2013

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An Innovative Application of Occupational Therapy Through the ADAPT Training Philosophy

**Description**
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**Disciplines**
Occupational Therapy

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An Innovative Application of Occupational Therapy Through the ADAPT Training Philosophy

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Advisor: John White, Ph.D., OTR/L

OT 633: Enacting Innovative Practice

Pacific University School of Occupational Therapy
Abstract

ADAPT has created a unique exercise approach to neuromuscular re-education in which clients with spinal cord injury and neuromuscular conditions receive training that often leads to new functional potential. This project explored and designed an OT program that meets the occupational needs of their clientele and supports the ADAPT philosophy.
Introduction: (adapted from Giuliani & Kuhl, 2012)

ADAPT Advanced is a program provided by ADAPT Training, a training facility in the Portland area. ADAPT Advanced provides clients with spinal cord injury (SCI) and other neurological disorders with a uniquely designed neuromuscular “redevelopment” program (ADAPT Training website, 2011). ADAPT Advanced staff is comprised of professional trainers with expertise in the rehabilitation process as well as a physical therapist. They are currently in the process of training a chiropractor. Their goals are to help clients maximize their level of function and independence and improve overall health. ADAPT Advanced goals are:

- “Educate individuals and their families on the realities of recovery.
- Diminish the deterioration of body function and increase the overall health and mobility of each client.
- Re-establish ideal body structure and alignment.
- Identify restrictions and create an optimal environment to eliminate those limitations through targeted progression-based stimulus.
- Create increased independence in daily living activities” (ADAPT website, 2011).

A new client’s level of functioning is assessed during an in-depth evaluation using *The Five Fundamentals of Movements* (range of motion, structural capacity, neuro function,
muscular function and the person’s instinctual motivation to move). This assessment is used to assess their status on the *Ten Stages of Adaptation* and allow professional trainers and physical therapist to customize a workout routine that will optimize their level of functioning. As part of the ADAPT team’s dedication toward helping each client reach her or his maximum potential, the team decided to explore the benefits that occupational therapy (OT) could bring to help clients transform strength and mobility improvements into optimal functioning levels in daily activities. The ADAPT Advanced team envisioned the role of OT as an extension of their work, providing support to their clients in their natural environment (Giuliani and Kuhl, 2012).

**Background Information:**

ADAPT Advanced clients with SCI have reported not receiving the needed therapy from occupational therapy to fully prepare them for life after discharge from inpatient rehabilitation or outpatient rehabilitation services. A study conducted by Whiteneck, et al. (2011) examined inpatient and post-discharge rehabilitation services provided during the first year of SCI. “The SCI literature has little to say about the nature and extent of post-discharge rehabilitation services” (Whiteneck, et al., 2011, p 366). The authors found that the majority of services are provided after inpatient therapy concludes, not during inpatient rehabilitation, which correlates to the decrease in length of stay in inpatient rehabilitation. For both PT and OT, the total number of hours of post-discharge therapy
was greater than the number of hours of inpatient therapy. The authors note that although there is ample evidence that inpatient rehabilitation length of stay is decreasing, there is an underreporting of the amount of post-discharge services that are being offered. This trend may lead to post-discharge therapy picking up more of the services previously offered in inpatient rehabilitation (p.367). This article supports the reports made by ADAPT Advanced clientele and supports a potential role of occupational therapy in this setting, especially in light of the trend of the ADAPT clients being nearer in time to their post-acute discharge.

The way individuals spend their time engaging in occupations (meaningful activities) and the impact of that engagement on physical and psychosocial health is a fundamental tenant of occupational therapy. When disability develops, the way an individual occupies his or her time may be significantly challenged and require change to meet life and health needs. “The person may need to spend increased time in self-care tasks, or may not be able to participate in full-time paid employment as he did prior to the injury” (Barclay et al., 2011, p. 573). Because the majority of clientele in ADAPT Advanced are individuals with spinal cord injury (SCI), it is important to consider the time use of this population from an occupational therapy perspective to design appropriate interventions; this is especially relevant because ADAPT Advanced clientele are regarded as unique in terms of their level of motivation and resources.
Barclay et al. (2011) examined the literature available regarding time use among individuals with spinal cord injury (SCI). Their examination focused on incidence and life expectancy, productivity, mental health, self-care, and leisure in regards to time use. While the results are from Australia, the statistics and findings are clinically relevant to individuals with SCI in the U.S. The authors conclude that the “intrinsic” aspects of an activity are more important than the “objective” aspects when considering time use in SCI (Barclay et al., 2011, p.579). “These intrinsic factors may override objective time use and compensate for ‘imbalance’; that is, little time spent doing a highly personally satisfying activity is more predictive of health and wellbeing than more time spent in minimally to moderately satisfying activities (Pentland et al 1998) (sic)” (Barclay et al., 2011, p.579).

