



CAOT · ACE

Canadian Association of Occupational Therapists
Association canadienne des ergothérapeutes

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The Canadian Framework for Ethical Occupational Therapy Practice is a system or guide designed to assist occupational therapists to practise well in complex and often challenging workplace settings.

All documents can be downloaded and printed for professional development and educational purposes. There are currently 3 documents available:

- Overview /Brochure
- Conceptual Model
- Workbook

(A revised CAOT Code of Ethics is coming in January 2007.)

For more information, visit our website at <http://www.caot.ca/default.asp?pageid=1527> or contact CAOT's Director of Standards and Professional Affairs at dklaiman@caot.ca

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Year End Editorial



Fern Swedlove

Reading is likely one of the most enduring, accessible occupations for many people. As an editor, reading becomes not only your livelihood, but it is continuously integrated into the fabric of your daily life. As an occupational therapist, reading has the potential to enrich your professional life and create new pathways for your clients.

Most of my career has been as a frontline occupational therapist. Five years ago after graduating from a communications program, I began working as the editor of the *Canadian Journal of Occupational Therapy* (CJOT) and this past April, I crossed over to *Occupational Therapy Now* (OT Now). This issue will mark my third issue as editor of this publication. As you are all likely readers of both publications, you can appreciate the counterpoint: CJOT is peer reviewed, with boundaries defined by the rigour of academic writing and OT Now is more representative of popular press writing. Is it possible to connect the dots between these two different reading experiences?

In my quest to answer this question, I searched for examples of partnerships from different aspects of our cultural heritage - Calvin and Hobbes, Professor Henry Higgins and Eliza Doolittle, Superman and Clark Kent or David and Goliath - and came up empty handed as they could not adequately depict the relationship

between OT Now and CJOT. Certainly I thought, there must be a way to exemplify this connection? The idea of a mirror image seemed to work as a way to represent the connection between these two publications. The image of each publication is one of integrity, intelligence and information. For occupational therapists, these publications are both required reading in our evidence-based culture. If you hold up each publication to a mirror, the reflected image is one of a different structure, but with the same fundamental purpose.

Both publications form a permanent record of the occupational therapy profession. As well, our writing may simply be a footprint, leaving an impression of some type. Possibly, it may provide a blueprint in the form of a plan, model or template for future work. And there is always the possibility that our writing will leave an imprint through a lasting impression or effect. Ultimately, our publications contribute to enabling occupation for our clients.

Whether it is a footprint, blueprint or imprint, this process of finding meaning from our publications begins with the simple act of reading. As editor, my goal is to help make this occupation of reading OT Now accessible and inviting, challenging and exciting, and above all meaningful. I look forward to working with the terrific community of occupational therapists from coast to coast who form the backbone of this publication and make OT Now a cornerstone of Canadian occupational therapy.

Fern Swedlove
Managing Editor of OT NOW

Writers wanted !

OT Now is looking for writers. All types of articles are welcome. Author's guidelines for OT Now can be found at www.caot.ca. If you enjoy writing and would like to contribute to our practice magazine, please contact **Fern Swedlove** at otnow@caot.ca or **(204) 453-2835**.

Thank You to the OT Now Community

Our OT Now community is comprised of many people who are primarily volunteers. As active individuals, they live extremely full lives but make their contribution to this publication a priority. This past year the CAPS (Critically Appraised Papers) Advisory Group was formed under the leadership of Lori Letts. This group has provided readers with thought provoking summaries and discussions of research papers. Also, the OT Then Committee was organized with Mary Clarke from the University of Toronto at the helm, which introduces readers to the fascinating world of occupational therapy history. Elizabeth Steggles has passed the reins as In Touch With

Assistive Technology column editor to the new team of Roselle Adler and Josée Seguin, both occupational therapists working at the Ottawa Children's Treatment Centre. Sandra Hobson from The University of Western Ontario is the new column editor for the Watch Your Practice column and takes over from Muriel Westmorland. Sandra Bressler succeeds Anne Carswell as the new WFOT delegate and will keep us up to date on International Connections. Thank you to our community of occupational therapists for your dedication and support.

Mary Clark and Fern Swedlove

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Client-centred Decision Making in Return to Work: A Systematic Approach Informed by Reflection

Mary Stergiou-Kita

Occupational therapists, with a focus on the person, occupation, and environment, are well-positioned to assess a client's capacities, work performance and work participation (Sandqvist & Henriksson, 2004). Thus they often are involved in assisting clients with their return to work goals. To determine the work-related services delivered by occupational therapists, Archer-Heese and Stratton Johnson (2002) conducted a nationwide survey sampling members of the Canadian Association of Occupational Therapists (CAOT) who identified employment assessment training and/or vocational rehabilitation as practice areas. Survey results indicated that occupational therapists were providing a wide array of services from both occupational and vocational rehabilitation perspectives, including the following: physical demands analyses, ergonomic assessments, assessments of daily living, functional capacity and disability evaluations, vocational assessments, pre-employment and post-employment assessments and reasonable accommodation consultations.

In their review of work, O'Halloran and Innes (2005) make a distinction between occupational and vocational rehabilitation. They view occupational rehabilitation as returning an injured or ill worker back to the pre-injury work level, and vocational rehabilitation as focused on the disabled individual's

need to choose, get and keep employment. To meet such varied goals, occupational therapists are often required to perform multiple roles in varied work contexts. In addition, more and more occupational therapists have moved from traditional health delivery settings into industry, labour and disability management contexts (CAOT, 2004; Lysaght, 1997). The latter move has meant that occupational therapists

have had to blend their constructs of work and occupation as they relate to health with a more focused view of work within labour and compensation perspectives. This shift in roles frequently requires the occupational therapist to work with multiple stakeholders who may have varied perspectives on the process of vocational or occupational integration.

Challenges to Client-centred Decision Making

Occupational therapy practice in the area of return to work may present specific challenges to therapists as they frequently are required to make informed decisions in collaboration with their clients, health care teams, employers and insurers. These decisions must be grounded in the principles of client-centred practice (CAOT, 1991), informed consent (College of Occupational Therapists of Ontario [COTO], 1996), and a respect for privacy issues (COTO, 2004; Legislative Assembly of Ontario, 2004; Office of the Privacy Commissioner of Canada, 2004). How can we ensure that we are incorporating these concepts into our day-to-day practice? A systematic process, which addresses these concepts, can be beneficial when dealing with multiple decisions involving multiple parties.

A Systematic Approach Informed by Reflection

The process of reflection outlined below consists of a series of self-directed questions and is a result of my own reflections on practice issues. These questions are by no means all inclusive and different scenarios, practice contexts, occupational performance issues and client populations may require alternate or additional considerations. The aim of the process is purely to encourage facilitation of client-centred informed decisions and to begin a dialogue among occupational therapists in the area of work rehabilitation.

Before moving on to the reflective questions, please take a few minutes to jot down your responses to the following general questions.

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You may choose to keep your responses to yourselves or to share with your colleagues in a reflective problem-solving manner.

- How do you incorporate client-centred practice principles into your return to work practice?
- Can you identify key points in the initial assessment and return to work processes where issues of informed consent become particularly relevant? How do you address these informed consent issues?
- How can you ensure your client is involved and comprehends all the steps in this often intricate process?
- How can you engage your client in the process so that he is able to make informed decisions?

Initial Assessment Process

Do I ...

