The Development of a Matrix for the Evaluation of Clinical Reasoning in Occupational Therapists

Elizabeth M. Torcivia
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The Development of a Matrix for the Evaluation of Clinical Reasoning in Occupational Therapists

By

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Submitted in partial fulfillment of the requirements for the degree of Doctor of Philosophy in Health Sciences
Seton Hall University
2006
Acknowledgements

This journey has been long, full of speed bumps and road hazards, but also offering some splendid vistas and the opportunity to visit places I would not have gone otherwise.

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Abstract

The Development of a Matrix for the Evaluation of Clinical Reasoning in Occupational Therapists

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Selon Hall University
November 27, 2006

Chair: Dr. Genevieve Pinto-Zipp

Problem: To date, no agreed-upon standard to analyse or evaluate clinical reasoning in occupational therapy exists either in practice or as part of the educational process. Many authors have defined types of clinical reasoning, but no analytic tools or exemplars of reasoning have been presented.

Method: The author developed two multimedia cases which were validated in an earlier study by experienced clinicians. The cases were paired with the Occupational Therapy Practice Framework categories in a Delphi study and sent to occupational therapy “experts”. The strength of a Delphi rests heavily on the level of expertise of the experts, care was taken to recruit experts that represented academic expertise, clinical competence and demonstrated familiarity with both the Practice Framework terms and elements of clinical reasoning. The 18 respondents were authors in refereed occupational therapy publications, faculty with 7 five years academic experience and/or board certified in Neurorehabilitation by the American Occupational Therapy Association.

Results: Three Delphi rounds were completed by all respondents. Respondents agreed on inclusion of 87.3% of categories of the Practice Framework relative to the content of the two multimedia cases. Agreement was not reached on 11.5% of the categories.

Conclusions: Responses regarding the Practice Framework categories were divided into include, exclude and neither. A matrix for each case was developed that presented the included categories agreed upon by the respondents in the study. Use of the matrix and the
corresponding case study can be used to compare interventions with the findings of the experts. Limitations of the study include the existence of only two validated cases, the nature of Delphi research and the limitations of the Practice Framework language.
Chapter I

INTRODUCTION

In his work researching common characteristics of professionals, Donald Schön (1983) explored the general issues of reasoning and reflection leading to professional action. According to Schön:

A professional practitioner is a specialist who encounters certain types of situations again and again... Thus a physician may encounter many different “cases of measles”; a lawyer, many different “cases of libel.” As a practitioner experiences many variations of a small number of types of cases, he is able to “practice” his practice. He develops a repertoire of expectations, images, and techniques. He learns what to look for and how to respond to what he finds (Schön, 1983, p. 60).

Schön (1983) coined the phrase “reflection-in-action” to argue for the idea that the performance of a professional was guided by the knowledge and belief system of each profession’s domain. The phrase also referred to the appropriate use of techniques or procedures
associated with that professional knowledge at the time of the performance and relative to the performance (p. 56).

In western medicine, healthcare professionals (including allopathic physicians, nurses, physical/physio therapists, and occupational therapists) have addressed how clinical reasoning is manifested both in relation to the knowledge base of each profession and to the practice of that profession. Each profession has examined the dichotomy of these two aspects of professionalism and, in several instances, has identified the critical elements in each. (Elstein & Schwartz, Pellegrin & Ritter; Jones; Jensen & Edwards, and Chapparo & Ranko, in Higgs, J. & Jones, M. (2000)).

Regardless of the profession, it is universally accepted that the processes of problem identification (or diagnosis), and intervention selection (treatment) are formed from the knowledge base of a given profession. Furthermore, in a delineation of the contextual elements that compromise clinical reasoning, Higgs & Jones (2000) suggested “clinicians operate within their professional frameworks (e.g. the ethical standards/requirements of the profession) and the context of professionalism” (p. 4).

The outcome of good clinical reasoning is effective clinical decision making demonstrated in efficient patient care. Clearly, the
expectations for what constitutes effective clinical reasoning for a profession are identified in each profession's literature. What is not clear is how each profession should evaluate effective clinical reasoning.