While there is quite often psychosocial support offered to individuals with SCI during their inpatient and outpatient treatment, the trauma of the injury and difficulty in accepting and understanding the related changes may continue well beyond the walls of the treatment setting. Psychosocial health is a critical factor in ensuring overall wellness for individuals who have such traumatic experiences and a continuation of psychosocial support, in various formats, has been shown to be beneficial for such individuals.

A study conducted by Kruse (1998) has shown that there is indeed a link between subjective well-being and spinal cord injury. A sample of 597 individuals with spinal cord injury with an average of 9.9 years since injury were asked to report on their current well-
being using the Life Situation Questionnaire (LSQ-R). Data were analyzed to determine the correlation between reported well-being and race-ethnicity, gender, and chronologic age. Results yielded that “minority participants [...] rated poorly with respect to living arrangements and family relations” as well as additional reported struggles with finances and career pursuits (Kruse, 1998). In relation to gender, loss of motor and sensory function led to a reported dissatisfaction with sexual activity in both male and female participants; however, the analysis of chronological age yielded minimal correlation, based on the suggested association between aging and a decrease in activity and increase in financial security (Kruse, 1998).

A similar study conducted by Kruse and Rube (1998) examined personality factors and life-adjustment post-injury. Using the well-known Minnesota Multiphasic Personality Inventory (MMPI) (Butcher, Dahlstrom, Graham, Tellegen, & Kaemmer, 1989) as well as the Neuroticism, Extraversion, Openness Personality Inventory (NEO-PI) (Costa Jr. & McCrae, 1992) and the Multidimensional Adjustment Profile (MAP), researchers gathered information about personality and life adjustment from 105 individuals with spinal cord injuries with an average 17.9 years post-injury. Results indicated a negative correlation between adjustment (as measured by the MAP) and neuroticism (as measured by the NEO-PI), a positive relationship between anxiety, self-consciousness and vulnerability when correlated with emotional distress, and a negative correlation between adjustment and
emotional distress, skill deficit and financial limitation (Kruse & Rube, 1998). Further
analysis yielded a prediction of outcomes, identifying depression as a significant predictor of
career and activity satisfaction. Additionally, skill deficit was predicted by positive
correlations with depression, impulsivity and anger-hostility (Kruse & Rube, 1998). These
results can be used to support the role of OT in serving individuals with SCI through
provision of psychosocial supports and functional skill-building which could in turn reduce
the negative physical and psychological effects associated with adaptation to life with SCI.

One potential evaluation to help obtain a client’s occupational functioning and
develop client-centered occupation-based interventions is the Occupational Self Assessment
(OSA), an assessment based on the evidenced-based Model of Human Occupation
(MOHO), developed by Gary Kielhofner. “The Occupational Self Assessment (OSA) was
designed to guide collaborative treatment planning and measure client-reported change to
document therapy outcomes” (Kielhofner, Dobria, Forsyth, & Kramer, 2010, p. 11). “One
of the barriers to use of self-reports for documenting outcomes is concern about the
dependability (reliability and validity) and sensitivity (ability to detect change) of such
assessments” (Kielhofner et al., 2010, p. 11). The authors conducted a study to assess the
ability of the OSA to detect change over time and its stability. The results of their study
“suggest that the OSA Competence rating scale is stable over time and the relative difficulty
of everyday tasks does not change during re-administration” (Kielhofner et al., 2010, p.
17). However, the authors noted that in the second readministration, the category “More Important,” in the Values rating scale was not chosen as frequently (p. 19). Nonetheless, their research supported the ability of the OSA to detect changes in competence and values based the report of the participants.

Another assessment is the Canadian Occupational Performance Measure (COPM) (Gustafsson, Mitchell, Fleming, & Price, 2012), an assessment based on the Canadian Model of Occupational Performance (CMOP). The COPM “uses a semi-structured approach within which occupational performance issues are defined by the client in collaboration with the occupational therapist (Law et al 2005) (sic). It allows the client then to rate his or her occupational performance (primarily self-care, productivity and leisure) and satisfaction with performance (Law et al 2005)” (sic) (Gustafsson, Mitchell, Fleming, and Price, 2012, p. 338). Gustafsson’s research group examined the clinical utility of the COPM during SCI rehabilitation. The authors found that the COPM promoted occupational engagement and increased motivation. However, the authors noted this assessment was more effectively utilized further along in the rehabilitation process rather than in the earlier stages. The authors stress that “the COPM demands a high level of therapist communication, interviewing, clinical reasoning and goal setting skills” (Gustafsson et al., 2012, p. 341).
In order to achieve the best possible outcome in spinal cord injury recovery, research suggests the involvement of an interdisciplinary team may yield the highest quality of change. An article written by Perry, Nicholas, and Middleton in 2011 summarized the design and implementation of a multidisciplinary cognitive-behavioral pain management program for individuals with spinal cord injuries. The results of this study indicated that the modifications made by a variety of professionals to the program throughout the design yielded an overall higher quality of life for individuals who participated in this pain management program. The involvement of the interdisciplinary team, including occupational therapy in the modification of the program proved critical in accommodating the unique needs of the spinal cord injury population (Perry et al., 2011). Extrapolation of these results may suggest that consultation with an interdisciplinary team in designing or modifying programs for individuals with spinal cord injuries will yield a more positive outcome for the clientele and the program as a whole.

