Case Report

Job Site Analysis Facilitates Work Reintegration

Mario Francisco Canelón

Key Words: disability evaluation • rehabilitation • working conditions

The Americans with Disabilities Act (ADA) offers challenges and opportunities in rehabilitative care for returning clients to previous employment after medical illness or injury. The process of work reintegration begins with assessing the client's rehabilitation potential to return to work. When clinical reasoning indicates a good rehabilitation potential, a job site analysis (JSA) is conducted to determine the essential functions of the client's work. Upon completion of the JSA, a variety of strategies can be used for successfully returning the client to work. The three case reports in this article illustrate that a JSA can serve as the basis for formulating a holistic treatment plan that addresses skill performance areas affecting work readiness for clients with neurologic and orthopaedic conditions and can facilitate successful work reintegration for these clients. The JSA links clients' rehabilitative care and work reentry after medical illness or injury and maximizes positive outcomes in reintegrating these clients to the workplace in compliance with ADA provision Title I, Employment.

The American Journal of Occupational Therapy

Mario Francisco Canelón, MS, MOT, OTR/L, is Staff Occupational Therapist III, McLeod Regional Medical Center, Rehabilitative Services, Occupational Therapy Hand Center, 901 East Cheves Street, Suite 150, Florence, South Carolina 29506. (Two of the case reports were completed while the author was on staff at the University of Virginia Health Sciences Center, Occupational Therapy Department, Charlottesville, Virginia.)

This article was accepted for publication August 9, 1994.
neurologic and orthopaedic conditions.

Job Site Timing and Indicators

The optimal timing for performing a JSA and the exact parameters determining JSA appropriateness should be based on the individual client’s situation. Indicators for the JSA must be considered in the context of the client’s predicted rehabilitation potential and then tailored for each case. In the three cases illustrated in this article, clinical reasoning dictated that the clients’ rehabilitation programs would be enhanced by the information obtained from the JSA. In Case 2, one specific goal for performing the JSA was to verify information obtained from the client’s interview and job description. The JSA was also vital for identifying and determining the factors at the workplace that were critical to returning the client to work so that interventions could be designed accordingly. These interventions focused on improving the essential functions needed for the clients’ return to work.

Clinicians need to be selective in predicting who might be a good candidate for return to work because not all clients have the potential to benefit from a JSA. The predictive models described by Black-Schaffer and Osberg (1990) and Velozo et al. (1991) have shown that specific factors may be attributed to clients having positive return-to-work outcomes. Predictive indicators of more successful return-to-work outcomes for clients with neurologic impairment included clients who were not aphasic and had shorter rehabilitation lengths of stay (Black-Schaffer & Osberg, 1990). In addition, clients with neurologic impairment who were light consumers of alcoholic beverages before their stroke were more likely to return to work than those who were heavy consumers of alcoholic beverages before their stroke (Black-Schaffer & Osberg, 1990). Predictive indicators for orthopaedic clients included clients who upon being questioned reported a low level of pain (Velozo et al., 1991). Another predictive indicator for orthopaedic clients was related to injury type: Clients with extremity injuries were more likely to return to work than clients with low back pain (Velozo et al., 1991). Psychosocial factors also are important indicators to consider in the client’s return to work (Velozo et al., 1991). The use of a JSA in the return-to-work process may be more appropriate for clients whose profile indicators resemble those just mentioned because their rehabilitation outcomes tend to be favorable. However, it is important to recognize that individual differences exist between clients and that these differences must be considered when rendering and planning treatment, inclusive of a JSA.