Generally, clinical reasoning is the thought process of a therapist as he/she makes assessment, treatment and discharge decisions. Benamy (1998) defined clinical reasoning in occupational therapy as the ...

...therapist's cognitive process or processes, guiding the ongoing acquisition, recall, sorting, weighing and prioritizing of information; the conclusions drawn, judgments and decisions made; the intervention plans designed; and the assessments of effectiveness of interventions and the re-designing of intervention plans that occur from the time a therapist is assigned to a patient until the course of treatment or the therapeutic relationship is complete. (p. 2).

A consensus-based, systematic study of clinical reasoning in occupational therapy is likely to have other benefits for the profession. So much of what occupational therapists do appears commonplace and a part of ordinary life that those external to the profession may consider it as unimportant and not requiring much thought. Benamy
(1996) suggested that outsiders "may be led to the mistaken conclusion that occupational therapy is easy, simply a matter of common sense, or trivial... Yet we know that it takes more thought and creativity to provide a meaningful experience for a patient using everyday objects and tasks than it does to set up the patient on a machine" (p. 3).

As mental processes, clinical reasoning strategies in occupational therapy are not visible to observers, and often are not consciously identified by the therapist him/herself. Wood (1996), noted that "although clinical reasoning is in the background of therapeutic interaction, the actions of the therapist, guided by her [clinical] reasoning, ensure that optimally competent functioning is elicited" (p. 631). Our knowing how, that is, our professional knowledge base, is in areas not related directly to disease but rather to the performance of activities and occupations in daily life despite ongoing disability. The clinical reasoning of an occupational therapist guides intervention and adaptation suggestions to clients about solutions tailored to them as individuals, not as members of a diagnostic group.

Joan Rogers (1983) applied the concepts articulated by Schön to the practice of the profession of occupational therapy. Rogers suggested that occupational therapists employ data-gathering
strategies that result in several inferences about a pattern or model of a client and how intervention should proceed (Rogers, 1983; Rogers & Holm, 1991). Rogers further suggested that the type of reasoning used by occupational therapists are grounded in scientific information as well as artistic and ethical dimensions. (Rogers, 1983).

Statement of the Problem

Students in the health professions are taught the theories and techniques that are used by members of their specific professions to address specific problems; this knowledge base forms the foundation for their early clinical practice. Expertise in practice, however, is more than a collection of theories and techniques. Schön (1983) discussed the elements that make up professional practice; that is, "performance in a range of professional situations" (p. 60). Expert practitioners call upon memories of a greater variety of professional situations; thus their clinical knowledge and experience inform their clinical judgments and reasoning at a greater depth.

Authors of several books and multiple articles have stressed the importance of developing clinical reasoning in occupational therapy educational programs (e.g., Benamy, 1996; Mattingly & Ferring, 1994; Dutton, 1995). Neistadt (1998) evaluated students' abilities to
demonstrate the use of defined clinical reasoning strategies. However, in the current occupational therapy literature the presence of a consistent tool for the analysis of clinical reasoning performance ability relative to a standard case study has not been noted. Royeen et al (2000) noted that the profession needed “various ways to measure and evaluate the development and improvement of clinical reasoning skills” (p. 109).

Developing such a measurement tool requires several steps. First, the cases or cases used must be complex, rooted in familiar diagnostic conditions, and representative of a potential clinical problem. These cases would then need to be validated by practicing clinicians who are at least competent with the specific diagnostic groups. Finally, systematic agreement about case information elements crucial for the evaluation of competency in clinical reasoning would need to be identified.

Occupational therapy training programs frequently mention the topic of clinical reasoning in the development of their curricula (Hammel et al., 1999; Wood et al., 2000). After graduation, practicing therapists are required to pursue continuing education for ongoing professional development as well as for ongoing certification by the National Board for Certification in Occupational Therapy (2009) and by
many state licensing authorities. Despite these requirements, there are no accepted methods for assessing clinical reasoning.

The challenge for occupational therapy educators is to teach clinical reasoning, and to evaluate it in a context that is removed from clients. Students can be evaluated on their ability to articulate and deliver specific treatment techniques and they can be assessed on their ability to identify diagnostic categories and intervention strategies. What they may lack, and what is difficult to assess, is the ability to integrate scientific and procedural knowledge and apply it in a meaningful way to the specifics of a given client case. Occupational therapy students (as well as their counterparts in the other health professions) have difficulty understanding and mastering the complexity of scientific and procedural knowledge and the variation and uniqueness of each human being. (Heisler, 1996).