1. Explain my services so the client understands what I can and cannot offer?
2. Ask the client what assistance he is looking for and why he agreed to the referral?
3. Clarify the purpose and source of the referral and services being requested by the referral source?
4. Explain the assessment process and our respective roles and responsibilities?
5. Discuss how the assessment results may be used in rehabilitation and return to work planning?
6. Provide the client with an opportunity to clarify information?
7. Outline the potential risks and benefits of the client's participation in return to work so that the client can make an informed decision about his participation? (e.g., financial, insurance, safety, work-home balance)
8. Obtain the client's expressed consent to participate in the assessments?
9. Have a process for documenting this informed consent?
10. Respect the client's decision not to proceed and have a process for discontinuing services if consent is not provided or withdrawn?

Information Gathering

Do I ...

1. Have a process for gathering medical information from a variety of sources such as clients, significant others, health care team (past and present) or the insurer?
2. Receive the client's informed consent (verbal and written) to request, gather and use this information?
3. Ensure the client knows how I will be gathering, utilizing and handling this information in accordance with relevant privacy legislation?

4. Have adequate information on the client's present status, job requirements, tasks, duties, skills and work environments to assist the client to make an informed decision regarding his work goal(s)?
5. Partner with the client in this information gathering process to assist him to better comprehend his present status (to encourage awareness to assist with process of informed consent)?
6. Have the client's informed consent to contact his employer or supervisor to collect work related information? If so, is the client made aware of the specific information I will be requesting? Has the client provided informed consent for the specific information I will be sharing with the employer?
7. Encourage the client to contact his employer to share and request information, and learn to advocate on his behalf?
8. Recommend the client becomes aware of financial issues related to return to work? Clarify process by which client might access further information about income replacement benefits during future work trials to assist him to make informed decisions?
9. Encourage the client to seek further information from (or initiate referral to) relevant persons when he has an insurance or legal question with regards to return to work?

Defining the Return to Work Goal

Do I ...

1. Ensure that the client is aware of his job requirements and work environment?
2. Make sure that the client is aware of his present skills, i.e., physical, cognitive, communication, psychosocial skills in relationship to his job requirements?
3. Partner with the client to identify his strengths and challenges in relationship to return to work goals?
4. Provide the client with education regarding his rights and responsibilities related to potential work place accommodations (e.g., modified hours, environmental modifications)?
5. Identify accommodations and supports to ensure a safe work trial in collaboration with the client, his treatment team and employer?
6. In collaboration with the client and his treatment team, determine the most appropriate work-related goal? For example, trial at return to pre-injury or pre-illness job, modified work, alternate vocation, volunteer opportunities.
7. Discuss the possible risks and benefits of a work trial with the client to ensure the client is able to make an informed decision on how to proceed?

Work Trials

Do I ...

1. Ensure I have the client's expressed consent to contact his health care team (i.e. physician, therapist's employer, union, insurer and other relevant persons) to establish a work trial when deemed medically ready to do so?
2. Discuss the recommended parameters of a work trial (e.g., hours, gradual resumption of tasks, and supervision plans) with the client and ensure the client is in agreement with the plan developed?
3. In partnership with the client and employer, determine the employer's needs prior to commencing a work trial (e.g., medical information, physician report, assessment with occupational health department, requirements of human resource department)?
4. Discuss options to minimize risks; for example, WSIB coverage during work trial, possibility of unpaid work trial and maintenance of income replacement benefits during work trial?
5. In collaboration with the client, his team and employer, establish how progress at the work trial will be monitored as well as methods of feedback and evaluation?
6. Ensure I have the client's on-going informed consent to ensure transparent, timely and accurate communication between all parties during the work trial?
7. Encourage mutual problem-solving when issues arise during the work trial?
8. Work in collaboration with the client, employer and team to determine when on-going occupational therapy services are no longer required and discharge is appropriate?

Informed decision-making in return to work can be a complex, multi-step process. It is important to familiarize yourself with your specific provincial college guidelines, as well as federal and provincial legislation relevant to privacy and informed decision-making. Building collegial networks and discussing such professional practice issues can further assist us in our daily practice.

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Helpful Websites and Resources

- The Functional Assessment Network (2003). A systematic approach to a functional assessment process: Guidelines for use with injured workers. - <http://www.fhs.mcmaster.ca/rehab/research/currentactivities.html>
- Paths To Equal Opportunities - <http://www.equalopportunity.on.ca/>
- Future Abilities and Creative Employment (FACE) http://www.accessibilitydirectory.ca/English/ShowOrg.asp?ORG_ID=147
- Ontario Human Rights Commission - http://www.ohrc.on.ca/english/publications/hr-at-work_3.shtml
- Ontarians With Disabilities Act - http://www.elaws.gov.on.ca/DBLaws/Statutes/English/01o32_e.htm
- Persons With Disabilities Publication - <http://www.hrsdc.gc.ca/en/gateways/topics/pyp-pup.shtml>
- Job Accommodation Network- <http://www.hrsdc.gc.ca/en/gateways/topics/pyp-pup.shtml>

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Introducing the Evidence-Based Occupational Therapy Web Portal

www.otevidence.info

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What is a Web Portal?

- A web portal is a website that acts as a main gateway or starting point to a wide range of resources and information.

What is the Evidence-Based Occupational Therapy Web Portal?

- The Evidence-Based Occupational Therapy Web Portal is a one stop destination for information, strategies and resources about evidence-based occupational therapy.
- The portal was designed with international colleagues to aid occupational therapists to find and apply evidence in order to support best practice in occupational therapy around the world.

What Does the Evidence-Based Occupational Therapy Portal Contain?

Free access to resources on evidence-based practice (EBP) for occupational therapy including:

- Articles and teaching materials to:
 - Increase knowledge about EBP in occupational therapy.
 - Develop systematic and targeted critical review skills to help easily find, appraise and implement required evidence.
 - View teaching presentations.
- Links and discussion forums.

Issues Leading to the Creation of the Web Portal:

- Research knowledge in occupational therapy has grown exponentially during the past two decades.
- The focus on and influence of evidence-based practice has also grown.
- Evidence-based practice centres on the act of decision-making during the provision of services and works best when it combines information from three sources: research, clinical experience and client preferences.
- The issue: Effective resources to support evidence based occupational therapy need to be developed.



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Development of the Web Portal:

- In the summer of 2004, an international conference on “Evidence Based Practice in Occupational Therapy” was held in Bethesda, Maryland.
- A primary recommendation from the conference was the development of improved methods to disseminate information on evidence-based occupational therapy.
- The recommendation was made that an evidence-based occupational therapy web portal be developed to facilitate online access to EBP resources.
- In the fall of 2004, Mary Law approached the Canadian Association of Occupational Therapists (CAOT) board for funding to develop a Web Portal to support evidence-based practice occupational therapy around the world.
- Funding was provided by CAOT and McMaster University, and support was given by the World Federation of Occupational Therapists (WFOT).
- The content of the web portal was developed by Mary Law (McMaster University, Canada) & Sally Bennett (University of Brisbane, Australia).

New Site Unveiled:

- The completed site was unveiled at the CAOT conference in Montreal in June, 2006 and was also presented at the WFOT meeting in Australia in July, 2006.

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You can access the EBP Web Portal - www.otevidence.info - through the CAOT website at www.caot.ca

The Ottawa Hospital Occupational Therapy Prioritization Guidelines

Renée Gauthier, Theresa Straathof and Sherry Wright

In a pressured work environment such as acute care, caseload prioritization is crucial for the successful delivery of occupational therapy services. Efforts to maximize efficiency and cost effectiveness are common in acute care and include limited hospital budgets, shorter lengths of stay and ongoing restructuring (Ontario Hospital Association, 2005). Due to the fast work pace inherent to acute care, staff turnover is high and requires constant adjustments in training of new staff (Irion, 1997). However, varying levels of experience contribute to inconsistencies in service delivery. The Ottawa Hospital reflects all of these realities.