Methods:

This project was conducted in conjunction with the Innovative Practice Project course requirements for the Master of Occupational Therapy degree in the School of Occupational Therapy at Pacific University. The project builds on an earlier collaboration between ADAPT and Pacific occupational therapy students, Giuliani and Kuhl (2012).
Information and data used in this study was collected in several ways. First, through the development of a literature review in order to find supporting evidence for proposed evaluations, assessments and intervention strategies that may be used in future segments of this project and which supported opportunities addressed in a completed SWOT analysis (see Appendix A: SWOT Analysis Grid). Secondly, through interview and observation of client training sessions at ADAPT Advanced—each author completed approximately 20 hours of observation over a three-week period at the beginning of the project. During observation, each author was able to gain insight into the training program’s philosophies and methods of intervention, informally interview clients about their experiences with occupational therapy in the past, and brainstorm with clients and their trainers about ways in which they might see an occupational therapy program function within the Advanced training program. Thirdly, data was gathered through a pilot study of the Occupational Self-Assessment (OSA). Self-assessment forms were distributed by the ADAPT staff trainers to 5 current Advanced clients, and the completed forms were returned to the authors for analysis approximately 4 weeks later (See Appendix B: The Occupational Self Assessment). Lastly, information was gathered through a round-table educational presentation and discussion facilitated by the authors with current certified Advanced therapeutic trainers (see Appendix C: PowerPoint for Advanced Staff). This round-table discussion was designed to provide some additional education about the domain and
process of occupational therapy and allow space for authors and trainers to continue to brainstorm and collaborate about future installments of the project.

In addition to the formalized work with the Advanced clientele and the ADAPT facility, authors were able to visit the home of a current Advanced client. The home, located in North Portland, was purchased by the client and his spouse and is in the process of being remodeled to the exacting needs of the client. Authors completed a home visit with the client’s spouse and completed the Shepherd Center SCI Inpatient Home Evaluation Form (Shepherd Center) (see Appendix D: Shepherd Center Evaluation Form) as a pilot tool to gauge its potential use for a home health component of a potential occupational therapy program at ADAPT Advanced.

Outcomes:

Results of the Occupational Self Assessment (OSA) Pilot Study:

The clients rated each activity category on the OSA based on their level of difficulty in the performance of those activities (see Appendix E: Results of OSA Pilot). Levels of difficulty were:

- “I have a lot of problems doing this.”
- “I have some difficulty doing this.”
- “I do this well.”
- “I do this extremely well.”
For the purposes of this outcome measure, categories were considered areas of difficulty if rated “I have a lot of problems doing this” or “I have some difficulty doing this.” Based on the results of the OSA with five clients from Adapt Advanced, the areas that the clients have the most difficulty are:

- “Getting done what I need to do.”
- “Physically doing what I need to do.”
- “Expressing myself to others.”

Also rated to be challenging areas were:

- “Taking care of the place I need to live.”
- “Getting where I need to go.”
- “Managing my finances.”
- “Relaxing and enjoying myself.”
- “Having a satisfying routine.”
- “Doing activities I like.”

The clients also rated the level of importance for each activity. Levels of importance were:

- “This is not so important to me.”
- “This is important to me.”
• “This is more important to me.”

• “This is most important to me.”

Again, for the purposes of this outcome measure, categories were considered important if they were rated “this is more important to me” or “this is most important to me.” The results showed that the client’s value:

• “Being a student, worker, volunteer, and/or family member.”

• “Working toward my goals.”

Generally speaking, the clients found value in all categories except:

• “Taking care of other for whom I am responsible.”

• “Getting along with others.”

• “Having a satisfying routine.”

Results of the Shepherd Home Evaluation Pilot:

Through use of the Shepherd Center SCI Inpatient Home Evaluation Form, a variety of measurements of the client’s home were recorded by the authors. A tour of the home by the client’s spouse (who is an occupational therapist) provided in-depth information about the renovation process, the factors considered when designing the new home, and some of the trouble-shooting and problem solving addressed during the remodeling. The client’s
spouse provided an enormous amount of insight, both from a therapist’s perspective but also from the viewpoint of an able-bodied individual designing an accommodating space that would provide a functional living environment for both herself and her husband.

In conversation about the use of this tool and the potential for use by the Advanced program, an interesting point of consideration was raised. As an occupational therapist, the client’s spouse was very aware of the importance of the functionality of the living space and suggested that an assessment such as the Shepherd form may be best use in conjunction with an additional assessment or interview and observation of the client using the space. In doing so, the home health evaluator would have the opportunity to observe the client working within the existing space and address some of the frustrations involved in navigating the un-modified space prior to making recommendations based on the results of the home evaluation.