Occupational therapy researchers have utilized two specific methods for the analysis of clinical reasoning. Fleming and Mattingly (1994) and Unsworth (2001a, 2005) conducted ethnographic studies of clinical reasoning on small samples of therapists using videotape and recall techniques. In contrast, Koene et al. (2000) developed a self-assessment of clinical reasoning that they used as a post-intervention measure. Neither of these methods, however, yielded quantitative,
measurable information regarding the use of specific elements of clinical reasoning, nor the level of reasoning achieved by the therapists in the studies. Therefore, the purpose of this study was to develop a method for the assessment of clinical reasoning in occupational therapy.

Purpose of the Study

This study was designed to develop a strategy to assess clinical reasoning abilities in occupational therapists, to 'name and frame it' as Schön suggests in his descriptions of professional reasoning behaviors (1983, p. 310). A panel of experts was asked to identify essential elements ('training') required for intervention based on two validated multimedia case studies. The goal was to identify which elements a panel of experts would agree are representative of the clinical reasoning process of any occupational therapist. This list of essential elements could then be used in the form of a scoring tool or matrix ('training') to study the differences in the reasoning strategies of the various levels of expertise, and eventually to allow individuals to identify their own levels of reasoning.

The outcome of this study was the development of a consensus-based scoring tool in the form of a matrix for the assessment of clinical
reasoning in occupational therapy. Such a matrix may be used by academic and clinical educators to assess student entry-level reasoning; by supervisors in clinical settings for assessing staff therapists' clinical reasoning; and by therapists as a self-assessment tool to reflect on one's own clinical reasoning abilities. The framework of this matrix will be adjustable to specific practice areas, such as mental health, pediatrics, or physical disabilities, and will include all the elements that have been identified by the American Occupational Therapy Association (2002) in the Occupational Therapy Practice Framework (Practice Framework) as a part of best practice.

Research Question

In order to evaluate clinical reasoning, it was first necessary to identify and define evidence of it. In her book, Benamy (1996) recognizes that clinical reasoning is an internal process; thus it can only be evaluated indirectly. One indirect method would be to evaluate projected treatment recommendations, based on case studies. Case studies have been used in curricula to provide students concrete examples of client problems and possible solutions. Caterina and Stern (2000) discuss the use of cases in a review of the literature on
problem-based learning; they specifically suggest that there is a role for cases in the stimulation and development of clinical reasoning. They further suggest that "Cases must be constructed in such a way as to ensure that students can generalize concepts that they learn to various clients" (p. 69). Nestadt (1996) suggested in her analysis of teaching strategies for the development of clinical reasoning that students be encouraged to both analyze and write client narratives. The narratives allow and support students' abilities to take the narrative information and turn it into "concrete clinical procedures" (p. 679).

Evaluation of a clinician's strategies when addressing specific client concerns based on a narrative case is proposed here as one method for measuring clinical reasoning. A scoring tool with objective criteria could be used to measure the level and quality of suggested clinical strategies.

Two preliminary activities were necessary for the development of this proposed measurement tool. One was identification of a valid sample case or cases from which criteria could be developed. The other was the development of the measurement tool itself, with the measurement criteria based on the consensus of a panel of occupational therapy experts.
Before a tool can be developed to assess clinical reasoning, it is necessary to determine what should be included in any measure of clinical reasoning. In occupational therapy, assessment of client needs includes an identification of specific client factors, areas of occupation, performance skills, contexts, performance patterns and activity demands. These categories reflect the Practice Framework (AOTA, 2002) and include information that would be expected in any occupational therapy intervention plan.

The elicitation of expert opinions relative to these categories, based on the content of two validated multimedia case studies is the foundation of this research study. Therefore, the first hypothesis of this study is that the case studies used in this study have content validity. The second hypothesis is that the criteria for the measurement of clinical reasoning could be developed by using a consensus method. The Delphi technique was used to survey a panel of diverse “experts” with the intent of developing a criterion-based scoring tool that utilized the Practice Framework terms relative to client information presented in two validated multimedia case studies.

