Changes in the health system require occupational therapy practitioners to focus their concerns on the long-term health needs of people and to help them develop healthy behaviors not only to improve their health, but also to minimize the health care costs associated with dysfunction. Occupational therapy practitioners must initiate efforts in the community to integrate a range of services that promote, protect, and improve the health of the public. This article shares the experiences of Canadian occupational therapy practitioners, who were challenged by their government nearly 15 years ago to establish a system that demonstrates effectiveness by improving the health of occupational therapy clients.

By focusing on occupational performance, occupational therapy practitioners assist clients in becoming actively engaged in their life activities. This requires client-centered and family-centered practice and services that span from the agency or institution to the community. Occupational therapy practitioners must work collaboratively with persons in the client's environment (e.g., family members, teachers, independent living specialists, employers, neighbors, friends) to assist the client in obtaining skills and to make modifications to remove barriers that create a social disadvantage. A focus on occupational performance requires occupational therapy personnel to reframe how we think about occupational therapy to a sociomedical context and to take an active role in building healthy communities.
Although it is important to place occupational therapy’s view within the overall context of our health-care delivery system, it is also important to address the needs of U.S. and Canadian societies as we struggle with issues of chronic disease, disability, and handicapping situations. To our societies, these issues mean lost productivity and costly services. To individuals, they mean poorer health and a compromised well-being. A brief review of the health issues of Canada and the United States will provide a context in which to examine what occupational therapy practitioners can do to highlight their contribution to helping both society and the individuals who can benefit from our interventions.

About 35 million Americans, 1 in 7 (Pope & Tatlov, 1991), and 4 million Canadians, 15% (Statistics Canada, 1992), have a physical or mental impairment that interferes with their daily activities, yet only 25% are so severe that they cannot work or participate in their communities. Disability is now a public health problem, affecting not only persons with disabling conditions and their immediate families, but also society (Pope & Tatlov, 1991). The problems associated with chronic disease and disability are so prevalent that in 1990, the U.S. government published the Healthy People 2000 (U.S. Department of Health and Human Services, 1991) objectives, with priorities that challenged communities and health professionals to promote prevention strategies for American citizens. A number of the objectives should be of interest to occupational therapy practitioners: (a) improving functional independence of American citizens; (b) preventing persons with illnesses from becoming disabled; (c) encouraging physical activity; (d) reducing the number of persons 65 years of age and older who have difficulty performing two or more personal care activities; (e) reducing deaths caused by motor vehicle accidents; (f) reducing fall-related injuries; and (g) increasing the proportion of primary care providers who routinely evaluate persons 65 years of age and older for visual, hearing, cognitive, and functional status impairments.

In Canada, the federal government has been working to improve the health and participation in the everyday life of Canadians through health-promotion strategies (Health and Welfare Canada, 1986, 1987). Health is viewed by the Canadian government as much more than the absence of disease, and many provinces have set health goals for their populations. For example, Ontario’s health goals emphasize (a) health promotion and disease prevention; (b) building healthy, supportive communities; (c) reducing illness, disability, and death; (d) improving the physical environment; and (e) ensuring accessible and affordable health services for all citizens (Premier’s Council on Health, Well-Being and Social Justice, 1993).

A Context for Practice in a Changing Health System: Strategies for a Managed Care Environment

Over the past two decades, our nations have shifted from being manufacturing societies to being information societies (Drucker, 1989). This shift has had a profound impact on how business is conducted and how health care is delivered. Occupational therapy practitioners are, as are all health professionals, required to go beyond performing services; their services must be understood by providers and by clients who do not have a health knowledge base. The emergence of clinical reasoning in health care is directly related to the need to make explicit that which we know and want to be understood by others.

The shift to an information society has also resulted in occupational therapy practitioners being forced to become specialists just to manage the breadth of knowledge required to be competent in practice. Unfortunately, because occupational therapy has been steeped in the medical model, we have built specialization around medical conditions rather than occupational performance needs. The professional need to access information requires that occupational therapy practitioners work collaboratively to meet clients’ needs. This collaboration takes place not so much across disciplines but within project teams. For example, rather than working as a specialist focused on the sensory integrative needs of children, occupational therapy practitioners are now working as experts in occupational performance on teams (clinical service lines) that address the rehabilitation or habilitation needs of these children. This expertise goes far beyond the child’s sensory integrative needs to include all factors that affect his or her performance.