Additional Outcomes:

Last year, two students from Pacific University assessed the benefits that OT could bring to ADAPT Advanced in the first phase of this project (Giuliani & Kuhl, 2012). They created a profile of ADAPT Advanced Clientele, a proposed OT position profile (with or without the use of ABT intervention), evaluation tools, and a resource guide for ADAPT Advanced clientele. Based on their work and the data we have collected, the current
authors are expanding on the previous project and on the potential role of OT at ADAPT, particularly with the ADAPT Advanced clientele.

**Discussion:**

Many of the clients expressed interest in ADL and IADL training. Based on conversations during observations, there appears to be a gap in inpatient/outpatient services and transitioning to home that could be addressed by OT in the ADAPT setting. Also, based on observations, there may be consultation that could be given to Advanced staff on transferring clients to exercise equipment that may decrease the potential risk for injuries.

The results from the OSA indicate that the clients have the most difficulty in accomplishing their day-to-day tasks, particularly in the context of their physical limitations. This supports the role of OT in teaching clients ways to improve their performance in ADL and IADL. It is of interest to note that the clients rated “expressing myself to others” as a significant area of difficulty. It is not clear in what context this is occurring, whether it is with personal caregivers or in personal relationships, etc. Furthermore, the results suggest that the psychosocial scope of OT practice may have a clinical benefit in this setting. The implications from the OSA results would be made clearer if there were a post-assessment interview.

The OSA results also indicate that the clients find significant value in being able to participate and fulfill their life roles. Additionally, the clients reported the importance of
working toward goals. Occupational therapy is able to address participation in life roles and not only help clients work toward their goals, but also collaboratively set realistic goals that will allow the clients to see progress. However, some of the results do contradict each other.

While the clients chose “expressing myself to others” as a high area of difficulty, they rated “getting along with others” low on the rating scale. Additionally, the clients rated “getting done what I need to do” high on the rating scale but rated “having a satisfying routine” low. These results may be related to the clients not understanding the items or rating scale, or it could be related to the client’s individual circumstances of which the authors did not have knowledge. This further highlights the relevance of including an interview into the OT evaluation.

Ideally, to help obtain a complete profile of ADAPT clientele and determine the potential role of OT in this setting, there are a number of things that the authors would have liked to have accomplished during this second phase of the project. First, in addition to the OSA, a pilot with the Canadian Occupational Performance Measure (COPM) would have contributed to the data but also have allowed authors to experiment with the clinical utility of this assessment as it relates to the potential use at ADAPT as compared to the OSA (see Appendix F: The Canadian Occupational Performance Measure). Also, focus groups would have been helpful in elaborating on the results of the OSA and contributing to the client profile and their particular needs and desires as it relates to OT at ADAPT.
Limitations:

Several limitations were present in this phase of this project. Firstly, the time constraints presented within the organization made it difficult for the authors to interview clients independently, outside of their time with their therapeutic trainers. Additionally, it was challenging at times to find the appropriate moment in training sessions to ask questions and address the client with an occupational therapy lens, as so much of the training session is made up of physical exercise and transition between exercises, including recovery periods.

Another time limitation presented itself throughout the project timeline. While the authors had designated observation and interview time, it was somewhat challenging to find additional times during the three and a half months to set up focus groups for both the clientele as well as the staff. Some of the goals intended for focus groups were met during the educational presentation with the Advanced staff; however, no time was available to the authors for client focus groups, which may have yielded additional data and provided increased insight into program needs and future program goals.

A third limitation was presented during the authors’ first meeting with the Director of ADAPT Therapy. In this meeting, the Director provided feedback about the 2012 phase of this project, reporting that while the project highlighted some key needs and provided ADAPT with some initial recommendations for implementation, these recommendations
did entirely match ADAPT’s underlying program philosophies and may not have been as realistic as the Director had hoped for. With this information, the authors needed to spend some additional time in researching and understanding ADAPT’s foundation, mission and philosophies to make recommendations which were more in line with the overall goals of the community organization.

**Future Recommendations for Innovative Practice:**

While this project is only in its second phase, with an opportunity for increased involvement and further partnership with ADAPT Advanced, there are several recommendations for the next phases of this project. An important step prior to full program implementation is to modify the existing Advanced evaluation, which is currently a 10-hour physical evaluation completed over 5 days. The Advanced trainers have communicated an appreciation for an assessment that may address additional client factors, specifically psychosocial factors, and they have articulated a desire to learn more about the administration of assessments which would target these factors. As part of this project, the Occupational Self Assessment (OSA) was piloted, with results indicating that this assessment would provide additional client insight for the Advanced trainers.