The first part of this project, validation of the case studies (found in Appendix C), provided a common base of client-related information (the specific scientific and narrative facts contained in the cases) upon
which an analysis of terms used by occupational therapists could be built. Expert clinicians recruited from the local geographic area (that is, within a 100 mile radius of the study site) reviewed the cases and verified that the clinical information presented in each case was correct.

The second part of this study sought to build agreement among a cohort of experts—published authors, experienced clinicians and experienced occupational therapy educators—about what elements from the cases were evidence of clinical reasoning. “Experts have an implicit understanding of a whole range of minute details of the phenomena that they understand. They recognize small details and nuances and interpret them with impressive speed and accuracy.” (Mattingly & Fleming, 1994, p. 27). Components of client information (in the cases), organized using the Practice Framework, served as the basis for consensus about the elements occupational therapists should address in a treatment plan regardless of their level of clinical reasoning ability. With this type of baseline measurement tool, it becomes possible to examine differences in levels of clinical reasoning that therapists demonstrate as their skills develop over time.

It is proposed that this assessment tool could then be used as a framework for reviewing the intervention strategies of therapists who
are at different expertise levels in their professional careers. Review of the strategies will enhance understanding about clinical reasoning in occupational therapy and the development process for advanced clinical reasoning for audiences both internal and external to the field, including therapists, educators, and other professionals. Development of exemplars of clinical reasoning for specific levels identified in the literature (Benner, 1984; Benamy, 1996; Neistadt, 1996) would allow for measurement of students' and clinicians' reasoning and for self-reflection about one's own clinical reasoning.
Chapter II

REVIEW OF THE LITERATURE

Professional training programs in the health sciences seek to instill in their students critical thinking regarding client needs as well as specific technical competence. Training in each health profession attempts to inculcate the specific beliefs and skills germane to that profession. An effective means to analyze the performance of students relative to the defined skills of each profession is necessary to determine the student’s competence to practice, and to identify areas that require further refinement.

Perspectives of Clinical Reasoning across Disciplines

Clinical reasoning in medicine, that is, the reasoning displayed by physicians, has been explored by a number of researchers using various paradigms. Most frequently mentioned in the recent literature is the cognitively-based work of Arthur Elstein. Elstein and Schwartz (2000) suggested the reasoning processes of physicians as being related to problem solving and decision making. The reasoning processes of
physicians relate to the identification of the problem (diagnosis) and matching of the diagnosis to previously identified intervention strategies. The desired outcome is remediation of the problem and/or removal of the causal agent. This differs from the reasoning required of other health professions, although it often precedes and forms the basis for intervention by them.

Elstein’s earlier work provided the base for further prescriptive models, including the model proposed by Campbell (1999) for use by pediatric physical therapists. The Hypothesis-Oriented Algorithm for Clinicians (HOAC), developed by Rothstein and Echternach (1986), is a decision model that frames the process of assessment and treatment planning of physical therapists, based on a formal problem statement generated from data collected from medical records and/or educational plans. Campbell further supported use of the HOAC when she suggested that physical therapists’ tasks (and therefore their reasoning) include evaluation of the client’s strategies for accomplishing a task, including efficiency, capacity and need for compensation or assistance (1999).

Clinical reasoning in nursing has been addressed in the literature from multiple angles, including content, context, and levels of reasoning ability. Fonteyn and Pitter (2000) suggested that knowledge
of nurses' clinical reasoning leads to educators' promotion of more sound reasoning strategies in their graduates. Good reasoning in nursing is related to outcomes that include patient stability, high quality care and positive outcomes. They suggest that poor reasoning may lead to mistakes including death. Benner (1984) related clinical reasoning ability in nursing to the Dreyfus Model of Skill Acquisition (1986), which was developed based on the study of chess players' and pilots' performances. It described hierarchical levels of reasoning from novice to expert, and gave examples of how each level differed from the previous one.

