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The Centennial Vision and Physical Disabilities Practice

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> We envision that occupational therapy is a powerful, widely recognized, science-driven, and evidence-based profession with a globally connected and diverse workforce meeting society's occupational needs. (American Occupational Therapy Association [AOTA], 2006a)

Since the adoption of the Centennial Vision in 2006, the profession has been addressing four strategic directions: (a) building the capacity to fulfill the profession's potential and mission; (b) demonstrating and articulating our value to individuals, organizations, and communities; (c) building an inclusive community of members; and (d) linking education, research, and practice. AOTA is organizing its work around six broad practice areas: children and youth; productive aging; mental health; health and wellness; work and industry; and rehabilitation, disability, and participation (RDP) (AOTA, 2007). These six areas cross all practice settings and reflect the practice areas that are inherent in the Special Interest Sections (SISs). In some cases, one of the six broad practice areas may align with one SIS more strongly than others, which is the case of RDP and the Physical Disabilities Special Interest Section (PDSIS). *RDP* is a broad, or inclusive, categorical term that reflects the multifaceted contributions of those working in physical disability settings where physical dysfunction affects clients' ability to participate to their fullest potential. Use of this term may serve as an alternate way of framing the concept of physical disabilities practice and assist practitioners in considering venues in which they currently work and how they can enhance practice beyond the constraints of the medical model and practitioner-focused institutional environment.

According to an AOTA (2006b) workforce and compensation study, approximately 57% of occupational therapists and 60% of occupational therapy assistants report physical disabilities settings as their primary worksite. Such a large percentage of RDP practitioners can influence at least two strategic directions of the Centennial Vision. The first is *demonstrating and articulating our value to individuals, organizations, and communities*, particularly *meeting societal needs for health and well-being*. By definition, this area expands the scope of physical disabilities practice from the more narrow and traditional medical model view focused on individuals to a practice area focused on the overall health, well-being, and functional participation capabilities of individuals as well as those in their immediate context and society as a whole. The second strategic direction is *linking education, research, and practice*, including creating evidence-based assessments, investigating outcomes of specific methods and modalities, and educating future practitioners to fulfill the profession's potential and mission.

This article highlights the specific practice venues related to the Centennial Vision in which occupational therapy practitioners are facilitating individuals' functional abilities through training, prevention of occupational dysfunction, remediation, and skill acquisition: (a) driving and driver rehabilitation, (b) prosthetics fitting and training, (c) oncology rehabilitation, (d) sexuality as one of the activities of daily living (ADL), and (e) occupational therapy educators and researchers. Examples include society-focused perspectives on education, awareness activities, and environmental modifications designed to change views about what constitutes disability and to facilitate participation of all. This article describes how the PDSIS seeks to advance practice to include venues that meet the needs of society.

Driving and Driver Rehabilitation

Occupational therapists and occupational therapy assistants working in driver rehabilitation can make connections, solve problems, and become leaders in the wellness community through their presence in an area not typically staffed by health care professionals. Additionally, practitioners focus on prevention and continuity of functional engagement. Driving is one of the instrumental activities of daily living (IADL) requiring high-level cognition, reasoning skills, visual and motor function, and process skills. Driver rehabilitation programs involve ongoing financial and community support and often are challenged to educate practitioners and the sponsoring facility about local resources, appropriate clients, assessment of skills, and program marketing. Clients of driver rehabilitation programs typically include persons with developmental delays, well seniors, veterans returning from military service, diverse populations with physical and cognitive disabilities, and the community at large whose safety must be ensured when these individuals are permitted to drive.

Practitioners must become familiar with their community and potential referral sources. Senior and community centers, social service, assisted living, and rehabilitation programs often serve persons who are either struggling to regain driving skills or hoping to maintain skills for aging in place, promoting long-term independent community functioning. The local department of motor vehicles can collaborate in identifying potential clients through state testing programs that screen seniors for driver safety and offer supportive services or remediation before deciding whether to take away this form of independent mobility. Additional programs on safe driving include computer media geared toward increasing awareness of skills and areas needing improvement; for example, the Auto Club's *Roadwise 55 Alive* educational classes can improve safety habits, possibly resulting in a reduction of insurance premiums (AAA, 2007;

AARP, 2007). These programs have used occupational therapists as consultants when creating their products.

Competent occupational therapy practitioners must consider whether a particular program will include a clinic evaluation alone (i.e., drivers are tested with simulation equipment for problem solving and reaction time) or on-the-road evaluation and training (i.e., the road is used to test their skills in a real context), and funding for equipment. Some programs address lost skills or prevention of skill loss in the well population. Therapists skilled in performing driver assessments and training who discover that a client is not able to resume driving safely may educate the client and his or her caregivers about appropriate transportation alternatives.