A more in-depth, mixed method assessment such as the Canadian Occupational Performance Measure (COPM) was also presented to the trainers and well received. While this measure would allow for further client-determine goal development and provide a
quantitative measure for satisfaction with performance, it is an assessment traditionally administered by a licensed occupational therapist. While ADAPT Advanced has expressed an interest in the hiring of an occupational therapist within the next several years, the therapeutic trainers also expressed an interest in having an assessment to include in their current evaluation to gain additional insight into the client’s needs more immediately, such as the COPM. One potential method to ensure that trainers are able to gain the information needed prior to the implementation of the OT program would be to temporarily modify the COPM into a “life-skills performance satisfaction” measure, drawing on many of the same aspects of assessment but incorporating it into the current Advanced physical evaluation to allow trainers the benefit of having this information available for goal setting and program planning. The authors of this project suggest that development of such an assessment be a focus of the next phase of development of the Pacific/ADAPT collaboration.

Another recommendation for future phases of this project would address the potential of including home evaluation and home health-type services for the Advanced clientele. While most clients are able to get to the Advanced gym on a regular basis, much of the training that is done in the gym is done with the assumption that it will somehow carryover into the clients’ ADL and IADL performance. With a home health component to the occupational therapy program at ADAPT Advanced, clients may see an increase in carryover from their physical training to in-home and community life-skill performance with
the additional guidance from an occupational therapist. The feasibility of these services may need to be further investigated, with additional research into funding opportunities and potential for insurance reimbursement, as well as the design of a home-health evaluation that would complement the occupational therapy and physical training programs at ADAPT Advanced.

As this project grows into the next phase, there may be potential for further collaboration that addresses occupational performance concerns of other ADAPT clients. Non-disabled and elite athletes (with and without disabilities could benefit from occupational therapy services that fit within the ADAPT model. One specific area of support targeted by the training staff is in working with the older adult population that come to ADAPT to stay active and healthy. Occupational therapy may be helpful in developing additional programming for the older adult population at ADAPT that address the unique needs that the older adult population experiences. Incorporating students from the Certificate of Gerontology program at Pacific University may provide additional interdisciplinary perspectives on how ADAPT may best meet the needs of their older adult clients.

**Proposed OT Position Profile** (adapted from Giuliani & Kuhl, 2012)

To best meet the needs of the Advanced clientele, authors recommend that ADAPT hire an occupational therapist with at least 2 years of experience working with spinal cord injury
clients in a rehabilitation setting, and preferably with experience in hand therapy, home health, or some combination. Some potential duties include:

- Providing a detailed occupational profile using an in-depth evaluation of the client both at ADAPT Advanced and in other occupational environments of functional application (e.g. home, leisure, or work settings). Potential assessment tools include the OSA and the COPM provided in appendix.

- Working in collaboration with ADAPT Advanced trainers and clients during the evaluation process to determine the current level of functioning and establish functional goals.

- Planning and implementing an upper extremity motor training program to enhance range of motion, dexterity, coordination and sensation especially of the hands to increase functionality (incorporating elements recommended by Giuliani and Kuhl (2012).

- Planning and implementing occupation-based interventions addressing ADL, IADL, and leisure participation within the Adapt Advanced facility, the community, or the client’s home.

- Consulting with clients on activity modification in different contexts.

- Environmental assessment and adaptation.
• Planning and implementing psychosocial interventions initially focusing on communication skills and social interactions individually or in groups, but continuing to assess for additional psychosocial needs.

• Educating clients and their families on available resources for individuals with SCI in the community, taken from the resource manual developed by Giuliani and Kuhl (2012), such as public transportation, assistive devices, adaptive sports, and homecare workers.

• OT may also be trained as an Adapt trainer to further expand the role of this position and ensure a need for the position when OT-specific services are not needed. This training would also assure that the OT fully understands the ADAPT approach to training.

Additional planning for the implementation of the program and OT position development was completed in a marketing plan; this plan included a program description for day to day occupational therapy intervention, both onsite and in the home and community, as well as an estimate of starting costs and expenses associated with an ideal implementation of the OT program. A 3-year projection budget was completed as well, with the total 3-year revenue approximated at $250,000 after all expenses, based on a clientele basis of 15 individuals utilizing both clinic services onsite as well as home health and/or community based services (Furlotte, 2013)
References


Shepherd Center. (n.d.). Shepherd center inpatient SCI home evaluation form. Atlanta, Georgia, United States of America.


