor skills, school motor skills, work motor skills)" (Fisher & Marterella, 2019, p. 331; see Table 7).

O

Occupation

Everyday personalized activities that people do as individuals, in families, and with communities to occupy time and bring meaning and purpose to life. Occupations can involve the execution of multiple activities for completion and can result in various outcomes. The broad range of occupations is categorized as activities of daily living, instrumental activities of daily living, health management, rest and sleep, education, work, play, leisure, and social participation (see Table 2).

Occupation-based

Characteristic of the best practice method used in occupational therapy, in which the practitioner uses an evaluation process and types of interventions that actively engage the client in occupation (Fisher & Marterella, 2019).

Occupational analysis

Analysis that is performed with an understanding of "the specific situation of the client and therefore [of] the specific occupations the client wants or needs to do in the actual context in which these occupations are performed" (Schell et al., 2019, p. 322).

Occupational demands

Aspects of an activity needed to carry it out, including relevance and importance to the client, objects used and their properties, space demands, social demands, sequencing and timing, required actions and performance skills, and required underlying body functions and body structures (see Table 10).

Occupational identity

"Composite sense of who one is and wishes to become as an occupational being generated from one's history of occupational participation" (Schell & Gillen, 2019, p. 1205).

Occupational justice

"A justice that recognizes occupational rights to inclusive participation in everyday occupations for all persons in society, regardless of age, ability, gender, social class, or other differences" (Nilsson & Townsend, 2010, p. 58). Occupational justice includes access to and participation in the full range of meaningful and enriching occupations afforded to others, including opportunities for social inclusion and the resources to participate in occupations to satisfy personal, health, and societal needs (adapted from Townsend & Wilcock, 2004).

Occupational performance

Accomplishment of the selected occupation resulting from the dynamic transaction among the client, their context, and the occupation.

Occupational profile

Summary of the client's occupational history and experiences, patterns of daily living, interests, values, needs, and relevant contexts (see Exhibit 2).

Occupational science

"Way of thinking that enables an understanding of occupation, the occupational nature of humans, the relationship between occupation, health and wellbeing, and the influences that shape occupation" (World Federation of Occupational Therapists, 2012b, p. 2).

Occupational therapy

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 person, their engagement in valued 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 (adapted from American Occupational Therapy Association, 2011).

Organization

Entity composed of individuals with a common purpose or enterprise, such as a business, industry, or agency.

Outcome

Result clients can achieve through the occupational therapy process (see Table 14).

P

Participation

"Involvement in a life situation" (World Health Organization, 2001, p. 10).

Performance patterns

Habits, routines, roles, and rituals that may be associated with different lifestyles and used in the process of engaging in occupations or activities. These patterns are influenced by context and time and can support or hinder occupational performance (see Table 6).

Performance skills

Observable, goal-directed actions that result in a client's quality of performing desired occupations. Skills are supported by the context in which the performance occurred and by underlying client factors (Fisher & Marterella, 2019).

Person

Individual, including family member, caregiver, teacher, employee, or relevant other.

Personal factors

Unique features of the person reflecting the particular background of their life and living that are not part of a health condition or health state. Personal factors are generally considered to be enduring, stable attributes of the person, although some personal factors may change over time (see Table 5).

Play

Active engagement in an activity that is intrinsically motivated, internally controlled, and freely chosen and that may include the suspension of reality (Skard & Bundy, 2008). Play includes participation in a broad range of experiences including but not limited to exploration, humor, fantasy, risk, contest, and celebrations (Eberle, 2014; Sutton-Smith, 2009). Play is a complex and multidimensional phenomenon that is shaped by sociocultural factors (Lynch et al., 2016; see Table 2).

Population

Aggregate of people with common attributes such as contexts, characteristics, or concerns, including health risks.

Prevention

Education or health promotion efforts designed to identify, reduce, or prevent the onset and decrease the incidence of unhealthy conditions, risk factors, diseases, or injuries (American Occupational Therapy Association, 2020a).

Process

Series of steps occupational therapy practitioners use to operationalize their expertise in providing services to clients. The occupational therapy process includes evaluation, intervention, and outcomes; occurs within the purview of the occupational therapy domain; and involves collaboration among the occupational therapist, occupational therapy assistant, and client.

Process skills

The "group of performance skills that represent small, observable actions related to selecting, interacting with, and using tangible task objects (e.g., tools, utensils, clothing, food or other supplies, digital devices, plant life); carrying out individual actions and steps; and preventing problems of occupational performance from occurring or reoccurring in the context of performing a personally and ecologically relevant daily life task. They are commonly named in terms of type of task being performed (e.g., [activity of daily living] process skills, school process skills, work process skills)" (Fisher & Marterella, 2019, pp. 336–337; see Table 7).