Fleming (1991a) examined the reasoning literature of medicine and contrasted it with the reasoning of occupational therapists. She suggested that much of the research in medical reasoning was aimed at reducing uncertainty and increasing the probability of "correct" clinical diagnosis. In contrast, the therapist is expected to use the information about the diagnosis to reflect how the client's functional performance will be affected and how specific details of the performance may change. In contrast to the clearly defined steps of the ROAC and the reasoning strategies of physicians, occupational therapists were suggested to use a "constant stream of small decisions or temporary hypotheses" (Fleming, 1991a, p. 992).
Clinical Reasoning in Occupational Therapy

In occupational therapy, the demand is for students and practitioners to demonstrate occupation-based reasoning that is holistic, client-centered and focused on outcomes rather than causes. "It's the clinical reasoning process, which guides the selection, use and adaptation of activities, that makes these elements 'occupational therapy' and that distinguishes adequate treatment from excellent occupational therapy." (Benamry, 1996, p. 3). Thus, an understanding about what constitutes clinical reasoning in occupational therapy, how we develop it and how it progresses from novice to expert, is desirable for scholars, educators, practitioners, and students.

Historical Review of Clinical Reasoning Research in Occupational Therapy

Joan Rogers addressed clinical reasoning as a topic for the profession in her 1983 Beatrix Clark Slagle Lecture. Her presentation, "Clinical Reasoning: The Ethics, Science and Art" examined the thinking that guides occupational therapy intervention across practice settings. She suggested that occupational therapists use multiple ways to address client needs, starting with an occupational therapy diagnosis, rooted in a biopsychosocial and scientific model, and
proceeding to "non-scientific intellectual processes" as they develop client-centered and directed intervention. Rogers was the first to suggest that occupational therapists use more than one kind of reasoning to meet client needs; she argued that clinical reasoning included reasoning in scientific, ethical and artistic dimensions. She also differentiated between the reasoning of experts and novices, and proposed an hypothesis to explain why experts can reason more effectively than novices: "The ability to think faster is thus a result of thinking more efficiently, more functionally, and more critically" (1983, p. 616).

One source Rogers referred to in her Slagle lecture references was the work of Donald Schön, an MIT professor who examined how professionals think about the way they work. His book, The Reflective Practitioner: How Professionals Think in Action (1983), gave vocabulary to and offered insight into the issues introduced by Rogers. Schön discussed some of his ideas, including how professionals "name and frame" issues and the "tacit" knowledge that professionals use, in a presentation at the American Occupational Therapy Association annual conference in 1984 (Gillette & Mattingly, 1987). He sparked an interest in researchers eager to examine clinical reasoning; as a result AOTA/AOTF (American Occupational Therapy Foundation) funded a
research study on clinical reasoning in occupational therapy (Gillette, 1987).

Supervised by Schön in Boston, a doctoral student named Cheryl Mattingly directed this study, called the Clinical Reasoning Study (Mattingly & Fleming, 1994). Mattingly's approach combined ethnographic and action research in a largely qualitative study. Maureen Fleming joined Mattingly as co-investigator in 1987.

Mattingly and Fleming presented their research to the profession in a special issue of the American Journal of Occupational Therapy (AJOT) in November 1991. A number of subsequent publications followed, including Clinical Reasoning: Forms of Inquiry in a Therapeutic Practice (1994). Again, the profession was introduced to new concepts and vocabulary regarding clinical reasoning in occupational therapy and expanded interest in the topic by both educators and researchers.

In 1991, Fleming proposed that occupational therapists use three "tracks" simultaneously and alternate among at least four types of reasoning: narrative, procedural, interactive and conditional (Fleming, 1991b). She also noted differences between expert or experienced therapists and novice or newer therapists in the type and speed of reasoning applied. In an article, Fleming (1991a) addressed the
differences between clinical reasoning in medicine and the clinical reasoning of occupational therapists. She urged the OT profession to pursue more qualitative research to further explore clinical reasoning types and strategies identified in the Clinical Reasoning Study.

Mufflingly (1991a) has pointed out that development of professional skills proceeds from a more structured "verbally based" knowledge to more fluid, intuitive "facit" knowledge. She described the difficulty that expert therapists have in identifying and verbalizing how they make decisions as opposed to the "stop and start motion" of the novice in treatment, who searches among his/her internalized rules for the right action.