The Ottawa Hospital is a 1064 bed, multi-site institution. In 2004, the occupational therapy department received on average 682 new referrals per month across the corporation, a trend which increased steadily throughout 2005. Yet a significant number of clients continue to be discharged prior to being seen by their occupational therapist. It is therefore important to effectively manage our caseloads to maximize our existing resources.

Background

There is a paucity of literature to assist occupational therapists in prioritizing their caseloads.

Approaches vary between those that rely on organizational factors external to the client, such as departmental policies and medical team directives (Dutterer & Gonzales, 1997), and those where cases are weighed according to client information including reason for referral, history of violence, diagnosis and living situation (Harries & Gilhooly, 2003). Some strategies for prioritization include a combined weighting of client factors and anticipated number of interventions required (Haylock & McGovern, 1989), as well as the assignment of client's based on case complexity matched with the

occupational therapist's knowledge base and level of experience (Fortune & Ryan, 1996).

In some clinical circumstances, Irion (1997) describes how the prioritization of service can be based on the referring physician and even individual preferences of the clinician. Without explicit guidelines, Irion suggests that there is a lack of objective awareness and an ensuing lack of accountability on the part of the therapist. The challenge at The Ottawa Hospital was to develop an objective and rapid tool that facilitated decision-making and prioritization in an acute care setting, ensuring an equitable approach in screening and targeting client needs.

Development of the Guidelines

In answer to this challenge, The Ottawa Hospital Occupational Therapy Prioritization Guidelines were developed for clients who were inpatients in physical medicine and psychiatry. Based on a tool developed at the Civic Hospital during the 1990s, the guidelines were modified once the Civic Campus merged with The Ottawa Hospital to reflect the corporation's statement of values. The guidelines were implemented after consultation with various stakeholders including senior levels of management and the provincial regulatory body.

Prioritization Guidelines

As demonstrated in Tables 1 and 2, (see page 11) the guidelines clearly outline departmental priorities and expected length of time to initiate service. Clients are considered to be an acute, high, moderate or low priority depending on multiple factors including diagnoses, social circumstances, anticipated discharge date and medical stability. The guidelines also clarify time standards for service delivery based on the date the referral was received by the occupational therapist.

The Ottawa Hospital Occupational Therapy Priority Guidelines have been in use since 2001 and therapists report that they are effective, concrete and specific. There is a greater confidence in decision making for new staff and the guidelines help to clarify the role of occupational therapy on a corporate level. One difficulty in applying the guidelines is the client's changing medical condition, which may preclude

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PATIENT PRIORITY LEVEL	DEFINITION OF PRIORITY LEVEL	SUGGESTED AREAS FOR ASSESSMENT & INTERVENTION
1. Acute priority *service within 24 hours	Immediate action is required to prevent deterioration or exacerbation of a medical condition.	<ul style="list-style-type: none"> • Environmental controls or equipment (e.g. adapted call bell) • Splinting • Positioning & seating (e.g. wheelchair, cushion)
2. High priority *service within 48 hours	Medically stable Anticipating discharge: <ul style="list-style-type: none"> • Home alone • Home with limited support 	<ul style="list-style-type: none"> • Initial assessment • Transfers (e.g. chair, bed, bath, car, wheelchair) • Physical (e.g. upper extremity function, skin integrity) • Psychosocial (e.g. social supports, coping skills) • Cognitive (e.g. memory, insight) • Perceptual • Activities of daily living • Instrumental activities of daily living • Consultation with caregivers, team & family • Regular monitoring (priority 2 & 3)
3. Moderate priority *service within 72 hours	Anticipating discharge: <ul style="list-style-type: none"> • Home with caregiver • Supportive environment (e.g. rehabilitation program, residence, convalescence home) Anticipating changes in discharge destination.	
4. Low priority	<ul style="list-style-type: none"> • Medically unable to participate in occupational therapy. • Needs can be met in the community. • Conditions are longstanding & will not change in the acute care setting. 	

PATIENT PRIORITY LEVEL	DEFINITION OF PRIORITY LEVEL	SUGGESTED AREAS FOR ASSESSMENT & INTERVENTION
1. Acute priority *service within 24 hours	Immediate action is required to prevent deterioration or exacerbation of medical condition.	<ul style="list-style-type: none"> • Environmental controls or equipment (e.g. adapted call bell) • Splinting • Positioning & seating (e.g. wheelchairs, cushions)
2. High priority *service within 48 hours	Anticipating discharge: <ul style="list-style-type: none"> • Home alone/limited support • Home with caregiver Presenting with 1st psychiatric admission. Referred to assist with diagnosis, functioning & level of care.	<ul style="list-style-type: none"> • Initial screening • Transfers (e.g. chair, bed, bath, car, wheelchair) • Physical treatment (e.g. upper extremity function, skin integrity) • Performance skills • Cognitive (e.g. memory, insight) • Perceptual skills • Activities of daily living • Instrumental activities of daily living • Consultation with caregivers, team & family • Psychosocial skills (coping skills: relaxation, stress management, emotion regulation, communication skills & goal setting)
3. Moderate priority *service within 72 hours	Anticipating discharge: <ul style="list-style-type: none"> • Supportive environment (e.g. residence, convalescence home) Intervention for prevention of relapse or readmission.	
4. Low priority	<ul style="list-style-type: none"> • Needs can be met in the community. • Conditions are longstanding & will not change in acute care setting. • Medically unable to participate in occupational therapy. 	

participation in occupational therapy even as other team members are planning discharge. Discharge destination may also change, affecting the client's prioritization level and this requires ongoing vigilance on the part of the occupational therapist.

Practice Implications

The development and utilization of The Ottawa Hospital Occupational Therapy Prioritization Guidelines is timely given that the Canadian Association of Occupational Therapists (CAOT) recently commissioned a study outlining the need for a national consensus on the issues of caseload assignment and management (CAOT, 2005). CAOT proposes six guiding principles to develop case management models, which can be used to examine the clinical utility of The Ottawa Hospital Prioritization Guidelines.

Evidence-Based Practice:

The guidelines were developed by occupational therapists with 5 to 20 years of experience, reflecting a vast knowledge base and clinical expertise in acute care. Higher priority is given to preventive care and the enabling of occupational performance based on the client's background, their previous living environment and functional baseline.

Cost-effectiveness:

The guidelines assist in standardizing the delivery of occupational therapy services within an acute care setting. Those clients for whom occupational therapy intervention could prevent further dysfunction are seen on a priority basis. The guidelines allow the hospital to provide targeted services with limited human resources. Referrals can be quickly screened against the guidelines with information obtained from the client's chart or team members and there are no inherent costs involved in the application of the guidelines.

Accountability:

The guidelines can be used as a basis for communication and education to nurses, allied health workers, physicians and management on the occupational therapy scope of practice in this setting and the limitations of departmental resources. They meet regulatory standards by enhancing transparency in service delivery.

Professional Leadership/Expert Judgment;

Comprehensiveness:

New staff and recent graduates have used the guidelines developed by their peers to orient their

practice in acute care. The tool has helped to streamline occupational therapy service delivery on different units within and across campuses. The Ottawa Hospital Prioritization Guidelines fully capture the role of occupational therapy in acute care, with both physical medicine and mental health service needs addressed.