The payment structures supporting health care in the United States are changing because information now links demographic, service delivery, and outcomes data. Rather than work as independent practitioners, occupational therapy practitioners are more and more working either directly or contractually for organizations that manage services on the basis of these data. This shift requires practitioners to document their effectiveness by entering standard data into large data sets; hence, the capabilities of the organization as a whole are being evaluated and recognized rather than those of the individual therapist. These changes offer practitioners an opportunity to affect the overall outcomes of the health delivery system, which wants to achieve high outcomes with minimal costs. What contributes more to the achievement of these outcomes than clients and their family members having the knowledge and skill to participate in the clients’ recovery
and to learn the behaviors that will sustain their health and function over time?

The changes in the health care system do not affect just occupational therapy practitioners but all health professionals. Even physicians are taking salaried positions. Being effective in this era of health care requires knowing how to work with and achieve the goals of the organization as a whole. Occupational therapy practitioners have traditionally stepped to the forefront in times of reform to prevent the clients' rights from being compromised by services not directed to support them. For example, our early leaders contributed to the reform of mental institutions by introducing the use of meaningful occupations to facilitate recovery. Understanding the needs of a changing system is a prerequisite to action.

Hospitals and health care agencies have been forced to restructure their health care delivery mechanisms because technological advances to save lives, coupled with an aging population, have made the cost of medical care a threat to the financial stability of our nations. Health care reform has been guided by business and its success in using interorganization mechanisms to take advantage of the economy of scale. Changes are rising from a mutual need for all health services to reach common objectives and a willingness to share risks and costs as well as knowledge and capabilities. Many of these changes make good sense: It is not logical or cost-effective to have empty beds, to bypass large discounts for purchasing, or to have multiple hospitals staffed and equipped to do open heart or transplant surgery. Much of the discussion on health care reform centers around costs, but any large change in health care delivery is difficult and will only be understood when the turbulence subsides.

Some benefits to interorganizational cooperation include the opportunity to learn and adapt to new competencies; gain access to resources; share risks, including the cost of products and technology development; manage uncertainty; and solve complex problems. With this cooperation, there are some costs, including a loss of autonomy and control; conflict over domains, goals, and methods; and delays in solutions because of coordination problems (Kaluzy, Zuckerman, & Ricketts, 1995).

The changes emerging with managed care are not the first our profession has seen, although we have not seen major health care reform since Medicare and Medicaid were initiated in the mid-1960s. It is important for those occupational therapy practitioners who have built their professional careers in a fee-for-service system that is changing to gain a historical perspective to see that the profession has endured many changes over the past eight decades.

A Context for Effective Occupational Therapy Practice

When occupational therapy began in the early part of this century, it was for moral reasons. In this period before drugs were used for treatment of mental illness, persons with mental conditions were institutionalized without means of occupying themselves. Professionals from the fields of medicine, neurobiology, nursing, social work, and architecture believed that residents of mental institutions had needs that could be met by giving them meaningful work. These professionals who shared a common interest in using occupation as treatment found each other, and the profession of occupational therapy was born (Christiansen, 1991). Finding ways to address the needs of persons as they use occupation to improve their health continues to be a challenge for occupational therapy today.

Occupation is a term that describes the interaction of the person with his or her self-directed life activities. Adolf Meyer (1922), a neurobiologist, psychiatrist, and founder of occupational therapy, proposed that "the proper use of time in some helpful and gratifying activity appears to be a fundamental issue in the [management] of any neuro-psychiatric patient" (p. 1). He professed that persons should attain and retain a healthful "rhythm in sleep and waking hours, of hunger and its gratification, and finally the big four—work and play and rest and sleep" (p. 3). Wilcock (1993) viewed occupation as a central aspect of the human experience and unique to each individual. The definition of occupation should be basic to every occupational therapy practitioner's vocabulary. Occupation meets "the [person's] intrinsic needs for self-maintenance, expression, and fulfillment within the context of personal roles and environment" (Law et al., 1996, p. 16). Thus, it is through the process of engagement in occupation that people develop and maintain health. Conversely, the lack of occupation causes a breakdown in habits, which leads to physiological deterioration and lessens the ability to perform competently in daily life (Kielhofner, 1992). As the health system changes its focus to persons' long-term health needs, issues surrounding occupation become central to promoting health and reducing the cost of chronic disability.