Appendix A: SWOT Analysis Grid

SWOT Analysis available upon request: Contact John White at: whit9986@pacificu.edu

Appendix B: The Occupational Self Assessment

### Occupational Self Assessment

| Name: ___________________________ | Date: _______________ |

**Myself**

<table>
<thead>
<tr>
<th>Step 1: Below are statements about things you do in everyday life. For each statement, circle how well you do it. If an item does not apply to you, cross it out and move on to the next item.</th>
<th>Step 2: Next, for each statement, circle how important this is to you.</th>
<th>Step 3: Choose up to 4 things about yourself that you would like to change. (You can also write comments in this space)</th>
</tr>
</thead>
<tbody>
<tr>
<td>I have a lot of problem doing this</td>
<td>I have some difficulty doing this</td>
<td>I do this well</td>
</tr>
<tr>
<td>Concentrating on my tasks</td>
<td>lot of problem</td>
<td>some difficulty</td>
</tr>
<tr>
<td>Physically doing what I need to do</td>
<td>lot of problem</td>
<td>some difficulty</td>
</tr>
<tr>
<td>Taking care of the place where I live</td>
<td>lot of problem</td>
<td>some difficulty</td>
</tr>
<tr>
<td>Taking care of myself</td>
<td>lot of problem</td>
<td>some difficulty</td>
</tr>
<tr>
<td>Taking care of others for whom I am responsible</td>
<td>lot of problem</td>
<td>some difficulty</td>
</tr>
<tr>
<td>Getting where I need to go</td>
<td>lot of problem</td>
<td>some difficulty</td>
</tr>
<tr>
<td>Managing my finances</td>
<td>lot of problem</td>
<td>some difficulty</td>
</tr>
<tr>
<td>Managing my basic needs (food, medicine)</td>
<td>lot of problem</td>
<td>some difficulty</td>
</tr>
<tr>
<td>Expressing myself to others</td>
<td>lot of problem</td>
<td>some difficulty</td>
</tr>
<tr>
<td>Getting along with others</td>
<td>lot of problem</td>
<td>some difficulty</td>
</tr>
<tr>
<td>Identifying and solving problems</td>
<td>lot of problem</td>
<td>some difficulty</td>
</tr>
</tbody>
</table>
Appendix C: PowerPoint for Advanced Staff

"So...you help people find jobs?"
A crash course in Occupational Therapy

Ryan Farwell, OTS  Pacific University
Claire Furlotte, OTS  School of Occupational Therapy

- Occupational therapists and occupational therapy assistants help people across the lifespan participate in the things they want and need to do through the therapeutic use of everyday activities (occupations)
• Schools
  • Fine motor skills
• Hospitals
  • Teach ADL's, neuromuscular re-education
• Clinics
• Rehabilitation centers
  • Upper extremity joint protection and sensory re-education
• Nursing care facilities
  • Teaching home management or managing behavioral health
• Home Health
  • Home modifications and energy conservation
• Private practice for individuals or families

Where do we work
Examples of duties

• "Occupations" are activities of everyday life, named, organized, and given value and meaning by individuals and a culture. Occupation is everything people do to occupy themselves, including looking after themselves, enjoying life, and contributing to the social and economic fabric of communities (Law, M., Polatajko, H., Baptiste, W., & Townsend, E., 1997).

Why does this matter?
Like any other profession, OT has a set scope of practice that is outlined in our professional framework, the Occupational Therapy Practice Framework (OTPF)

The OTPF articulates "occupational therapy's contribution to promoting the health and participation of people, organizations, and populations through engagement in occupation." (AOTA, 2008)

The OTPF helps us zoom in on what to evaluate, assess, treat, and recommend with any given client in any given setting

**Practice Framework 101**

- **Areas of Occupation** (ADLs, instrumental ADLs (IADLs), Rest/Sleep, Leisure, Work, Education, Play, Social Participation)
- **Client Factors** (Values, Beliefs, Spirituality, Body Structures and Body Functions)
- **Performance Skills** (Sensory, Motor/Praxis, Emotional Regulation, Cognitive, Communication and Social)
- **Performance Patterns** (Habits, Roles, Routines, Rituals)
- **Context/Environment** (Cultural, Personal, Physical, Social, Temporal, Virtual)
- **Activity Demands** (Objects and Their Properties, Space Demands, Social Demands, Sequencing/Timing, Required Actions, Required Body Functions, Required Body Structures)

**Aspects of the OT Domain**
• We are the second wave of 3rd year students from Pacific doing an Innovative Practice Project (IPP) in partnership with Adapt

• Last year's group conducted a needs assessment to collect evidence to show that an OT program would be beneficial for Adapt Advanced

• This year, our goal is to develop some concrete plans for assessment and intervention strategies that fit with the current Advanced program and gather some feedback from Advanced clients about how they might benefit from OT support at Advanced

**Why We're Here...**

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• Observed training sessions with Advanced clients and their trainers (thanks Kandice and Jerod!!)

• Informally interviewed clients about their experiences with OT after their injury

• Conducted a SWOT analysis to determine the strengths, weaknesses, opportunities and threats of the Advanced program and the proposed OT program

• Conducted a pilot study of the Occupational Self-Assessment (OSA) to gather data about current clients’ occupational performance

• Conducted literature reviews to gather evidence to support our ideas for an OT program at Adapt

• Brainstormed...a LOT...