Other authors in the same 1991 issue of AJOT examined levels of clinical reasoning and the elements that differentiate a novice from an expert. Soter and Cohr (1991) suggested that the analysis of practice developed in the Clinical Reasoning study could also be used to address professional development. They used a model of professional skill development proposed by Dreyfus and Dreyfus (1986) and Benner (1984). Skills identified for nurses by those authors were juxtaposed with the perceived reasoning strategies of occupational therapists. Dreyfus and Dreyfus suggested that the levels of development were "novice, advanced beginner, competent, proficient and expert". Soter and
Cohn argued that using reflection on one's level of clinical reasoning and practice might generate more awareness and appreciation of the different levels of ability. They suggested that professional development activities that included recognition and fostering of advanced clinical reasoning might prove to be a tool for staff recognition and retention (1991).

In 1993, Schell and Cervero generated a comprehensive review of the clinical reasoning literature in occupational therapy. They reviewed the reasoning types suggested by Rogers, Mattingly, and Fleming. Additionally, they reviewed studies by other authors and suggested including another type of reasoning: pragmatic reasoning (p. 608). Schell and Cervero also called for more research into the role of context relative to clinical reasoning and its implications for both pre-professional and professional development of this type of reasoning.

These studies of clinical reasoning indicated to the profession the existence and importance of using more complex reflection and reasoning as well as advanced technical skill to achieve effective patient outcomes. Occupational therapy theorists adapted the levels of competency identified by Benner (1984) in nursing and applied them to the practice of occupational therapy. Important elements of
Benner's descriptions are the exemplars she used to describe the levels of clinical reasoning in nursing. Such exemplars have not been paralleled in the occupational therapy clinical reasoning literature.

Clinical Reasoning in Occupational Therapy Education

The development of clinical reasoning ability is an important element in the preparation of therapists and therefore an important issue for educators. The American Occupational Therapy Association developed and published a self-study guide for clinical educators; in it, there is a lengthy discussion of the development of clinical reasoning as a part of clinical fieldwork experience. Early introduction of reflection on the reasoning process during the clinical experience addresses the student's use of scientific and procedural information and suggests strategies for fieldwork educators to introduce more client-centered reasoning strategies (AOTA, 1991).

Neistadt and Alkens (1996) reviewed types of reasoning embedded in the occupational therapy curriculum at the University of New Hampshire. It was the authors' perception that even experienced occupational therapists working in physical disability settings had biases regarding the importance of the different types of reasoning. The authors sought to investigate if educational practices were to
blame. They discovered their own curriculum taught different types of reasoning at different times relative to the perceived need in specific orthopaedic and rehabilitation courses. Thus, the clinical reasoning of the experienced therapists who were trained in this program may have been influenced by the content of the courses.

The literature also ties clinical reasoning to the educational preparation of therapists. Neuhauß (1988) pointed out the conflict for students as they struggle to become therapists; she suggested that "students yearn for some security and consistency, and they lack the two ingredients that might offer a sense of direction: facts and experience" (p. 292). Neistadt (1996) suggested that the language and concepts of clinical reasoning that had been articulated in the literature as a result of the Clinical Reasoning Study should be integrated into the professional educational process. She suggested that educational practices that identified the types of clinical reasoning and tied them to specific assignments would alert students to inclusion of the reasoning types. In the interest of facilitating the progress of entry-level therapists to a competent level of functioning, Neistadt also proposed the use of specific teaching strategies designed to address the development of each of the types of reasoning.
Following a design suggested by Dutton (1995) to tie clinical reasoning to physical disabilities case studies, Neistaft (1998) developed what she considered an “external aid” for teaching a thinking frame to students—the Clinical Reasoning Case Study Format (CRCS). The use of the thinking frame was suggested as a method for the organization and support of a thought process (Neistaft, 1998). The CRCS was used by University of New Hampshire students as a part of a clinic-based independent study course. The results were measured by rating participants’ definitions of clinical reasoning in a quiz format as well as analysis of student-generated case studies. Use of the CRCS was found to enhance the quality of rationales developed by students for intervention plans as well as confidence in their choices (Neistaft, 1998).