Flexibility:

Because The Ottawa Hospital Prioritization Guidelines are meant to guide practice, they allow flexibility when clinical reasoning or team driven priorities dictates a different need of focus for intervention. The priority headings are common but definitions vary with client population in physical and mental health, and the reality of practice in acute care. Clients continue to be assessed on a case-by-case basis.

Conclusion

The Ottawa Hospital Occupational Therapy Prioritization Guidelines provide occupational therapists with a framework to optimize efficiency and target interventions where they are most needed. With a well defined scope of practice, occupational therapists across the corporation benefit from greater professional cohesion and accountability. The guidelines are clear, easy to use and realistically reflect what can be achieved in an acute care setting.

Acknowledgement: The authors wish to thank Rachel Gervais for her assistance in the reviewing and finalizing of this article.

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Update on Enabling Occupation 2007

I would like to thank all of the members who participated in the pan-Canadian forum titled "Seeking National Input: An Extended Session on Enabling Occupation - The Sequel" at Conference 2006 in Montreal on June 1, 2006.

In this extended session, a brief overview of the draft plans and content were presented for the sequel to the 1997 publication "*Enabling Occupation: An Occupational Therapy Perspective*". Participants discussed and recorded feedback on the content, practice scenarios, consumer perspectives and publication strategies. Feedback from this session will be used to further guide the development of these important Canadian guidelines for occupational therapy practice.

Over the summer, more than 50 contributors representing diverse geographic and practice regions from across Canada have been writing chapter pieces. The upcoming months will be

busy for the primary authors Elizabeth Townsend and Helen Polatajko as they integrate these contributions into a cohesive document. Once it is in a full draft form, we will be sending it out for peer review to an expert group of individuals representing national, international and consumer perspectives. This group will provide discerning feedback on the entire document to the primary authors.

This exciting document will be available July 2007 in English and French. For more information on project details or if you would like to add a comment on the public discussion board, please visit the Enabling Occupation web page at www.caot.ca.

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Occupational therapy then: Stories from our past



OT Then Teaser ...

In my 1948 Canadian Association of Occupational Therapists Presidential address, I described occupational therapy as a "marvelous field for helping less fortunate citizens who have fallen aside in life's current."

Who am I?

For the answer to this question, please visit the CAOT website at www.caot.ca

Canadian Association of Occupational Therapists Conference 2007: Join us this July in Spectacular Newfoundland



Photo courtesy of Newfoundland and Labrador Tourism

C AOT is proud to invite you to Conference 2007, July 11 to 14 in St. John's, Newfoundland, Canada's oldest and possibly most dynamic city. Steps from the picturesque North Atlantic, you will discover breathtaking natural settings where the sky, land and water intertwine. Glaciers and time have carved a rugged coastline with freshwater fjords. Majestic icebergs cross paths with humpback whales. Breathe in the fresh air and enjoy the ocean breeze as scenic coastal roads lead into quaint, colourful colonial towns. In St. John's you will find genuine people with small-town warmth and big-city style, where occupational therapists will gather to discuss leading the way to healthy occupation.

What to do in St. John's

Explore the history, legend and lore of the city. Newfoundlanders have welcomed many settlers such as ancient Vikings, English, Irish, Scottish,

French, Basques and Aboriginal Peoples. National historical sites abound and include Signal Hill, where the first wireless signal was received in 1901, the Cabot Tower and Anglican Cathedral of Saint John the Baptist. The Rooms is the location where Newfoundland and Labrador's history, heritage and artistic expression fuse as the provincial museum, art gallery and archives are found under the same roof.

Take a boat tour around St. John's harbour, which was the first stop for most ships heading to North America and be awed as you pass through the rocky cliffs of The Narrows at the harbour's entrance. For those who love to shop, you will find tradi-

tional Newfoundland wares in the many craft and gift shops, or take a gander in the boutiques and two large malls. Handmade quilts and rugs, knitted clothing, paintings and photographs by local artists, decorative knickknacks, beautiful furniture and antiques, as well as moose, bottled jam and other preserves are unique souvenirs.

Newfoundland is alive with many festivals throughout the summer, showcasing everything from traditional Newfoundland step dancing and storytelling circles, North America's oldest rowing regatta, and the largest international festival of choral music.

In the heart of downtown St. John's, experience the world famous George Street closed to traffic every night for party goers who want to raise a glass. This very short street has the most bars and pubs per square foot of any street in North America. Get screeched in, kiss the cod and tap your feet to some traditional Celtic music in any of the 40 plus establishments.



Photos courtesy of Newfoundland and Labrador Tourism

For further information on St. John's and the Newfoundland region visit <http://www.newfoundlandandlabradortourism.com/home.zap>

Explore the Region

Hikers can enjoy a network of trails not only within the city of St. John's but throughout the woodlands of the province. There is a spectacular coastal hike on the East Coast Trail in the southeastern portion of the island. You will find some of the world's biggest seabird colonies, the greatest concentration of humpback whales in North America and an annual parade of gigantic icebergs.

Have a picnic at Cape Spear National Historic Site, the most easterly point in North America, which is the first place in Canada to see the sun rise each day and where you will find the oldest surviving lighthouse in Newfoundland and Labrador. Take a walk in the boreal forest of Terra Nova National Park. You can also go sea kayaking, golfing, scuba diving or sailing.

Visit Gros Morne National Park, one of the two United Nations World Heritage Sites chosen by the United Nations Educational, Scientific and Cultural Organization (UNESCO). The park is renowned for its mystical waterfalls, unique fjords and sandy beaches. L'Anse aux Meadows National Historic Site is the second UNESCO site, the only authentic Viking settlement in North America.

Treasures from the Land and Sea

Savour fresh lobster or barbequed steak and live traditional music when you grab a seat at a lobster boil. Taste Atlantic salmon at the start of the season, enjoy steaming mussels, fried cod tongues, fish 'n brewis. Or fill your boots with Jiggs Dinner, piping hot toutons (fried bread dough) or a slice of bakeapple pie.

Stunning seascape and landscape, momentous history, abundant wildlife and distinct culture. Come be enchanted by the province of Newfoundland and Labrador - a land by the sea, in harmony with nature.

Developing a Business Model for a Private Practice Partnership

Ruth Duggan, Lisa Saunders-Green, Donna MacLeod and Denise Johnston

Forging into private practice can be a big step for any occupational therapist. After all, we are clinicians, not business people. Therapists may take different approaches to private practice, from jumping in head first in a sole proprietorship, to working for an established company, dabbling by taking on the occasional private file while working full time, or easing into it by gradually reducing hours worked in the public system. But to really become established in private practice with the benefits of partnership, the development of a sound business model is important in meeting the needs of all the partners.

This article will present the process taken by our group to step into a private practice partnership and to structure the type of business model that we grew into. This is meant to be a practical guide for anyone who might be considering private practice.

The process started in the spring of 2002 when the four of us discovered a mutual interest in occupational therapy private practice. Our first gathering was a lunch where we discussed the concept of forming a partnership. We all agreed to gather for a meal once a month to consider different issues. The meetings that followed developed as we thought about areas of importance. The questions we reflected on and discussed included the following:

1. What is our vision and mission for the practice and what exactly do we want from the business?

Our vision and mission not only focused on providing quality occupational therapy services, but also on meeting our personal needs. For example, we wanted the partnership to ensure that

those with families could continue to have quality family time, work in a variety of practice areas, allow flexible work hours and opportunity to take extended periods away from work for travel, as well as earn a reasonable living (the value of which was different for each of us). We have a wide variety of personal interests and our vision was that the business of our partnership supported our personal goals, while at the same time provided meaningful work for all of us.