Clinical Setting

A discussion of how clinical setting affects clinical reasoning and practice is beyond the scope of this article. However, the challenges that the clinical setting imposes on allied health care personnel providing care in rural areas include shortages in personnel (American Medical Association, 1989; Cordes & Wright, 1989) and lack of specialized training (Offner, 1989; Page, 1989). The factors affecting rural allied health care resources may necessitate that rural health care providers, including occupational therapists, expand their roles or assume additional roles to provide comprehensive rehabilitative care to their clients. Given the shortage in rural communities of formal return-to-work programs that have an interdisciplinary team approach, an occupational therapist may use the JSA information as the basis for formulating a holistic treatment plan. The holistic treatment plan makes it possible for the client’s total rehabilitative needs to be met. Without such a plan, the comprehensive work reentry therapy needs of clients living in rural areas may go unmet. Cases 1 and 3 illustrate that, via a holistic treatment plan, an occupational therapist working in a hospital-based outpatient setting can provide comprehensive work reentry therapy for clients living and working in outlying rural areas.

Case Reports

Case 1

Medical History. A 25-year-old black woman sustained a right basal ganglia internal capsular hemorrhage, with severe stenosis of the right middle cerebral artery and right anterior cerebral artery. Ten days before her admission to an acute care hospital she had an induced abortion because of an anencephalic fetus. The client had no history of hypertension associated with the pregnancy. Once she was medically stable, she was transferred from the hospital to inpatient rehabilitation services for 6 weeks and then referred for continuation of occupational therapy and physical therapy services in a hospital-based outpatient setting (see Table 1).

<table>
<thead>
<tr>
<th>Variable</th>
<th>Case 1</th>
<th>Case 2</th>
<th>Case 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age (years)</td>
<td>25</td>
<td>43</td>
<td>45</td>
</tr>
<tr>
<td>Gender</td>
<td>Female</td>
<td>Female</td>
<td>Male</td>
</tr>
<tr>
<td>Marital status</td>
<td>Single</td>
<td>Divorced</td>
<td>Married</td>
</tr>
<tr>
<td>Diagnosis</td>
<td>(R) Stroke</td>
<td>Subarachnoid hemorrhage</td>
<td>(R) Distal ulna fracture</td>
</tr>
<tr>
<td>Onset</td>
<td>6/26/91</td>
<td>5/29/91</td>
<td>4/1/92</td>
</tr>
<tr>
<td>Dominance</td>
<td>Right</td>
<td>Right</td>
<td>Right</td>
</tr>
<tr>
<td>Initial outpatient</td>
<td>8 weeks</td>
<td>3 weeks</td>
<td>10 weeks</td>
</tr>
<tr>
<td>presentation</td>
<td>Assembly</td>
<td>Policy clerk</td>
<td>Dry end</td>
</tr>
<tr>
<td>Occupation</td>
<td>worker</td>
<td></td>
<td>assistant</td>
</tr>
<tr>
<td>Time of job site</td>
<td>16 weeks</td>
<td>7 weeks</td>
<td>52 weeks</td>
</tr>
<tr>
<td>analysis</td>
<td>Light</td>
<td>Sedentary</td>
<td>Very heavy</td>
</tr>
<tr>
<td>Physical demands</td>
<td>24 weeks</td>
<td>17 weeks</td>
<td>59 weeks</td>
</tr>
<tr>
<td>Time of return to work</td>
<td>Job rotation</td>
<td>Previous job</td>
<td>Reassignment</td>
</tr>
</tbody>
</table>

Table 1

Patient Profiles and Outcomes

*After onset of illness.
Residual Deficits. This client's residual deficits in the physical domain included mild tone throughout the left upper extremity, slow fine and gross motor dexterity of the left hand, fair bilateral coordination, and poor work tolerance with the left upper extremity. In the psychosocial domain, she showed a passive communication style that adversely affected her self-esteem and coping skills.

JSA. Four months after the client's stroke, a JSA was conducted to determine her work readiness. Before the stroke, she had worked as an assembly line worker for 3 years.

The client's employer produced 5,000 fire extinguishers per day with a work force of 120 persons. The job emphasis for the assembly line workers was to work fast and produce. The JSA revealed that there were no job rotations or part-time employees at the company.

Assembly line workers performed physical, manual, and repetitive work tasks and were switched to other assembly stations to meet the changing needs of the multiple production lines. Assembly line workers were required to lift fire extinguishers varying in weight from 5 lb to 50 lb, place brackets on the extinguishers, and wipe the extinguishers down. To work on the assembly section of the production line, workers were required to lift up to 15 lb intermittently but at frequent intervals, varying from 5 sec to several minutes.