Case studies, problem-based learning and clinical reasoning

Several authors studied clinical reasoning and developed practice-specific reasoning strategies tied to specific frames of reference, using cases related to those practice domains in occupational therapy. Dutton (1995) proposed that clinical reasoning about physical disabilities could be taught if combined with case studies and “training in how an experienced therapist solved the same
case studies” (p. 9). She advocated a method of “chunking” (organization of data into manageable groups that are less cognitively demanding) and reflection-on-action progressing to reflection-in-action. Her text addressed clinical reasoning as applied to biomechanical, Neurodevelopmental Treatment (NDT) and rehabilitation frames of reference.

Benamy (1996) published a manual designed to develop clinical reasoning as a part of ongoing staff and professional development plans. Her suggestions included structured reflection and observation of assessment and intervention by both novice and more experienced therapists. She also suggested that a case story presentation enhances a therapist’s ability to think about his/her thought processes.

The trend toward problem-based learning in several occupational therapy curricula in the late 1990s was inclusive of clinical reasoning development as a teaching outcome. Van Liej (1995) noted that case study methods were specifically used in combination with traditional methods at the University of New Mexico to address the development of specific types of reasoning. She suggested that the methods of presentation of cases (paper, videotape, simulated and real cases) were more important than the content of the cases to the type of reasoning being taught.
Royer (1995) outlined the use of cases and problem-based learning throughout the occupational therapy curriculum at Shenandoah University. The problem-based learning format was used to focus on the development of "reflection and clinical reasoning" rather than on acquisition of knowledge and understanding through teacher-centered methods. In 2001, AOTA further supported the use of structured clinical cases in problem-based learning in occupational therapy education; several cases which were representative of different areas of practice were disseminated to educators in a series of problem-based learning workshops for use with students.

Heistad (1998), Royeen (1995) and Duffon (1995) specifically mention case studies as tools to enhance and teach clinical reasoning. Case studies have been used in medical education since the methodology was adopted by faculty at Harvard Medical School (McGinity, 2000). The use of cases is generally organized into a framework which includes a narrative about facts, which students review by themselves, a group discussion, and reflection on outcomes. The strength of the method comes from the generation of student-centered solutions (McGinity, 2000).

The case studies used in this study incorporate the experience of two therapists and the combined narratives of former clients treated
by each of them. The narratives are structured to present information from the perspective of the clients about their views of the disabilities and problems that have developed as a result of illness or trauma. The cases were developed with the types of occupational therapy clinical reasoning in mind. This includes the scientific/procedural information related to the diagnosis and medical treatment of each client; narrative issues (actually offered by the individuals playing the client roles) and pragmatic issues related to their personalities and their probable discharge contexts. Each case was designed to elicit hypothetical discharge plans and intervention strategies based on the narrative information contained in the cases.
Research findings from specific studies of clinical reasoning in occupational therapy

Several authors have undertaken studies to examine elements of clinical reasoning and differences in clinical reasoning in occupational therapy. Most have relied on qualitative methods similar to the Clinical Reasoning Study.

Strong, Gilpert, Cassidy and Bennett (1995) summarized the occupational therapy clinical reasoning literature, particularly AJOT articles, and were the first to examine the differences between the reasoning of experts and students. The researchers used a qualitative methodology (nominal group process) to examine the opinions of nine expert clinicians and ten fourth-year post-clinical students regarding the factors they felt to be important in clinical reasoning. Experts were nominated by the researchers, based on their experience and success; no other information about practice habits, specialty areas or length of experience was disclosed. No statistical analysis was reported in the study.

The results of the study included the findings that experts perceived their clinical reasoning skills to be better than those of the students; more factors were identified in the clinical reasoning process by
experts than by students; and differences in the types of reasoning valued varied from the experts (scientific and narrative reasoning) to the students (pragmatic and narrative). Suggestions by the authors for further investigation included a comparison of the reasoning skills of experts with students on a particular case, or observing an actual therapist-patient interaction and participating in a post-hoc interview.