**What We've Done So Far...**
• This is only the 2nd phase of this project. There will likely be several more before an actual OT program is implemented...
  • Integrate OT evaluation into the initial client evaluation to get a more holistic view of the client (not just physical performance factors) to help develop client-centered program
  • Select 1-2 evidence-based assessments to use with new and current clients to have a better understanding of current occupational performance and levels of independence
  • Support client in their home environments by conducting home evaluations and assisting in home modification and home programming to help maintain the gains made in the gym
  • Support increased client independence in ADL, IADL, leisure and social performance goals
  • Energy conservation, joint protection, wheelchair positioning and postural support to help clients maintain gains made in the gym
  • Family/caregiver education

**Where We're Going...**

• How else might Occupational Therapy be involved in the Advanced program?

**Your Turn!**
Please complete and return this form along with pictures of your family member's home to the case manager, PT, or OT by the end of the patient's second week at Shepherd. Returning this form quickly will allow us to make suggestions sooner so that you may begin changing your home as soon as possible. Or Fax this form to your case manager at (404) 603-4295

**Type of Residence:**
Do you live in a ___house ___apartment ___single wide ___double wide ___ Other? __________
How many levels are in your home? ___ one ___ two ___ split ___ other? ________________
Is your home ___ owned or ___ rented?
Can you make changes to your home? ___ yes ___ no
If apartment, what floor is it on? ___ Does the apartment have an elevator? ___ yes ___ no

**Approach to Home:**
Is the home on a flat lot? ___ yes ___ no. If no, please explain: __________________________
Does the home have a ___ garage ___ carport ___ driveway? What is the surface? __________
What size is the garage/carport? ___ 1 car ___ 2 car ___ other? ___________________________

**Entrances to Home:** To ensure that your family member can enter the house with a wheelchair or any assistive device, it is extremely important that the doorways are carefully measured. Follow the directions carefully and measure all doorways this way

1) Open the door to 90 degrees.
2) Stand in the middle of the doorway.
3) Measure the narrowest part of the door while it is open making sure to include the thickness of the door as it is open. See picture.
**Entrances to Home:**

<table>
<thead>
<tr>
<th>Question</th>
<th>Primary Entrance</th>
<th>Secondary Entrance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Which level does doorway enter on?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Is the entrance in front, back, side?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>How many steps lead up to this door?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Height of each step?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Do the steps have hand rails?</td>
<td>___left ___right ___both</td>
<td>___left ___right ___both</td>
</tr>
<tr>
<td>How tall is threshold at doorway?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Does door open in or out?</td>
<td>__in __out</td>
<td>__in __out</td>
</tr>
<tr>
<td>Does door open 90 degrees?</td>
<td>___yes ___no</td>
<td>___yes ___no</td>
</tr>
<tr>
<td>Is there a porch? How wide and long?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>If there is a porch, is it covered?</td>
<td>___yes ___no</td>
<td>___yes ___no</td>
</tr>
</tbody>
</table>

Is there a basement? ___yes ___no ___other? ______________________________
Can it be accessed from the outside? ____________________________________
What is the terrain to the entrance? ____________________________________

**Inside of Your Home:**

**Hallways:** How wide are your hallways? ________________________________

**Bedroom:**

Is there a place for your family member to stay on the first floor? If not, what floor? ______
What is the width of the doorway to the bedroom? (measure as above) ________________
What type of flooring? If carpet, what type of carpet? __________
Is there padding underneath the carpet? ___yes ___no
What is the size of the bed? ___twin ___double ___queen ___king ___other ____________
What is the height of the bed from the floor to the top of mattress? ________________
Is there a night stand near the bed? _________
How wide is the space between the wall and the bed? __________Can it be wider? How much?____
Is there a 5 x 5 foot space for turning a wheelchair in the bedroom? ________________
Is the bedroom on the same level as the bathroom and kitchen? ________________

**Kitchen:**

What is the width of the doorway into this room? ____________________________
Is there a 5 x 5 foot space for turning in the kitchen? ___yes ___no If not, then what is the width
at the narrowest points in the kitchen? (please describe) ______________________
What type of refrigerator do you have? ___side by side ___freezer on top ___freezer on
bottom
Do you have a dishwasher? ___yes ___no If yes, what type of controls? ___dial ___buttons
Do you have a microwave? ___yes ___no If yes, what type of controls? ___dial ___buttons
Where is the microwave located? __________________________________________
How high are the counter tops from the floor? ______________________________
What is the depth from the front of the counter to the sink controls? ______________

**Miscellaneous:**
Do you have central air?  ____yes  ____no
Do you have room/window air conditioners?  ____yes  ____no  If yes, what rooms?  __________
Can you reach the air conditioner controls from a seated position?  ____yes  ____no
How is your home heated?  ______________________________________________________________________
Do you have a cordless phone or cell phone?  ____yes  ____no
Do you have a smoke detection system?  ____yes  ____no