Adopting interventions to support the health and function of persons in their communities was a plea expressed some time ago (Finn, 1972; West, 1968). We no longer can ignore the challenges of finding mechanisms to meet community health needs if occupational therapy is to remain "a sufficiently vital and unique service for medicine to support and society to reward" (Reilly, 1962, p. 1). These mechanisms are currently being developed by large community health systems under the label of disease management.
Disease management is a comprehensive, integrated approach to care and reimbursement that is based on the natural course of a disease. Intervention is designed to address the illness by maximizing the effectiveness and efficiency of service delivery. Disease management differs from care paths in that it attempts to encompass the entire course of a disease, whether it is in an acute phase or remission and whether the care is delivered in the hospital, the home, or the community. This approach also considers the consequences of the condition across time. The purpose of disease management is to help people develop healthy behaviors not only to improve their health, but also to cut health care costs associated with secondary conditions. In the United States, nurses and health educators are carrying out much of this work.

Occupational therapy practitioners in the United States can learn from the experiences of Canadian occupational therapy practitioners who have had to address similar issues. In Canada, occupational therapy practitioners were challenged by their government nearly 15 years ago to put in place a quality assurance system that would demonstrate effectiveness by improving the health of occupational therapy clients (Canadian Association of Occupational Therapists [CAOT], 1991; CAOT & Department of National Health and Welfare, 1983). Rather than focusing only on the process of therapy, the therapists who accepted this challenge proposed a client-centered model of practice that would span from institutional-based services to community-based services. Because this client-centered model has already been developed and tested, it can serve as a model for the development of community-based services in the United States.

Building a community model requires moving beyond the medical model, which focuses on cure and management of the disease and where the relationship is between the patient and physician (Jeison & Rudin, 1983), to a model of active collaboration between occupational therapy practitioner and client to resolve occupational performance problems. Such a model would focus on the psychosocial, as well as medical, needs of clients and encourage them to be as autonomous as possible, providing opportunities for choice in decisions and activities (Smith & Eggleston, 1989).

Occupational therapy practice has been limited by the health care system’s focus on acute medical management. Recent expansion of vertical health systems has resulted in subacute, rehabilitation, home health, and work-related programs becoming integrated parts of the health system. As hospitals build community health initiatives, networks with independent living centers, schools, fitness and wellness programs, and vocational rehabilitation programs will become important. The team that historically focused on acute medical care has been limited primarily to traditional medical rehabilitation professionals, including physicians, occupational therapy practitioners, physical therapy practitioners, speech-language pathologists, psychologists, and rehabilitation nurses. The community approach expands rehabilitation to include a whole new cadre of colleagues, including persons with disabilities, engineers, architects, personal assistants, independent living counselors, recreation and exercise personnel, city planners, law enforcers, and transportation specialists.

Consumers (i.e., clients, policymakers, insurers, physicians) are seeking different information from occupational therapy practitioners. Performance component information will still play a role in the occupational therapy practitioner’s clinical reasoning process. However, with the focus on outcomes and improved well-being, occupational therapy practitioners are increasingly expected to report on personal and environmental assets and limitations that relate to the client’s occupational performance and the services needed to facilitate healthy behaviors. Occupational therapy practitioners should be seen as experts in applying effective intervention strategies that contribute to optimal occupational function, including self-sufficiency, social integration, improved health status, and employment, in persons with chronic disease and disability.

Rather than focus on professionally controlled services that promote dependence, the new health paradigm (see Table 1) will emphasize the development of community partnerships in which consumers and professionals work together to develop strategies to manage health problems and prevent secondary disabling conditions that can compromise function and translate directly into increased medical costs. Although many of the changes associated with this shift in focus are painful, the ultimate goal, which focuses more on prevention, fits well with the philosophy of occupational therapy, which supports the healthful behaviors and function of persons in their daily lives.

Occupational therapy practitioners must assume responsibility for shaping their own future in the changing health care system. Basic to implementing a model to manage a client’s long-term health and occupational needs is placing value in the client directing his or her own care. Occupational therapy practitioners use terminology and design programs described as patient centered, client centered, patient focused, client driven, partnerships, and family centered. What do these terms mean, and how do we assure that we are leaders in shifting the paradigm?