The subassembly line workers of the production line had several tasks that were self-paced. These tasks involved manual dexterity and the use of machinery. Bilateral hand function, grasping, and fine motor control were required to operate the machines.

The work was done in frequent and varied body postures, such as bending, standing and walking, and grasping and handling while reaching. The physical demand characteristics of the client's job were categorized as light because the maximum weight she would be required to lift was 15 lb.

JSA findings and recommendations. The findings of the JSA indicated that tasks for this client in the subassembly line section of the company appeared possible. This assignment would occur during a transitional period that would enhance the client's work readiness for the assembly line.

After discussion with the director of personnel at the client's company, the subassembly assignment as well as a job-rotating position between the subassembly and assembly line were proposed for the client. This rotational position would both meet the employee productivity expectations of the company and assure that the client would have a reduction in the repetitive lifting component associated with the assembly line section. Structuring the self-paced activities of the subassembly section into the client's workday would also minimize an increase in the mild tone that the client experienced throughout her left extremity.

Therapeutic program. Information gained from the JSA was used to structure the client's therapy to return her to work. Her therapy addressed skill performance areas that affected work readiness in the physical and psychosocial domains (see Table 2). For example, in the physical domain she worked on simulating the placement of the brackets on the fire extinguisher to improve her bilateral coordination. Work conditioning was also a component of this client's treatment. A work conditioning treatment is defined as treatment occurring up to 5 times per week for up to 4 hr per day and up to 8 weeks (American Physical Therapy Association, 1993). Work conditioning, which for this client occurred 3 times per week for 1 hr to 3 hr, was used to facilitate an improvement in muscle endurance and strength. The client's ability to sustain the lifting component of the assembly line job was therefore improved through the work condition-

### Table 2
Summary of Treatment Goals and Interventions for Cases 1, 2, and 3

<table>
<thead>
<tr>
<th>Treatment Goals</th>
<th>WC</th>
<th>WS</th>
<th>CA</th>
<th>GI</th>
<th>RP</th>
<th>JC</th>
<th>GW</th>
<th>HP</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical domain</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Improvement of muscle endurance</td>
<td>1-3</td>
<td>1-3</td>
<td>2</td>
<td></td>
<td>2</td>
<td>1-3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Improvement of muscle strength</td>
<td>1-3</td>
<td>1-3</td>
<td>2</td>
<td></td>
<td>2</td>
<td>1-3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Improvement of standing tolerance</td>
<td>1-3</td>
<td>1-3</td>
<td></td>
<td>1-3</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Improvement of sitting tolerance</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td></td>
<td>2</td>
<td>2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cognitive-perceptual domain</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Improvement of attention span and concentration</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Improvement of visual scanning</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td></td>
<td>2</td>
<td></td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Improvement of figure-ground perception</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Improvement of sequencing</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td></td>
<td>2</td>
<td>2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Psychosocial domain</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Improvement in self-esteem</td>
<td>1-3</td>
<td>1-3</td>
<td>2</td>
<td>1-2</td>
<td>1-3</td>
<td>2</td>
<td>1-3</td>
<td></td>
</tr>
<tr>
<td>Improvement in coping skills</td>
<td>1-2</td>
<td>1-3</td>
<td>2</td>
<td>1-2</td>
<td>1-3</td>
<td>2</td>
<td>1-3</td>
<td></td>
</tr>
<tr>
<td>Improvement in communication skills</td>
<td>1-2</td>
<td>1-3</td>
<td>2</td>
<td>1-2</td>
<td>1-3</td>
<td>2</td>
<td>1-3</td>
<td></td>
</tr>
<tr>
<td>Environmental</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Improvement in coping with auditory and visual distractions</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Note: WC = work conditioning, WS = work simulation, CA = computer activities, GI = guided imagery, RP = role playing, JC = job coach, GW = graded work reentry, HP = home program activities.
ing intervention.