2. What do we each have to gain or lose from forming a partnership?

Again, for each of us, the answer was different, particularly respecting what we had to lose. For those who had established sole proprietorships there was the potential loss of self determination in their work and the loss of recognition for programs and resources developed prior to the partnership. Those who also worked in the public sector or with other companies had the risk of conflict of interest, or the loss of security and stability of a paid position. It is often these fears of loss that prevent occupational therapists from taking the step into the private world. And so these fears were balanced with what we had to gain: caseload coverage, sharing of common expenses, increased social and community aspect of working as a group, mutual support in professional development and quality assurance, team support, diversity of skills both clinically and from a business perspective, increased flexibility, and establishing a brand or profile that makes our group recognizable within the occupational therapy community.

3. What are the potential conflict of interest issues?

Using the CAOT Code of Ethics (see www.caot.ca) and other professional resources as a guide, we examined our current practices, how the new company would fit with other work we

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Column editor: Lorian Kennedy.

were doing and how there could be potential conflict between partners. When working in the public sector, there is risk of perceived conflict when clients could receive the same or similar services in the public system. When working with other companies, many of us have signed non-competition agreements that limit our ability to offer certain types of services or who we may market our services to. We also recognized that there may be potential conflict between partners in that we may effectively be vying for the same work; in a dog-eat-dog business world this potential was very real.

By identifying this and bringing it to the forefront, we were able to decrease the potential for such conflict. We agreed to manage conflict through transparency. This included an explicit commitment to openness and honesty among ourselves, as well as providing written notice to any parties who may perceive a conflict. For example, where subcontracts were in place, the contractor was notified both verbally and in writing about the intentions of the group. This opened discussions with outside agencies regarding boundaries and avenues for growth.

Recognizing that ongoing management of conflict of interest would be a challenge particularly as the new company grew and expanded, we identified a long term plan for eliminating these conflicts. For example, we began by gradually decreasing hours at the local hospital, eliminating subcontracts and waiting out agreed non-competition clauses. The four of us worked together as a group, identifying each of our personal goals and developing a team plan for managing these changes while ensuring there was enough work for all of us as the business grew.

4. What services will we offer?

Of course, setting up a partnership required us to identify what exactly we would be offering and what our product would be. We conducted an informal market scan to determine existing services and to define the gaps in services with existing private practices. We reviewed the overall past work experience of each partner, then identified areas of work that we wanted to pursue as individuals and as a group. Questions we asked ourselves included:

- What kinds of work do we enjoy?
- What kinds of work are required in the local community?

- Who is paying for that work?
- Who are our potential customers?
- What do customers want that an occupational therapist can offer?
- Where do we want to offer our services (i.e. community based in people's homes and work places as opposed to clinic-based practice)?

Fortunately, occupational therapists have a broad skill base and can offer a multitude of service options. When reviewing our skill set we determined that collectively we had the clinical experience to competently offer a wide range of services.

When starting out, we recognized that in order to earn an income, one sometimes must do the work that is available, which is sometimes not as enjoyable. Fortunately again, each of our group had a variety of interest areas and background experience. We identified a comprehensive list of services that one or more of us would like to offer and that were identified as needed in the community.

5. What is the legal commitment and do we each want to buy into it?

Partnership is like a marriage; this is the conclusion from a meeting with a lawyer to discuss legal issues and any other outstanding factors that we had not considered. We also reviewed the partnership act, as well as the provincial occupational therapy act and regulations to ensure we would be practicing within the law. While each situation would be different, we determined that we did not require a formal contract, but did need to keep records of any group decisions that were made. We identified the extent of liability with respect to finances and professional responsibility.

The legal review helped us to ensure that we were explicit about our liability to the company and each other. During a weekend retreat, we answered questions such as:

- How would we manage administrative duties?
- How to divide up the work that comes into the group (referral process)?
- What to do when a partner wants to leave the group?
- What if we want a partner to leave the group?
- How do we make decisions that affect the group?
- How to deal with competition between partners,

- particularly if a partner leaves the company?
- What is the ownership of proprietor information (e.g. templates, programs developed, etc.)?
 - How we contribute to common expenses and what would those expenses be?
 - What are we individually responsible for with respect to finances?

With these issues identified and decisions made regarding expectations, we had the beginnings of our policies and procedures, a unique business model and were ready to begin our launch as a group partnership.

What is our business model?

Cornerstone Occupational Therapy Consultants (COTC) is now a four-year old private practice company located in Nova Scotia. If we were to name our business model, it would be a shared-flexible partnership where we have equal shares and responsibility in decision making, while being flexible to meet our individual needs. COTC is equally owned and operated by four partners, all occupational therapists. The purpose of our group is to provide quality, meaningful occupational therapy work that provides the partners with flexibility and a professional, social and supportive community. Our vision is that Cornerstone has a stable core of therapists with efficiency, balance and a steady referral base of high value work.

Management and operational activities are shared between all partners. Resources such as the telephone, fax and website, in addition to our personal resources are also shared among our group. This includes mutual support to provide clinical/consultation services, ensure quality of the product, resource books, teach each other and help with development of individual and group skills. Our business model is based on the dynamic and continually changing needs of each group member. The amount of management and administrative activities performed by any partner varies depending upon interest areas as well as personal availability and commitments.

Over the years, we have identified a number of words which begin with the letter "F" that describe our business model. While these words may not be found in any business administration text book, they describe the business model for our unique company of unique individuals:

- Freedom to change.
- Fun.
- Financial benefit.
- Flexibility.
- Friends.
- Fine balance.
- Fantastic quality.
- Frank honesty.
- Fair.

COMING LATE 2006!

Business in Clinical practice: How to get there from here

Diana H. Hopkins-Rosseel | Bradley Roulston

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This publication has been designed to assist health professionals successfully open their own practice or clinic. This practical and user-friendly book will empower clinicians and give them the tools to secure their business and life goals. This resource also provides you with a financial spreadsheet that has been developed and copyrighted expressly for the purpose of enhancing the clinician's abilities to develop a feasible financial plan for their proposed business. For ease of use, this valuable planning tool can be accessed from the CD ROM included in each book. This book will be invaluable for clinicians navigating the exciting world of business!



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On Your Behalf

Canadian Coalition for Seniors' Mental Health (CCSMH)

<http://www.ccsmh.ca>

Through the CCSMH Steering Committee and partners across Canada, CCSMH works towards advocating for seniors' mental health at a national level. The committee ensures that seniors' mental health is recognized as a health and wellness issue and facilitates public and professional awareness of seniors' mental health issues. In May 2006, CCSMH released National Guidelines for Seniors' Mental Health in the areas of depression, delirium, suicide and mental health issues in long term care. The guidelines are available to download from the CCSMH website.

New! CCSMH Research and Knowledge Exchange Network:

<http://researchnetwork.ccsmh.ca>

The objectives of the network are to provide public access to a database of researchers and research information in seniors' mental health, provide opportunities for exchange of information and ideas, and create linkages to build research capacity for seniors' mental health in Canada.