The Unique Contribution of Occupational Therapy to a Managed Care System

Man is an organism that maintains and balances itself in the world of reality and actuality by being in active life and active use...It is
Table 1
A Changing Health System Paradigm

<table>
<thead>
<tr>
<th>Area</th>
<th>Old</th>
<th>New</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>The model</strong></td>
<td><strong>Medical model</strong></td>
<td><strong>Sociopolitical (community) model</strong></td>
</tr>
<tr>
<td><strong>Episodic care</strong></td>
<td></td>
<td><strong>Planned or managed health</strong></td>
</tr>
<tr>
<td><strong>The focus</strong></td>
<td><strong>Focus on illness</strong></td>
<td><strong>Focus on wellness</strong></td>
</tr>
<tr>
<td><strong>Acute care outcomes</strong></td>
<td></td>
<td><strong>Well-being, function, and life satisfaction</strong></td>
</tr>
<tr>
<td>Individual</td>
<td><strong>Deficiency</strong></td>
<td><strong>Capability</strong></td>
</tr>
<tr>
<td>Survival</td>
<td><strong>Survival</strong></td>
<td><strong>Functional ability, quality of life</strong></td>
</tr>
<tr>
<td>Professionally controlled</td>
<td></td>
<td><strong>Personal responsibility flexible, choice</strong></td>
</tr>
<tr>
<td>Dependence</td>
<td></td>
<td><strong>Interdependence, participation</strong></td>
</tr>
<tr>
<td>Treatment</td>
<td></td>
<td><strong>Treatment, prevention</strong></td>
</tr>
<tr>
<td><strong>The system</strong></td>
<td><strong>Institution centered</strong></td>
<td><strong>Community centered</strong></td>
</tr>
<tr>
<td>Single facility</td>
<td></td>
<td><strong>Networked system</strong></td>
</tr>
<tr>
<td>Competitive focus</td>
<td></td>
<td><strong>Collaborative focus</strong></td>
</tr>
<tr>
<td>Fragmented service</td>
<td></td>
<td><strong>Coordinated service</strong></td>
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the use that we make of ourselves that gives the ultimate stamp to our every organ. (Meyer, 1922, p. 5)

Engagement in occupation is the way that people use their motor and memory skills to enhance their performance and maintain both cognitive and physiological fitness. Reilly (1962) stated that "there is a reservoir of sensitivity and skill in the hands of man which can be tapped for his health [and a] rich adaptability and durability of the central nervous system which can be influenced by experiences" (p. 2). As our colleagues in nursing, medicine, and physical therapy use terminology and approaches with the intent of improving function, we also must make our unique contribution to function visible and understood. The term occupational therapy practitioners use for function is *occupational performance*, or the point when the person, the environment, and the person's occupation intersect to support the tasks, activities, and roles that define that person as an individual (see Figure 1).

Being able "to do" requires the integration of factors within the person with those external to the person (i.e., culture, economics, resources, the physical and social environment). Of particular interest is how these environmental factors interact with the person's occupational structure. Persons who perceive that they have control over their environments and can address obstacles derive satisfaction from their occupational roles (Burke, 1977; Sharott & Cooper-Fraps, 1986). Thus, the unique contribution of occupational therapy is to maximize the fit between what the person wants and needs to do and his or her capability to do it (see Figure 2).

Some key concepts must be mastered to describe how occupational therapy fits into the larger context of medicine and rehabilitation. The traditional approach to medical care has focused on *impairments* or the loss or abnormality of mental, emotional, physiological, or anatomical structure or function. This term includes all losses or abnormalities, not just those attributable to the initial pathophysiology, and includes pain as a limiting experience (National Center for Medical Rehabilitation Research [NCMRR], 1993). When there is an interruption or interference of normal physiological and developmental processes or structures the term used is *pathophysiology* (NCMRR, 1993).

Acute rehabilitation usually focuses on *functional limitations* (i.e., restrictions or lack of ability to perform an action or activity in the manner or within the range considered normal) that result in impairment or failure of a person to return to a preexisting level or function (NCMRR, 1993). This impairment is synonymous with occupational therapy practitioners' description of performance components. In contrast, *disability* is defined as an inability or limitation in performing socially defined activities and roles within a social and physical environment as a result of internal or external factors and their interplay (NCMRR, 1993).

As the occupational therapy practitioner approaches problem solving with clients, three sets of information are basic to the plan: (a) *person factors*, which are the person's neurobehavioral, cognitive, physical, and psychosocial strengths and deficits (Christiansen & Baum, in press);
Figure 2. Occupational therapy process environment. Note. Adapted with permission from: Fearing, V. G., Law, M., & Clark, J. (1997). An occupation performance process model: Fostering client and therapist alliances. Figure 4. Canadian Journal of Occupational Therapy, 64, p. 11.