Given her passive communication style, the client was unable to effectively communicate her needs and limitations to her supervisor. The use of guided imagery and role playing enhanced her communication and coping skills.

The majority of the program was conducted in the occupational therapy clinic. This client returned to full-time work status 24 weeks after her illness in the rotation position recommended.

**Employer response.** The client's supervisor initially opposed the job rotation recommendation. Subsequently, it was stressed to the director of personnel at the client's company that, according to the ADA guidelines, a job rotation for restructuring the client's work schedule would be an advised reasonable accommodation serving to facilitate her return to work. The director of personnel was helpful in relaying information to the client's supervisor and in coordinating the implementation of the job rotation recommendation.

**Case 2**

**Medical history.** A 43-year-old white woman who had emergency surgery to repair a subarachnoid hemorrhage via clipping of the left posterior communicating artery aneurysm was referred 3 weeks after surgery for outpatient occupational therapy, physical therapy, and speech therapy in a hospital-based outpatient setting. She was evaluated by both physical therapists and speech therapists and discharged from their care after 1 week (see Table 1).

**Residual deficits.** This client's residual deficits were primarily in the cognitive-perceptual domain. The impairments adversely affecting her included a decrease in attention span and concentration and difficulty with visual scanning, figure-ground perception, and sequencing. In the psychosocial domain, she showed a tendency toward high anxiety that lowered her self-esteem and adversely affected her coping skills. She was particularly anxious that she would have a relapse of the hemorrhage.

**JSA.** After 1 month in occupational therapy, a JSA was conducted to determine the client's work readiness. Before the hemorrhage, the client had worked for 24 years in an insurance company, in which she had spent the last 10 years as a policy clerk.

The JSA revealed no possible job rotations and a job emphasis on working quickly to produce as many transactions as possible during the work day. Policy clerks had to perform data entry of policy issuance transactions; receive, check, sort, count, and examine the deposit transactions before sending them to the next work station; sort, index, and assemble papers and other written documentation; and use a video display terminal with keyboard to enter policy issuance transactions. The work environment was an open space with multiple visual and auditory distractions. The work demands were high for cognitive and visual endurance and attention to detailed information. The job tasks required constant analysis and interpretation of applicable codes for data entry. The policy clerk had to remember multiple application codes to be entered, switch computer screens to access additional information to complete the entry as needed, and re-check both her own and her partner's work for errors. These tasks were performed on the video display terminal.

The physical demand characteristics of the client's job were categorized as sedentary. Job tasks required repetitive manual and finger speed to type the information and bilateral hand function and fine motor control to operate the keyboard. The work required the carrying of transaction documents weighing up to 5 lb, three to four times per day. The additional documents to be processed were located in a nearby unit. The work was performed in an upright sitting posture with occasional standing and walking and constant handling and reaching while sitting at the terminal.

**JSA findings and recommendations.** Although the client was medically cleared by the neurosurgeon to return to work 2 months after surgery, her cognitive-perceptual skills at that time required further refinement for her successful return to work. The findings of the JSA indicated that the essential functions of a policy clerk appeared possible for this client. A graded work reentry was recommended to facilitate her return to work as a policy clerk.

**Therapeutic program.** The information from the JSA was used to devise a graded work reentry program for the client. Therapy addressed skill performance areas affecting work readiness in the physical, cognitive-perceptual, psychosocial, and environmental domains (see Table 2). Part of the program was conducted in the occupational therapy clinic. Essential job functions (e.g., switching screens and switching to the appropriate screen on the computer) were simulated to identify what difficulties she would experience. Once the difficulties were identified, reasonable accommodations were proposed. For example, having a sheet listing key functions in her station allowed her to increase her speed, sequencing, and recognition when switching to other screens. The majority of the program was conducted at her workplace where she was able to work on actual job samples. This client returned to full-time work status 17 weeks after her illness.

**Employer response.** The supervisor valued this employee and was cooperative through every phase of the work reintegration process. The supervisor provided me with weekly productivity and quality work ratings of the client's job samples during the actual workplace process.