Canadian Collaborative Mental Health Initiative (CCMHI)

<http://www.ccmhi.ca>

The CCMHI ended in June 2006. The goal of CCMHI was to improve the mental health and well-being of Canadians by increasing collaboration among health care providers, consumers, families and communities. Visit the CCMHI web site for the following project deliverables:

- 1) A series of papers which document the state of collaborative mental health care from various perspectives and include papers on policy, human resources, education and best practices.

http://www.ccmhi.ca/en/products/series_of_papers.html

- 2) Toolkits to help establish and participate in a collaborative care network in their community for i) Consumers, families and caregivers ii) Health providers and planners, and iii) Educators. <http://www.ccmhi.ca/en/products/toolkits.html>

- 3) The Canadian Collaborative Mental Health Care Charter which is a pledge among the 12 national steering committee organizations to work together to support the delivery of mental health services in primary care through interdisciplinary collaboration. For a copy of the charter document and poster, please see:

<http://www.ccmhi.ca/en/products/charter.html>

A CD containing information on CCMHI's research series, toolkits, charter and other project information is available through CAOT. The price is \$5.00 CDN to cover the cost of shipping and handling. Please contact education@caot.ca to order a CD.

CAOT would like to thank Dr. Terry Krupa, the CAOT volunteer representative to CCMHI, for her valuable contribution and commitment to advancing occupational therapy in mental health.

Canadian Mental Health Commission

In May, 2006, the Senate Committee on Social Affairs, Science and Technology released its final report on mental health "Out of the Shadows at Last". Many references were made to the work of the CCMHI and the importance of consumer-centred care, as well as the provision of mental health services in primary health care. CAOT submitted a letter to the Right Honourable Stephen Harper in support of a Canadian Mental Health Commission with the inherent components of collaborative relationships with all stakeholders, a national Knowledge Exchange Centre and an anti-stigma campaign. To view "Out of the Shadows at Last", please visit the Senate of Canada website: http://www.parl.gc.ca/common/Committee_SenRep.asp?Language=E&Parl=39&Session=1&comm_id=47

Canadian Patient Safety Institute (CPSI)
<http://www.patientsafetyinstitute.ca/index.html>
 CPSI is a new representation activity for CAOT. The CPSI was initiated in December, 2003 as an independent, not-for-profit corporation with the mandate to build and advance a safer health system for residents of Canada. CPSI provides leadership on patient safety issues, supports healthcare professionals in their development and implementation of patient safety programs and promotes innovative ways to improve patient safety. CAOT joined CPSI as a voting member in October, 2005. Esther Fine, an Ottawa occupational therapist, represents CAOT on CPSI and recently attended a workshop that presented information on the CPSI grant competition. Funding for research can range from \$9,300 to \$100,000 per project, with the average amount granted being \$67,000. The two competition streams are as follows:

Stream 1 – Applied Health Services Research:

- Identification, prevention or mitigation of adverse events outside the hospital care setting, in particular in home care, long term care and health care associated infections.
- The role of innovative interventions to improve safety, such as technology (including

patient simulation), education programs and practices.

- Identification of professional and/or organizational factors/conditions related to the development of safety practice and culture, such as reporting and/ or disclosing adverse events Inter-professional education.

Stream 2 – Demonstration Projects:

- Implementation and evaluation of new mechanisms for communication and handoffs within and between caregivers, teams or organizations that lead to improved safety.
- Interventions to improve work design for enhanced safety, such as care delivery processes and human factors considerations.
- Evaluating the impact of tools (i.e. root cause analysis, hand hygiene campaigns, adverse event reporting and learning systems) in identifying and reducing critical incidents in health care.

For further information regarding the CPSI, please contact:

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Canadian Association of Occupational Therapists (CAOT) Board of Directors 2006–2007

On October 1, CAOT welcomed returning and new members to the CAOT Board of Directors. All directors can be contacted at their address, telephone number and e-mail address below.

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To learn about the latest news from CAOT, watch for our free news bulletins sent to you by e-mail during the first week of every month or visit our web site at www.caot.ca.

News from the World Federation of Occupational Therapists

Anne Carswell



G'day mates. I am writing these notes on the last day of the World Federation of Occupational Therapists (WFOT) 2006 Congress, held in Sydney, Australia from July 23 to July 26. I will report on

the council meeting, which was held during the week prior to the congress, and some of the highlights of the congress.

WFOT Council Meeting

Both Jocelyn Campbell (the CAOT alternate delegate) and I attended the council meeting where a great deal of business was conducted over six days. The first day consisted of a Focus Day where eight groups of delegates and alternates from 42 countries discussed the future of occupational therapy (2015) and how the WFOT can position itself to meet the future in a proactive way. The results of this day will comprise the 2007-2012 WFOT Strategic Plan. This will be available to individual members on the WFOT website.

At the council meeting the WFOT welcomed four new full members (Estonia, Mauritius, Iran and Palestine) and three associate members. There are now 78 members within the WFOT. The council passed position papers on Human Rights, the Role for the WFOT in Research, Community Based Rehabilitation, Occupational Science and Autonomous Practice. The WFOT reported on close relations with the World Health Organization (WHO) and the United Nations (UN), as well as many associations with international non-governmental organizations (NGO), one of which is the Para-Olympic Committee.

In response to the tsunami disaster, the WFOT prepared a Disaster Preparedness and

Response Package that helps occupational therapists interested in working with survivors of both natural and man-made disasters. It is based upon individual's experiences and will be for sale through the WFOT.

A number of new International Advisory Groups (IAG) were approved during the council meeting. These included the IAG for Accessibility and Participation and the IAG for Occupational Therapy and the International Classification of Functioning, Disability and Health (ICF). Watch this space for further information on these and other IAGs.

The WFOT has designated October 27, 2006 as International Occupational Therapy Day. This is a great opportunity to fund raise on behalf of the WFOT. During the past two years, two student groups in Canada (University of Toronto and Dalhousie University) conducted a number of fund-raising activities to support the WFOT. These funds enabled a number of occupational therapists from developing countries to attend the congress. Participants who benefited came from

During the past two years, two student groups in Canada conducted a number of fund-raising activities to support the WFOT ... I challenge other university programs to do the same!

Botswana, Lebanon, Tunisia, and Georgia. Congratulations to these student groups and I challenge other university programs to do the same!

This is just a short summary of the work undertaken by the WFOT during the past two years and approved at the council. The council then worked for two days on specific projects that will constitute the work for the coming two years. For further details please go to the WFOT web site.

WFOT Congress

The WFOT Congress is four days of scholarship, socialization, sharing, learning and networking. Over 2000 occupational therapists from 73 countries in one place at the same time! And we all talk the same language! It is a moving experience. After the completion of the impressive march past comprised of all the delegates and alternates attending the congress, the Minister of Human Services opened the congress.

There were four keynote speakers, each of whom provided a different and challenging perspective on occupational therapy. Dr. Sohail Inayatullah, regarded as a leading researcher of the future, spoke on the topic "Mapping Occupational Therapy Futures". Dr Ruth Watson from South Africa spoke on the second day and her topic was "Being Before Doing - The Cultural Identity of Occupational Therapy". The morning of the third day was given to Marilyn Pattison who gave the Sylvia Docker Lecture (similar to the Muriel Drive Lecture in Canada) and her talk was on "Occupational Therapy - Outstanding Talent : An Entrepreneurial Approach to Practice". It was inspiring and uplifting. The final day keynote speaker was Dr. Rachel Thibeault from Canada. Her presentation "Occupational Therapists and Globalization: Critical Choices for a Congruent Practice" was dynamic and definitely inspiring.

Over 1800 oral papers and poster presentations were given during the congress and partici-

pants were challenged to move the profession forward in a number of ways. There were also the usual exhibits that also helped to give participants new ideas and ways of doing things. There was also time for fun and socialization at a reception on opening night and a grand soiree on the Thursday evening. These activities, in addition to the lunch and tea breaks each day where participants met each other, provided opportunities to make life-long friends and share new and wonderful ideas. At the closing ceremonies an invitation was made to attend the next WFOT Congress in 2010 in Santiago Chile. So save your pennies (and dimes and dollars) and come to Santiago Chile in 2010.