(b) environmental factors, which include the person's cultural, economic, institutional, political, and social context (Christiansen & Baum, in press); and (c) occupational factors, which include the person's self-maintenance, work, home, leisure, and family roles and activities. The unique term occupational therapy practitioners use to express function is occupational performance. It reflects the person's dynamic experience of engaging in daily occupations within the environment (Law & Baum, 1994).

A social disadvantage or handicap results when a person is not able to fulfill a role that he or she expects or is required to fill. If the environment presents a barrier to the performance of an activity (e.g., a nonaccessible building, an attitude of discrimination, a policy that denies access), the barrier is defined as a handicapping situation (Fougeyrollas, 1994). When societal policy, attitudes, and actions, or lack of actions, create a physical, social, or financial barrier to access health care, housing, or vocational or avocational opportunities, the term used is societal limitation (NCMRR, 1993).

Client-Centered Practice

A managed care occupational therapy practice that is based on concepts of client-centeredness is more likely to engage clients in the occupational therapy process and lead to increased adherence and satisfaction with therapy (Law, Baptiste, & Mills, 1995) than a service focused only on what the therapist perceives as a problem. Client-
centered practice creates a caring, dignified, and empowering environment in which clients direct the course of their care, calling on their personal and spiritual resources to speed the healing process (Matheis-Kraft, George, Olinger, & York, 1990).

In a client-centered approach, clients and therapists work together to define the nature of the occupational performance problem, the focus and need for intervention, and the preferred outcomes of therapy. Basic assumptions of a client-centered approach are: (a) clients and their family members know themselves best, (b) all clients and family members are different and unique, and (c) optimal client performance occurs within a supportive family and community context (Law et al., 1995). On the basis of these assumptions, clients and therapists can focus on their unique contribution and responsibilities to building a client-centered partnership. In such a partnership, clients expect to lead the decision-making process. To do this, clients require information that will enable them to make decisions about the services that will most effectively meet their needs. This information, when given in an understandable way, will ensure that clients can define occupational performance priorities for intervention. Clients expect to receive a service in a timely manner and to be treated with respect and dignity during the occupational therapy process. The therapist encourages clients to use their own resources to help solve occupational performance problems. Clients participate at different levels, depending on their capabilities, but all are capable of making at least some choices about how they spend their daily lives.

A client-centered approach encourages occupational therapy practitioners to assume new responsibilities in enabling clients to identify their own needs and to individualize service delivery. With this approach, therapists support client decisions or communicate the reason why he or she cannot support the client's decision. Additionally, therapists respect the client's values and visions as well as the client's style of coping without judging what is right or wrong. They encourage clients to recognize and build on their strengths, using natural community supports as much as possible.

A Model for Planning and Implementing Client-Centered Occupational Therapy Services

An occupational therapy practitioner brings knowledge and experience to the therapeutic relationship, as does the client. When a new therapeutic relationship is evolving, it is important for the context of that relationship to be understood by both parties. It is just as important for clients to understand why an occupational therapy practitioner is involved in their care and what they can expect to achieve through occupational therapy as it is for the therapist to understand the client's issues and needs. Additionally, it is important for the client to understand the scope of the therapist's knowledge and access to resources. Likewise, the client's knowledge of his or her condition, experience with the problem, and goals must become clear for the relationship to progress. If the client has a cognitive deficit or is a child who as yet does not have the capacity for independent decision making, the parent or person selected to be the guardian or caregiver must participate in this phase of treatment planning. If the occupational therapy practitioner does not have the knowledge to address the client's needs, the therapist should help the client seek the resources needed in order to be sure to address the problem.

It is important for the occupational therapist to design the first phase of the intervention to seek information from the client about his or her perception of the problem, needs, and goals. Information is shared to build the occupational performance history, which includes information about the person, the environment, and the occupational factors that require intervention. The seven steps of this process are:

1. Name, validate, and prioritize the client’s occupational performance issues
2. Identify potential intervention model(s)
3. Identify occupational performance components and environmental conditions
4. Identify strengths and resources
5. Negotiate targeted outcomes, develop action plan
6. Implement plans through occupation
7. Evaluate occupational performance outcomes

Implementing an Occupational Performance-Based Model

The implementation of an occupational performance model requires reexamination of how therapists access information to support a client-centered approach. Traditionally, therapists have measured the components of function or the impairments of a person with a functional problem. A top–down approach (Mathiowetz & Haugen, 1994; Trombly, 1995) is used in which the therapist determines with the client what the client perceives to be the important occupational performance issues causing difficulties in carrying out his or her daily activities (i.e., work, self-maintenance, leisure, rest).