**Case 3**

**Medical history.** A 45-year-old white man incurred a fracture of the right distal ulna while working as a dry end
assistant at a paper mill company. He underwent day surgery for an open reduction internal fixation of the distal right ulna 6 weeks after his initial injury. His past medical history included insulin-dependent diabetes and hypertension. He had been followed in occupational therapy as an outpatient for 9½ weeks after surgery. Nine months after injury, however, he was placed under my supervision at a hospital-based outpatient setting (see Table 1).

Residual deficits. Subsequent to the wrist fracture, the client sustained ulnar nerve impairment that delayed his hand and digital recovery. The primary physical residual deficits were decreased right hand grip strength and sustained gripping, decreased muscle endurance with limited range of motion of the wrist, and decreased work tolerance. The client was particularly anxious about losing his job (psychosocial domain). These feelings contributed to a lowering of self-esteem that adversely affected his coping skills.

JSA. The JSA was conducted 1 year after the client's injury. Before the fracture, he had worked for his company for 16 years.

The JSA revealed that the company in which the client was employed had no job rotations or part-time employees. The emphasis was on teamwork because dry end assistants performed whatever duties needed to be done at each station. Employees used a variety of work-specific tools to complete their jobs. A dry end assistant worked on a paper machine station and had to be knowledgeable in operating the heavy machinery at the station. Workers were also placed at other paper machine stations throughout the plant as needed.

Workers had to know a variety of procedures to perform this job. The work was physical, manual, and repetitive. Workers were switched from any of the station area according to the changing needs of the production line. Bilateral hand function, heavy grasping, and fine motor control were required in operating the machines. Right hand use during work entailed lifting and attaching chains to hoists and then controlling the hoists. The psychosocial aspects of treatment were addressed via role playing and home program activities. According to the physical capacity corresponded to the job reassignment to a vacant position, would not impose undue hardship on the company. The employer provided the client with 1 week of on-the-job training to prepare him for the refiner laboratory helper position.

Discussion

Skill performance affecting work readiness may include physical, cognitive-perceptual, psychosocial, and environmental domains. Because these domains affect the work readiness of the client's transition in returning to work, they must be addressed during the rehabilitation process. The JSA lays the foundation for determining these factors at the workplace. The JSA allows for understanding the essential functions of the client's workplace and formulates treatment strategies addressing the skill performance areas that need improvement.

In the three cases reported, a combination of treatment strategies was used to improve specific skills that the clients needed for work reintegration (see Table 2). These therapeutic interventions made the clients' transi-
tion from therapy to return-to-work status easier because they perceived their abilities to be proficient and to match the job demands.

In each case, graded work conditioning and work simulation were used to increase physical skill requirements such as muscle endurance, strength, bilateral coordination, lifting, standing, and sitting tolerance. The increase in physical tolerance may be achieved via the use of a Baltimore Therapeutic Equipment (1992) work simulator, manual dexterity activities, and computer programs.

Computer activities for cognitive-perceptual rehabilitation are a common therapeutic tool (Ross, 1992; Spicer & McMillan, 1987). In Case 2, computer programs were initially part of the client's therapy. The focus was to work on cognitive-perceptual skills such as attention span, visual scanning, figure-ground perception, and sequencing. The client's improved ability to attend to task and visually scan with the clinic computer made the transition to her work computer more effective. This intervention also served to improve the client's coordination and dexterity in the upper extremity that was needed at her workplace.

Psychosocial factors were addressed throughout treatment in all three cases. One identifiable positive psychosocial factor contributing to the successful return-to-work outcomes was the intrinsic motivation of the clients. The clinical manifestation of intrinsic motivation was displayed by each client's basic worker behaviors of good attendance, timeliness, and self-responsibility in their therapeutic program.

The disruption of work routine resulting from events such as illness has been shown to increase a person's stress level, which in turn erodes the person's perceived self-esteem and sense of mastery (Pearlin, Menaghan, Lieberman, & Mullan, 1981). This erosion of self-esteem was found in all three cases during the return-to-work process. As the work reintegration time approached, the clients reported increased anxiety. The clients all expressed doubts about their ability to succeed in the job because of their medical illness. In addition, they expressed fear that the job would result in a subsequent illness.