The Association of Driver Rehabilitation Specialists (www.driver-ed.org) offers a certified driver rehabilitation specialist (CDRS) credentialing process to all professionals with varying levels of education. Occupational therapy assistants can receive a CDRS credential, promoting the occupational therapist–occupational therapy assistant partnership. AOTA also offers a specialty certification open to both levels of practice that acknowledges special skills within this practice setting.

While working toward improving safe and effective functional mobility with clients, occupational therapy practitioners can expand the awareness of our services through making connections with physicians and educating the public. Coordinating with driving educators and learning appropriate compensations and remediation for disabilities are necessary steps toward moving a driver and driving rehabilitation program forward. Practitioners should be involved with national-level programs and projects such as CarFit (check of driver and vehicle fit and adaptations; www.asaging.org) and task forces that address older driver issues. Finding solutions and being an essential part of the community is our quest as we look forward to 2017.

Prosthetics Fitting and Training

The ongoing conflict in Iraq and Afghanistan has highlighted the importance of occupational therapy skills and perspective in the care of persons with an amputation. Clients receiving training to maximize the benefit and function of a prosthesis particularly will benefit from occupational therapy services for education, wound healing, range of motion, conditioning, psychosocial support, adaptive equipment, environmental modification, balance and posture training, and prosthetic training. Early introduction of all team members involved in the care of a client with limb amputation is paramount.

Providing early education is critical to support the client and family in making psychological adjustments to an amputation. Initially, occupational therapy services prevent joint contractures, support wound healing, facilitate independence in ADL, and expedite limb preparation for prosthetic fitting. As the client progresses, practitioners provide continued psychological support through peer visitation, support groups, and activity-specific groups for persons with limb amputation. Continued therapy includes prosthetic operation skills; IADL retraining; and transition to the community, school, and work settings. Throughout intervention, the client is educated about adaptive equipment, environmental modifications, posture, conditioning, and prevention of overuse or misuse injuries. After discharge, the client is provided with ongoing services, including prosthetic follow-up and the development of new occupational goals. The therapist also is a point of contact for developing technology appropriate for the specific interests and goals of clients with upper-limb amputation.

When the client has gained a level of acceptance of his or her changed body, the therapist encourages the client to use that acceptance as a way to share experiences with someone who has had a more recent amputation. Role modeling can be accomplished through a variety of venues, including a peer training and coordination organization such as Amputee Coalition of America or UpperEx. As clients resume previous roles and take on new challenges, we see the positive impact they have on the entire community and as role models for other persons with disabilities.

Education for clients with upper-limb amputation extends beyond the basics of prosthetic training, offering hope for the client feeling despondent over the trauma and for the family and providing knowledge of what the future will hold. The team works with the individual to develop client-centered goals, and occupational therapy practitioners continue to educate physicians, prosthetists, case managers, physical therapists, and insurance adjusters about the positive impact of occupational therapy services on the outcome of rehabilitation after an upper-limb amputation. We deal in the cornerstones of life from basic daily tasks to the ability to perform the activities that give clients meaning in their lives. We envision an American society in 2017 where these occupations are not taken for granted and our message and services are embraced and supported.

Oncology Rehabilitation

In oncology practice, several examples of the four strategic directions of the Centennial Vision exist within the RDP area. To build the capacity to fulfill the profession's potential and mission within oncology practice, occupational therapy practitioners must first acknowledge that we make a valuable contribution. We belong not only in medical facilities and in leadership roles in the community, promoting wellness and disease prevention, but also in the model curriculum for occupational therapy education that currently is being developed.

Fulfilling the profession's mission in oncology practice is related to the ability to recruit and retain adequate numbers of professionals to work in this area. As we move toward the Vision, being evidence based and science driven is critical for practitioners working in oncology to better articulate our value and knowledge base to individuals, organizations, and communities. The profession must prepare clinicians to contribute to its evidence base and to assume such leadership roles as overseeing hospice and community-based programs that provide support and resources to persons who have survived cancer and those still facing the challenges of the disease.

Although cancer commonly is associated with the perception of terminal illness, nearly two thirds of persons with cancer will be alive in 5 years (Ries et al., 2004). If we view cancer as a chronic illness with periods of exacerbation and remission, then it is easier to look beyond the possibility of death and see the disabilities caused by the disease and their treatment. Occupational therapy practitioners are uniquely trained to facilitate rehabilitation and participation from these impairments. The therapist's role is to collaborate with

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the client to identify meaningful roles, ability to participate in those roles, and the level of satisfaction derived from participating in those roles (Shelton, Lipoma, & Oertli, 2007).