**Bathroom:**

<table>
<thead>
<tr>
<th>Question</th>
<th>Primary Bathroom</th>
<th>Secondary Bathroom</th>
</tr>
</thead>
<tbody>
<tr>
<td>On what level of the house is the patient’s bathroom located?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>What is the width of the doorway into the bathroom?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Does the bathroom have a stall shower, standard tub, or garden tub?</td>
<td>____stall shower  ____standard tub  ____garden tub</td>
<td>____stall shower  ____standard tub  ____garden tub</td>
</tr>
<tr>
<td>If shower, does it have a shower door, curtain, or other?</td>
<td>____door  ____curtain  Other? _____</td>
<td>____door  ____curtain  Other? _____</td>
</tr>
<tr>
<td>If shower, does it have a lip? If so, how high is it?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Is there an open space under the sink to allow space for the patient’s knees in sitting?</td>
<td>____yes  ____no</td>
<td>____yes  ____no</td>
</tr>
<tr>
<td>Are pipes under sink exposed?</td>
<td>____yes  ____no</td>
<td>____yes  ____no</td>
</tr>
<tr>
<td>How high is the bottom of the mirror from the floor?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>How high is the towel rack from the floor?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Please draw a floor plan of the bathroom including measurements between the tub, toilet & sink as well as measurements between the toilet and any surrounding walls:

![Bathroom Floor Plan](image-url)
Please, draw a floor plan of the main level of your home following this example.

Floor plan:

Will the patient need access to any living areas that are not on the main level of the home? (ie. Kitchen, laundry room) Please, identify what these areas are and include the level of the home that the area are located on.

If the patient will need access to floors other than the main level, please draw a floor plan of that level and attach on an additional page.
## Appendix E: Results of OSA Pilot

### Ratings of Level of Difficulty:

<table>
<thead>
<tr>
<th>5</th>
<th>4</th>
<th>3</th>
<th>2</th>
<th>1</th>
<th>0</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Getting done what I need to to</strong></td>
<td>Physically doing what I need to</td>
<td>Taking care of the place where I live</td>
<td>Taking care of myself</td>
<td>Concentrating on tasks</td>
<td>Getting along with others</td>
</tr>
<tr>
<td><strong>Expressing myself to others</strong></td>
<td>Getting where I need to go</td>
<td>Managing my Basic needs (food, medicine)</td>
<td>Taking care of others for whom I am responsible</td>
<td>Handling my Responsibilities</td>
<td></td>
</tr>
<tr>
<td><strong>Managing my Finances</strong></td>
<td>Managing my Finances</td>
<td>Being involved as a student, worker, volunteer, and/or family member</td>
<td>Identifying and solving Problems</td>
<td>Using my abilities effectively</td>
<td></td>
</tr>
<tr>
<td><strong>Relaxing and enjoying myself</strong></td>
<td>Relaxing and enjoying myself</td>
<td>Working Toward my Goals</td>
<td>Making decisions based on what I think is important</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Having a Satisfying Routine</strong></td>
<td>Having a Satisfying Routine</td>
<td>Accomplishing what I set out to do</td>
<td></td>
<td></td>
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<tr>
<td><strong>Doing activities I like</strong></td>
<td></td>
<td></td>
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<td></td>
<td></td>
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<tr>
<td>Ratings of Level of Importance:</td>
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<td>-------------------------------</td>
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</tr>
<tr>
<td>5</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Being involved as a student, worker, volunteer, and/or family member</strong></td>
<td>Physically doing what I need to</td>
<td>Concentrating on tasks</td>
<td>Taking care of others for whom I am responsible</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Working Toward my Goals</strong></td>
<td>Taking care of myself</td>
<td>Getting where I need to go</td>
<td>Getting along with others</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Managing my Basic needs (food, medicine)</td>
<td>Managing my Finances</td>
<td>Having a Satisfying Routine</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Identifying and solving Problems</td>
<td>Accomplishing what I set out to do</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Getting Done What I Need to do</td>
<td>Handling my Responsibilities</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Doing activities I like</td>
<td>Making decisions based on what I think is important</td>
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</tbody>
</table>
Appendix F: The Canadian Occupational Performance Measure

CANADIAN OCCUPATIONAL PERFORMANCE MEASURE

Authors:
Mary Law, Sue Baptiste, Anne Carswell,
Mary Ann McColl, Helene Polatajko, Nancy Pollock

The Canadian Occupational Performance Measure (COPM) is an individualized measure designed for use by occupational therapists to detect self-perceived change in occupational performance problems over time.

<table>
<thead>
<tr>
<th>Client Name:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Age:</th>
<th>Gender:</th>
<th>ID#:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Respondent (if not client):</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Date of Assessment:</th>
<th>Planned Date of Reassessment:</th>
<th>Date of Reassessment:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Therapist:</th>
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<table>
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<tr>
<th>Facility/Agency:</th>
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<table>
<thead>
<tr>
<th>Program:</th>
</tr>
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</table>