You really must try the new and improved WFOT web site (www.wfot.org). It has really changed with a members' only area, chat rooms, OTION (Occupational Therapy International Outreach Network), and all sorts of new bells and whistles! Also now that there is a password protected area for individual members, all the more reason to become an individual member! Did you know that there are over 5 MILLION hits on the WFOT website per month and over 50% are repeat visitors? This is another good reason to advertise through the WFOT.

I am thankful to all those individuals who have supported me during the past eight years as the CAOT delegate to the WFOT and trust that they will give the same support to Sandra Bressler, the new WFOT delegate.



Visit our new and improved website!

Packaging the Tool Kit: Development of Best Practice Guidelines within an Insurance System

Andrea Duncan, Erin McKenna, Sharon Gordon and Debra Carmichael

Regulated health care professionals are becoming increasingly aware of the importance of research and the need to translate this knowledge to guide practice. In third party payer industries, use of current evidence is critical to support decision-making, and to ensure both the worker and funding agency are receiving the best possible intervention. At the Workplace Safety and Insurance Board (WSIB), decisions are made based on legislative authority and existing policies, and are case-by-case. However, when considering individual requests for assistive devices, these policies at times do not provide sufficient direction. The members of the Service Delivery Team (i.e. the occupational therapist, nurse case manager and claims adjudicator) must then use their own knowledge and expertise to guide decisions within the context of current WSIB policies and practice. Without proper training and support, this can lead to some variation in decision-making across the organization, and confusion for the clients if they do not understand how the final decision was reached.

While the Service Delivery Teams (SDT) attempts to use current evidence regarding assistive devices, several barriers limit knowledge translation: inconsistent application of research findings into practice, lack of randomized controlled trials for assistive devices, limited research specific to third party payer systems, as well as a lack of time and resources to implement evidence-based practice. To improve the quality of our service, ensure more consistent decision-making and increase transparency with injured workers to the WSIB, the SDT developed best practice guidelines for assistive devices. The following assistive devices were

included in the development of these guidelines: bathroom equipment, manual and power wheelchairs, scooters, power-assist devices, easy-lift chairs, adjustable beds, pressure relief surfaces and standers.

Developing Best Practice Guidelines

It was crucial that the project be led by a multi-disciplinary steering committee which had representation from all major stakeholders in the organization, as implementation of the guidelines represented a cultural change within the organization. This high level support was essential to ensure success. This committee, while not holding clinical expertise, was able to assist in the anticipation of operational issues that might have jeopardized the success of the project. A comprehensive business plan with a budget and deliverables was developed and accepted. The resultant project was resourced and staffed accordingly.

It was also important to obtain buy in from the front-line staff and ensure that the tool kit would best meet their needs. This was accomplished through the use of focus groups at different stages of the project. The initial focus groups provided information about current practice and helped identify the assistive devices that were most common and problematic for decision-making. This process also identified tools and systems for decision making, as well as the preferred format and mode of access. Strong feedback resounded about the need for guidelines.

The project conducted an initial literature review and surveyed current practice related to the use of the identified assistive devices inside and outside of the WSIB. Based on this research, a comprehensive document was created which included: descriptions of each device, typical functional presentations which would warrant the device prescription, additional clinical information, generic product specifications and issues to consider in clinical decision-making. Occupational therapists from WSIB were selected to translate this document into guidelines that were simple, readily accessible and user-friendly for staff.

Andrea Duncan is a professional practice leader in occupational therapy, **Erin McKenna** is the director of the Serious Injury Program, **Sharon Gordon** and **Debra Carmichael** are occupational therapists at the Workplace Safety and Insurance Board of Ontario. For questions or comments, please feel free to contact Andrea at: andrea_duncan@wsib.on.ca
Column editor: Sandra Hobson.

Such guidelines needed to incorporate the evidence-based research in relation to WSIB's existing policies and procedures.

Prior to finalizing the document, the last round of focus groups with WSIB staff and meetings with clinical educators from major vendors were held to validate the content and usability of the proposed guidelines. Individuals at WSIB with varying backgrounds, expertise levels, and representing different geographical locations were selected to assess the suitability of the guidelines. Feedback from these meetings was documented and incorporated into the final product.

An interactive, on-line format was selected as the primary method for communicating these guidelines to staff. Staff also identified a need for a hardcopy of the tool kit; therefore, a summarized pamphlet was created for use as a quick desk-top reference. Staff was made aware through various mediums, including distribution of the pamphlets, broadcast intranet messages, team meetings and personal e-mail regarding the availability of the tool kit.

Challenges to Developing the Guidelines

Decisions to fund assistive devices in insurance-based systems cannot be based solely on evidence-based practice. Although best practices may support providing a device for a worker, if the request does not meet WSIB policy or the rationale for the provision is not related to the workplace injury, funding for the device may be denied. Therefore, the guidelines need to consider what is most appropriate and suitable for the worker within the context of current WSIB policies and practice.

WSIB needs to be accountable to both the employers who ultimately fund the system and the injured workers who depend on the system. A decision-making tool for assistive devices needs to reflect current best practice, yet must also show that it is reasonable in terms of anticipated benefits, cost-effective relative to other options, and reasonable based on the assessment results from a regulated health care practitioner, typically occupational therapists.

There was limited research available on certain topics, particularly standers, power-assist wheels and therapeutic tubs, and limited studies supporting the effectiveness and outcomes for use of the assistive devices. Additionally, workers with similar injuries may have different levels and function and therefore there are different

issues involved in choosing the right assistive device. This made it more difficult to provide the decision-maker with definitive criteria to help determine when a device may or may not benefit a worker and when it would meet policy criteria. The focus of the guidelines therefore shifted to highlighting the issues to consider for each device.

The varying levels of clinical knowledge of the SDT members presented a challenge during the creation of the tool kit. Focus groups which included individuals with various backgrounds were useful in ensuring the appropriateness of the language and content.

The intention of this project was to develop considerations for decision-making on assistive devices. It needed to be clear that it was not to infringe upon existing policies and was not to be interpreted as policy by staff. The goal was to promote consistency and accountability within the organization, yet be flexible enough to allow for individual decision-making based on the merits and justice of each particular case.

Funding and resources for this project were time limited. Goals and expectations needed to be realistic based on the authorized time frame. This did not allow for an opportunity to pilot the guidelines across the organization and subsequently allow for further revisions and feedback.

Outcomes and Future of the Guidelines

The guidelines have been available to SDT for several months. Initial informal feedback received from staff has been positive, with frequent reports that the tool kit is comprehensive and easily accessible. Staff has reported that the tool promotes their ability to make informed and appropriate decisions on the identified assistive devices.

Evidence-based practice must be continually reviewed and updated to reflect new research findings. The online format for the guidelines allows for easy editing to incorporate new evidence and future changes to best practice. The tool kit can also be modified should there be any changes to WSIB policies.

The next step is to secure the appropriate resources and time to formally evaluate the overall effectiveness and benefit of the tool kit, as well as update it as needed. Evaluation methods will include online surveys and focus groups with SDT to evaluate the usefulness. The timing of this evaluation needs to be carefully considered to ensure that the staff has had sufficient exposure and practice with its use in order to provide

detailed feedback, therefore evaluation will begin one year following the implementation of the best practice guidelines.