Sexual Functioning as ADL

Sexuality is a universal concept not unique to any one population. The topic of sexuality within the United States—as ADL for the purpose of procreation, a leisure activity, and a means of social participation—is gaining more media coverage through television programming, commercial product marketing, and the Internet. The heightened discussion of sexuality and marketing of products intended to enhance and promote sexual function may well be due to the aging baby boomers. As a group now entering its retirement years, these youthful elders have no intention of becoming "old" and are making life choices that reflect their interest in maintaining youth and vigor in all areas of daily function.

Occupational therapy practitioners working in the area of RDP and supporting the Centennial Vision realize that our future not only will be involved with clients who have acquired a physically disabling condition, but also will be dealing with well elderly persons who wish to maintain their ability to participate in desired activities. Natural physical changes attributed to aging may cause a client to seek guidance and assistance with the pragmatics of sexual functioning (e.g., positioning), but appropriately, practitioners also address the emotional, spiritual, and cognitive processes involved. In addition to questioning their ability to safely and effectively conquer the physical challenge of sex without injury to changing joints and muscles, clients may express concerns about their intellectual and physical attractiveness, ability to be intimate, self-worth, and ability to be loved. As we look to the future of our profession, practitioners interested in RDP can embrace our wide-ranging skills and potential to work with clients to ensure and enhance their engagement in all desired life tasks, including this important leisure activity.

Occupational Therapy Educators and Researchers

Occupational therapy practice, research, and education should be linked to ensure the viability of physical disabilities practice. Clinicians, researchers, and educators are ultimately responsible for the development and dissemination of our knowledge base. What we teach and learn in occupational therapy education programs must reflect and contribute to what is current in practice. Practice must be studied to ensure effectiveness and efficiency of services. The profession must be proactive in building collaborative mechanisms among clinicians, researchers, and educators to determine what applied knowledge is relative to the individuals we serve and how services can be most effectively delivered (Mortera, 2007).

The National Institutes of Health (2006) Roadmap for Medical Research has determined that health care providers must strive for collaborative and translational research. These goals are in line with our profession's goals for collaborative work among clinicians, researchers, and educators and for developing and testing clinical questions. Prioritizing the development and testing of our applied knowledge base fulfills our ultimate obligation to society for the delivery of reimbursable services and access to quality care.

Applied scientific inquiry focuses on applied research questions addressing the reliability and validity of assessments and practice approaches or frames of reference to establish their soundness, adequacy, or effectiveness (Mosey, 1996). It provides evidence for best practice and subsequently the reimbursement of services (Gutman & Mortera, 1997). Additionally, developing and testing our applied knowledge base are critical for providing sound information to occupational therapy educators and students in preparation for generating strong clinicians, researchers, and educators.

The reliability and validity of clinical assessments are critical applied research questions relative to what assessments are truly germane to occupational therapy practice. Assessments used in physical disabilities practice must have rigor and soundness in what they measure, must serve the occupational therapy profession in terms of functional or ecologically valid measurement, and must determine how clients will best perform in real-life daily activities (Mortera, 2006).

Additional clinical research questions with regard to treatment guidelines must be studied relative to (a) specificity, or when, how often, what amount, and how long; (b) efficacy, or the extent to which treatment is safe, effective, efficient, and acceptable to clients; (c) context of use, or the combinations in which frames of reference are used; and (d) effect of treatment with different populations (Mosey, 1996). Without applied research studies, the necessary evidence to support education and practice would not exist. Providing necessary resources such as time, money, and appropriate mechanisms for clinicians, researchers, and educators to do applied research studies is critical to ensuring the implementation of such work (Mortera, 2007). Additionally, as the profession grows and changes to develop collaborative relationships, it is crucial to ensure the viability of physical disabilities practice, all occupational therapy practice, and sound clinical care.

Conclusion

AOTA has a vision in which an occupational therapy practitioner is the first professional sought whenever the potential exists for physical dysfunction to interfere with desired participation in life activities. Occupational therapists and occupational therapy assistants working in physical disabilities practice must meet the call of the Centennial Vision by being open to the possibilities that exist beyond the hospital setting, clinic, and skilled nursing facility. We must continually look to how our skills can be used outside these venues, ensuring wellness and prevention of dysfunction in addition to treating the illness or disability. As a profession and as practitioners, we must believe in the breadth and scope of occupational engagement and show our societal value and worth in all areas that require physical participation in life. ■

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