Because occupational therapy assessments are only part of the system of care, therapists must be able to communicate with their colleagues in medicine, institutions, and the community; with the client; and with the family members. Even though the occupational therapist may measure performance components and environmental conditions to understand why problems occur and what
might be done about them, the unique measurement contribution is at the occupational performance level where the client interacts with his or her environment to perform occupations and roles of choice.

Comprehensive measurement models are beginning to emerge (see Figures 3 and 4) that support the new health paradigm. We have expanded these models to demonstrate the measurement issues that can be addressed when building a comprehensive outcomes-based model for occupational therapy (see Figures 5 and 6).

Whether the Internal Classification of Impairment, Disease, and Handicap (ICIDH) model or the NCMRR model is used in organizing assessments, interventions, and services, one issue is critical to the survival of occupational therapy in the changing health system: Occupational therapy practitioners must place their primary focus at the level of the person–environment interaction so that occupational performance issues can be assessed and addressed in the therapy plan. These issues are addressed in the ICIDH model at the life habit, environmental factors, and disability, and in the NCMRR model at the disability and societal limitations levels. When occupational performance issues are not addressed, the contributions of occupational therapy are not made explicit, and clients are left to fend for themselves in resolving the problems that will compromise their function and health.

**Influencing Outcomes**

The health system is focusing on outcomes because of the need to be accountable not only to the clients in need of services, but also to the third-party payers. With a shift in focus toward primary and secondary preventive care, it is important to know whether interventions are successful in reducing the impact of secondary problems. Outcomes are being defined as well-being and quality of life. Improved occupational performance is a critical construct in measuring quality of life, regardless of the measure used (Edwards, in press). There is increasing evidence that client-centered practice improves not only the process, but also the outcomes of care. This practice has led to increased client satisfaction and adherence to therapy recommendations, increased client participation in the occupational therapy process, improved client self-efficacy, and improved functional outcome (Dunst, Trivette, Boyd, & Brookfield, 1994; Dunst, Trivette, Davis, & Cornwall, 1988; Greenfield, Kaplan, & Ware, 1985; Moxley-Haeggert & Serbin, 1983; Stein & Jessop, 1991).

**Responsibilities of Therapists in a Changing System**

All health professionals are being challenged to demonstrate a broader understanding of the determinants of health, such as environments, socioeconomic conditions,
behaviors, medical care, and genetics. Occupational therapy practitioners must initiate efforts to work with others in the community to integrate a range of services that promote, protect, and improve the health of the public. The Pew Health Professions Commission (1993) described the health professional of the future as one who collaborates, is an effective communicator, and works in teams to meet the primary health needs of the public. Occupational therapy practitioners are uniquely qualified for this role because of our focus on productive living.

The government and leaders of health delivery systems are looking for solutions to the health care crisis. Occupational therapy practitioners should seek to understand both health and the delivery of health services from a broad political, social, economic, and legal perspective. We should come forward to lead in the development of resources to support the health of our communities by helping to eliminate the disabling conditions that are so costly not only to health care systems, but also to individuals and to society.

What Do Therapists Need To Know To Deliver Effective Care?

Much of what occupational therapy practitioners currently know has come from a rich experience, but it is not well documented in studies. The field's growing cadre of trained scientists can answer important questions to guide programs and policy. The plan prepared for the U.S. Congress by the NCMRR (1993) at the National Institutes of Health posed a number of questions that should be addressed by occupation scientists to guide practice. Therapists in practice can help answer these questions by joining research teams with faculty members and students in academic institutions:

- Identify factors that enable persons with disabilities to perform self-care or to create and manage support networks to provide assistance in activities of daily living (ADL).
- Identify the strategies that contribute to optimal function, including self-sufficiency, social integra-
Societal Limitation | Disability | Functional Limitation | Impairment | Pathophysiology
---|---|---|---|---
Restriction, resistance to social policy or barriers (structural or attitudinal) which limit fullfillment of roles or denies access to services or opportunities. | Impairment or limitation in performing socially defined activities and roles within a social and physical environment as a result of internal or external factors and their interplay. | Loss and/or abnormality of mental, emotional, physiological or anatomical structure or function; including secondary losses and pain. | Interruption or interference of normal physiological and developmental processes or structures. |
Performance of Roles by Person in Societal Context | Task Performance of Person in Physical and Social Context | Performance of Action or Activity | Organs and Organ Systems | Cells and Tissue
Roles: Worker * Student * Friend * Parent * Spouse/Partner * Volunteer * Recreation Context * Attitudes, customs, beliefs, norms * Accessibility * Inclusion * Accommodation | Task Performance: Basic Self-Care * Instrumental Tasks * Worker Tasks * Leisure Activity/Play * Education Context * Physical Environment * Social Environment including family * Cognitive Environment * Culture | Action or Activity: Initiate, Organize Sequence, Judge Attend, Select * Sit, Roll, Lift, Stoop Squat, Stand, Climb, Ambulate Reach, Finch, Grip, Grasp, Hold, Release * Relax, Interrupt, Cope Manage, Adapt Read, Write, Learn, Understand |
Hearing, Vision * Speech Articulation * Tone * Comprehensive Understanding * Problem Solving * Pattern Recognition * Attention * Memory * Motivation * Mood |
* Neurological Deficit * Physiological Deficit * Immunological Deficit * Nutritional Deficit * Occupational Exposure * Behavioral Risk * Genetic Abnormality

**Figure 6.** Measurement model built on the National Center for Medical Rehabilitation Research scheme (NCMRR, 1993).

- Identify the factors that contribute to successful long-term integration of persons with functional impairment into families and communities.
- Seek means of modifying habits or behavior patterns that contribute to substance abuse in persons with disabilities.
- Determine how to understand and enhance human learning, cognition, and skill acquisition after brain injury.
- Develop, apply, and evaluate personal, environmental, and activity-specific technologies that will enable persons with disabilities to perform ADL, including vocational and recreational activities.
- Study the effects of disability on children, including physical and cognitive functioning, educational attainment, and transition to adult roles, and of educationally related services in the public schools.

**Building the Future**

In order for a profession to maintain its relevancy it must be aware of the times, interpreting its contribution to mankind in accordance with the needs of the times. (Finn, 1972, p. 59)

The profession’s focus—enhancing the fit between a person and his or her environment in order to support the person’s ADL—is appropriate for the emerging health system. Services framed within the medical model alone will face ongoing cuts, whereas services framed within a broader, community-based model will enable clients to be responsible for their own health and occupational function. The challenge is to build occupational therapy service models that will support the daily functions of persons in the community across a continuum of primary, secondary, and tertiary care. This fits nicely with the evolving model of population-based care.

The rapidly changing health system is challenging all service delivery models. These challenges can be perceived as a threat to current occupational therapy practice or as a unique opportunity to renew our historical focus on enabling occupational performance as well as enabling persons with disabilities to lead independent and healthful lives.

We envision that occupational therapy practice will focus on occupational performance; will be more client and family centered; and, as a result, will be community based. We see occupational therapy practitioners building partnerships with clients and working collaboratively with persons with chronic health conditions and disabilities to remove environmental barriers that diminish or discourage their participation in everyday life in their community.

This type of practice requires all occupational therapy personnel to become active in their communities. Occupational therapists and occupational therapy assistants can help clients obtain the skills for living, Occupational ther-
apy educators can instill in students the importance of lifelong learning and provide them with the skills to use technology in order to access and produce information. Additionally, occupational therapy education must be expanded to include consultative and educational roles.

This type of practice also requires evidence that the occupational therapy services delivered are effective. For practitioners, this means using standardized measures and basing our practice on client-centered goals and evidence-based practice. For occupational therapy educators, this means educating students to be lifelong learners who can use technology to access and produce information and serve in consultation and educational roles. By understanding and facilitating the relationship between occupational and health, occupational therapy personnel can play an important role within the changing health system to ensure the desired outcome of health and well-being. ▲

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The American Journal of Occupational Therapy 287
American Journal of Occupational Therapy, 49, 711–714.


**UPDATE**

**Coming in May:**

- The Effects of a Neonatal Positioner on Scapular Rotation
- Teaching Diagnostic Reasoning: Using a Classroom-as-Clinic Methodology With Videotapes
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