Professional reasoning

"Process that practitioners use to plan, direct, perform, and reflect on client care" (Schell, 2019, p. 482).

Q

Quality of life

Dynamic appraisal of life satisfaction (perception of progress toward identifying goals), self-concept (beliefs and feelings about oneself), health and functioning (e.g., health status, self-care capabilities), and socioeconomic factors (e.g., vocation, education, income; adapted from Radomski, 1995).

R

Reevaluation

Reappraisal of the client's performance and goals to determine the type and amount of change that has taken place.

Rehabilitation

Services provided to persons experiencing deficits in key areas of physical and other types of function or limitations in participation in daily life activities. Interventions are designed to enable the achievement and maintenance of optimal physical, sensory, intellectual, psychological, and social functional levels. Rehabilitation services provide tools and techniques clients need to attain desired levels of independence and self-determination.

Rituals

For persons: Sets of symbolic actions with spiritual, cultural, or social meaning contributing to the client's identity and reinforcing values and beliefs. Rituals have a strong affective component (Fiese, 2007; Fiese et al., 2002; Segal, 2004; see Table 6).

For groups and populations: Shared social actions with traditional, emotional, purposive, and technological meaning contributing to values and beliefs within the group or population (see Table 6).

Roles

For persons: Sets of behaviors expected by society and shaped by culture and context that may be further conceptualized and defined by the client (see Table 6).

For groups and populations: Sets of behaviors by the group or population expected by society and shaped by culture and context that may be further conceptualized and defined by the group or population (see Table 6).

Routines

For persons, groups, and populations: Patterns of behavior that are observable, regular, and repetitive and that provide structure for daily life. They can be satisfying and promoting or damaging. Routines require momentary time commitment and are embedded in cultural and ecological contexts (Fiese et al., 2002; Segal, 2004; see Table 6).

S

Screening

"Process of reviewing available data, observing a client, or administering screening instruments to identify a person's (or a population's) potential strengths and limitations and the need for further assessment" (Hinojosa et al., 2014, p. 3).

Self-advocacy

Advocacy for oneself, including making one's own decisions about life, learning how to obtain information to gain an understanding about issues of personal interest or importance, developing a network of support, knowing one's rights and responsibilities, reaching out to others when in need of assistance, and learning about self-determination.

Service delivery

Set of approaches and methods for providing services to or on behalf of clients.

Skilled services

To be covered as skilled therapy, services must require the skills of a qualified occupational therapy practitioner and must be reasonable and necessary for the treatment of the patient's condition, illness, or injury. Skilled therapy services may be necessary to improve a patient's current condition, to maintain the patient's current condition, or to prevent or slow further deterioration of the patient's condition. Practitioners should check their payer policies to ensure they meet payer definitions and comply with payer requirements.

Social interaction skills

The "group of performance skills that represent small, observable actions related to communicating and interacting with others in the context of engaging in a personally and ecologically relevant daily life task performance that involves social interaction with others" (Fisher & Marterella, 2019, p. 342).

Social participation

"Interweaving of occupations to support desired engagement in community and family activities as well as those involving peers and friends" (Schell & Gillen, 2019, p. 711) involvement in a subset of activities that incorporate social situations with others (Bedell, 2012) and that support social interdependence (Magasi & Hammel, 2004; see Table 2).

Spirituality

"Deep experience of meaning brought about by engaging in occupations that involve the enacting of personal values and beliefs, reflection, and intention within a supportive contextual environment" (Billock, 2005, p. 887). It is important to recognize spirituality "as dynamic and often evolving" (Humbert, 2016, p. 12).

T

Time management

Manner in which a person, group, or population organizes, schedules, and prioritizes certain activities.

Transaction

Process that involves two or more individuals or elements that reciprocally and continually influence and affect one another through the ongoing relationship (Dickie et al., 2006).

V

Values

Acquired beliefs and commitments, derived from culture, about what is good, right, and important to do (Kielhofner, 2008).

W

Well-being

"General term encompassing the total universe of human life domains, including physical, mental, and social aspects, that make up what can be called a 'good life'" (World Health Organization, 2006, p. 211).

Wellness

"The individual's perception of and responsibility for psychological and physical well-being as these contribute to overall satisfaction with one's life situation" (Schell & Gillen, 2019, p. 1215).

Work

Labor or exertion related to the development, production, delivery, or management of objects or services; benefits may be financial or nonfinancial (e.g., social connectedness, contributions to society, adding structure and routine to daily life; Christiansen & Townsend, 2010; Dorsey et al., 2019).

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