The WSIB performs periodic audits on claim files to determine the quality, consistency and rationale for decision-making. It is expected that the rationale and decision-making for assistive devices will improve given the introduction and use of this tool kit. Information obtained from the audits will

assist in determining if such a change has occurred and further discuss the nature of this change.

These assistive devices guidelines now serve as a template for the development of other types of advice/guideline tools at WSIB. The development of these tools demonstrates the commitment of WSIB to improve accountability to all stakeholders and ensure that workers receive the best standard of care.

Example of Guidelines

Manual and Power Wheelchairs

Manual wheelchairs generally have large rear wheels and small front castors. Workers can self propel the wheelchair using hand rims on the rear wheels. This requires good upper body strength and endurance. If the worker is not able to do this, a caregiver can propel the wheelchair using push handles.

Electric or power wheelchairs are motorized wheelchairs. These devices are typically controlled by a joystick or an alternative input device. They are considered for workers who are not able to safely use a manual mobility device.

Guiding Principles

Wheelchairs may benefit workers who:

- are having difficulty or are unable to walk for daily living activities
- cannot use another mobility device (such as a cane or walker) to carry out daily living activities.

Initial Considerations

What is needed:

- a compensable condition that causes difficulty with walking
- review of the worker's present equipment (if any), and clarification of why it is no longer meeting their needs
- a mobility assessment.

Mobility Assessment

A regulated health care practitioner must assess the worker and provide a written recommendation for a wheelchair. (See Referral Guidelines section).

The Mobility Assessment Report should demonstrate that:

- indoor and/or outdoor mobility is significantly restricted without the use of a wheelchair
- current equipment is not meeting daily needs and /or places the worker at risk of further injury
- simpler and more cost-effective alternatives have been considered, but are not able to meet the worker's needs (e.g. cane, walker)
- wheelchair will be used for essential mobility and daily living activities (if for hobby purposes only, may require a 60% NEL or 100% PD for consideration)
- a successful trial of the wheelchair (or a similar one) has been completed
- worker is safe to operate the wheelchair or a caregiver is available to provide needed assistance
- wheelchair addresses a permanent or long-term need (otherwise, may consider whether rental is more appropriate)
- there is a back-up system in place if wheelchair requires repairs
- wheelchair will fit into the worker's home environment or necessary home modifications are outlined
- wheelchair can be transported in the worker's vehicle (if required) or a plan for necessary vehicle modifications is identified
- consideration has been given to the use of the wheelchair in the workplace or school environment, if applicable.

An equipment prescription and quote from a Preferred Provider should be included in the report.

Additional Features

Tilt/recline may be an appropriate option if the worker:

- has, or is at risk of developing, skin breakdown
- requires assistance to transfer or change position in the wheelchair
- has compromised respiratory function or spasticity.

NOTE: Pain alone is not sufficient justification for this feature.

Pressure relieving cushions may be appropriate if the worker:

- has, or is at risk of developing, skin breakdown
- experiences pain and discomfort in sitting.

Repairs and Replacement

Consider repairs if:

- medically necessary for safe and proper use of the wheelchair
- there has not been a significant change in the worker's medical or functional status
- cost for repair is less than the cost for replacement
- wheelchair is in good condition, and not expected to need replacement in near future.



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Upcoming Competitions

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- COTF Research Grant
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- SickKids Master's Scholarship - \$5,000 (COTF is partnering with SickKids with each organization contributing \$2,500 towards the scholarship.)

For details and application forms, see the grants section at www.cotfcanada.org.

Congratulations to the 2006 Research Grant Winners!

- Rebecca Renwick - COTF Research Grant (\$5,000)
- Barry Trentham - COTF Research Grant (\$5,000)
- Claude Vincent - COTF Research Grant (\$3,000)
- Elizabeth Townsend - Isobel Robinson Historical Research Grant (\$2,000)
- Michelle Ryan - Marita Dyrbye Mental Health Award (\$500)



COTF 2006 Award Recipients (L to R): Lynn Shaw, Deborah Laliberte-Rudman, Lori Letts, Michèle Hébert, Annette Rivard, Claire Dumont, Nora Fayed, Heather Colquhoun, Leslie Johnson, Jacinthe Savard, Gayle Restall, Jennifer Klein.
Presenter: Sandra Bressler

Isobel Robinson Historical Research Grant

The Isobel Robinson Historical Research Grant was first introduced in 2004 to honour her legacy to the field of occupational therapy. Elizabeth Townsend is the first recipient of this grant. She shares a long standing connection with Isobel Robinson who she first met in 1964 when enrolled at the University of Toronto's Diploma in Physiotherapy and Occupational Therapy program. At that time, Isobel was already a Canadian icon as an occupational therapy professor. Through social and academic events, Elizabeth has maintained

contact with Isobel over the years. Elizabeth has admired Isobel's growing attention to historical research in occupational therapy and greatly appreciates the financial support to complete her own historical research.

Remember to Update Your COTF Contact Information

COTF would greatly appreciate it if you would inform Sandra Wittenberg of any changes to your COTF contact information. Sandra can be reached at swittenberg@cotfcanada.org or 1-800-434-2268 x226

Your Support Counts!

COTF sincerely thanks the following individuals, companies and organizations for their generous support during the period of May 1 to July 31, 2006. For those individuals whose names do not appear in this listing, please see the January issue of OT Now.

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Contact: Heather Adams

Tel: (902) 471-7864

Fax: (902) 421-1292

E-mail: info@pdp-pgap.com

Website : www.pdp-pgap.com

Therapists advanced clinical day:

December 2, 2006

Contact: Caroline Hui

Tel: (450) 242-2816

Fax: (450)242-2331

E-mail: floortimemontreal@sympatico.ca

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Contact: Judith Skelton-Green

Tel: (705) 549-7749

Fax: (705) 549-8906

E-mail: Judith.skelton-green@transition-hod.ca

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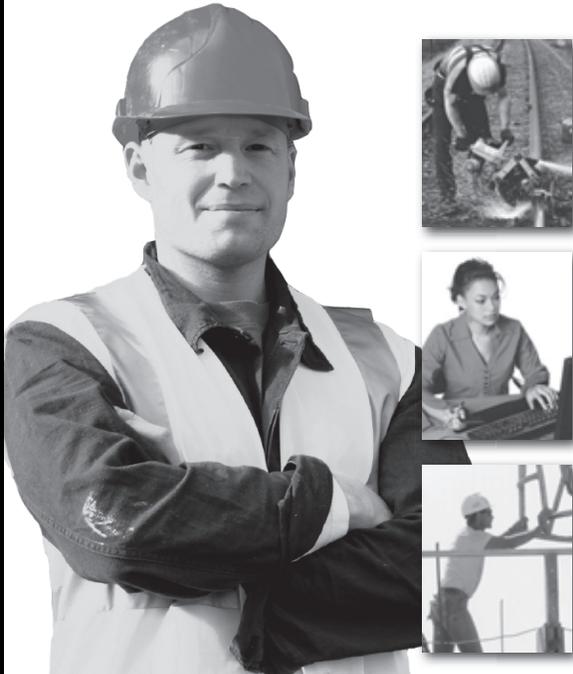
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CAOT Publication



Research on the Canadian Occupational Performance Measure: An Annotated Resource

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

Price: \$47.89 CAOT member (\$63.86 non-member)

In this annotated resource, the authors of the Canadian Occupational Performance Measure (COPM) bring you the research that has been conducted on the measure since its initial publication in 1991. Annotations accompanying each article focus on research results and implications for the use of the COPM in research and practice. This annotated resource marshals the evidence in support of the COPM, and provides responses to issues that have arisen over the years.

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