Strategies aimed at minimizing clients' stress levels and associated anxiety accompanying the return-to-work process included guided imagery and role playing. In two of the cases, guided imagery techniques were used to help alleviate anxiety levels, and the clients' subjective report of the experience was positive. Another useful technique that was used was to role play interpersonal scenes with the clients that they might encounter with coworkers and supervisors. The clients found this experience helpful in facilitating the learning and practicing of assertive communication. These techniques were also incorporated as part of the home program to boost the clients' coping skills, their confidence and, subsequently, their self-esteem.

In Case 1, the role-playing interventions of assertive communication were used to help the client to be more at ease in stating her needs and limitations to her supervisor. Speaking with the director of personnel to discuss the client's passive communication style and methods to help the employer facilitate dialogue between them also improved their communication. This aspect of the program was important because it helped both parties to understand each other's expectations and needs.

In each case, education of other work-site employees on the client's type of medical illness and expectations of the client was necessary to diminish coworker anxiety, fear, and anger regarding the returning employee. In Case 3, the safety director expressed anger because the client had been out for more than 1 year with a wrist sprain. This director was angry because he believed that the client did not have a serious wrist problem and was abusing the system. He was informed that the injury was a wrist fracture and not a wrist sprain. Because of the education that they received, the coworkers were receptive to the JSA and its corresponding recommendations. This education of coworkers on the disability and expectations of the returning employees was one of the goals of the JSA.

The environmental domain must be a consideration in the work reintegration process. In Case 2, during the initial workplace therapy sessions, the client was isolated from her coworkers in an effort to minimize environmental distractions and facilitate her attention to task. Under my supervision, the client worked for a 2-hr period, and any situational job-related issues that arose during that time were solved together. To ensure that the client's job samples were correct, they were checked by the unit leader. For the next several weeks, the client's hours of work were increased, the environmental distractions were gradually increased, and her work was checked daily until she was meeting the expected productivity level. After 5 weeks of the graded work reentry program, the client returned to work on full-time status.

The ADA requires consideration of alternative work if persons cannot return to the previous job with reasonable accommodations. Alternative work may include job rotation, part-time work, or reassignment to another job with different physical demands. In Case 1, the recommendation was return to work in a job rotation; in Case 3, return to work in a reassignment position. The employers complied with these recommendations after receiving an explanation of the rationale for the recommendations. It may be necessary to use the results from objective tests such as a functional tolerance screenings, functional capacity evaluations, upper-extremity evaluations, and cognitive-perceptual evaluations to support the recommendations made.

The outcome for each client was eventual reintegration into the workforce. These clients were followed 1
After discharge from therapy, each had returned to full-time status and was meeting employer expectations. Currently, all continue to be productive employees.

**Conclusion**

The process of work reintegration begins with assessing the client’s rehabilitation potential to return to work. When clinical reasoning and assessment dictate that a good rehabilitation potential exists, a JSA is conducted to determine the essential functions of the client’s workplace. Upon the completion of the JSA, a variety of strategies can be used for returning clients to work. The JSA can assist clinicians in formulating holistic treatment plans in returning appropriate clients with neurological and orthopaedic disabilities to 'work in compliance with the ADA (1990). The relationship between prevention and return to work after stroke: Development of a predictive model. Archives of Physical Medicine and Rehabilitation, 71, 285–290.

**Acknowledgments**

I thank Barbara C. Canelon, DOT OTR/L, for comments on a draft of this article, and Cheryl Matthews, Administrative Assistant, for final preparation of the manuscript. I also thank the three clients for allowing me to share our experience with others.

**References**


Page, C. (March, 1989). Rural rehabilitation: It's time now. In G. Foss (Ed.), Meeting the rehabilitation needs of rural Americans. Papers from the first national conference of the research and training center on rural rehabilitation services (pp. 1–2). Missoula, MT: RTC Rural.