A more specific study was done by Creighton, Dijkers, Bennett and Brown (1995) to examine clinical reasoning relative to a specific patient population. The purpose of the study was to investigate decisions made and reasoning exhibited when proficient occupational therapists used activities as treatment with spinal cord injured patients. The treatment strategies of four occupational therapists were observed, with actions and verbal communication documented in field notes. Some sessions were videotaped. Post-hoc interviews were conducted with each therapist after each observation; these were audiotaped and transcribed.

Examination of the results in this study yielded the following conclusions: occupational therapists demonstrated multiple concurrent reasoning styles suggested by Mattingly and Fleming; treatment decisions were reflective of a sequential, hierarchical style of thinking; contextual issues were seen to be inherent parts of the
reasoning process; and much of therapists' knowledge came from experience with patients. These researchers suggested further studies to address the relationships between a specific area of practice and type of reasoning used by clinicians. Other studies suggested included investigation of the hierarchical organization strategies of expert therapists as well as methods of facilitation of reasoning in beginning therapists (Creighton et al., 1995).

In 1996, Neistadt coupled her observations of the development of clinical reasoning in students with an analysis of teaching methods (Neistadt & Akins, 1996). A thematic analysis of the course content in the UNH curriculum was done to determine whether narrative reasoning was included in orthopedic subject matter. The study was done in two parts: analysis by a student (the second author) and analysis by the first author of teaching practices across the curriculum. The student analysis looked for themes that corresponded to different types of clinical reasoning in the materials used in the course text, related readings and course work as well as a literature review. Her analysis was discussed with classmates who concurred with her findings. The curriculum analysis was done by each faculty member. Each was asked to indicate the types of reasoning emphasized in each course. Data analysis suggested that narrative reasoning was not
valued in the orthopaedic course. The findings from this study supported the need for curricular review so that all types of reasoning could be related and applied to any diagnostic group (Neistadt & Akins, 1996).

Further investigation of clinical reasoning as a dimension of educational practice was done by Neistadt, Wight, and Mulligan (1998) in a study examining the use of “clinical reasoning case studies.” This method, described in Neistadt’s (1996) article, suggested that the use of case studies structured in a particular format (the clinical reasoning case study format) would help students “become aware of their own clinical reasoning skills and lay the foundation for the continued development of occupational therapy graduates’ clinical reasoning abilities.” (p. 482). The study contrasted the use of the clinical reasoning case studies with traditional narrative paper case studies by students. A three-part design using a test-retest activity first examined student intervention plans for evidence of clinical reasoning. Additionally, a copy of the clinical reasoning case study was highlighted by students to reflect information that they believed to be important. Finally, post-hoc analysis of discussions regarding student perceptions of their experiences was done.

Findings were generated by thematic analysis, peer debriefing, and notations and categorization of highlighted information in each case.
study. Quantitative analysis of students' confidence ratings and number of words highlighted (converted to percentages) revealed themes in the intervention plans. The themes suggested that the clinical reasoning case studies promoted the development of "more comprehensive intervention plans" by the students, that the clinical reasoning case studies also led to more specific activities identified for treatment than were suggested for the traditional case study; that more active treatment suggestions were elicited by the case studies; and finally that the intervention plans based on the clinical reasoning case studies were more inclusive of social context factors than were generated in response to the traditional case studies.

The researchers concluded that the clinical reasoning case studies were a better vehicle for students to assess the use of narrative and interactive reasoning. They suggested testing the use of these kinds of case studies with problem-based learning and other educational methods as areas for more research.

Neistadt did a further analysis of the use of a clinical reasoning "thinking frame" as a teaching strategy in 1998 (Neistadt, 1998). A convenience sample of 16 occupational therapy undergraduate students participated in a quasi-experimental, pretest-post test study using "clinical reasoning quizzes" as well as student development of a
clinical reasoning case study based on fieldwork experience, using the clinical reasoning case study format (Neiswander, 1998). Analysis of the quizzes involved rating quiz definitions and subjecting ratings to statistical analysis (Wilcoxon signed rank test); the inter-rater reliability of the two raters was not analyzed. Results of this study suggested that students became more aware of clinical reasoning subtypes and that using the clinical reasoning case study format aided their ability to include all subtypes in application of the concepts. The authors suggested that further research in this area might support the hypothesis that students can be taught to organize clinical observations according to clinical reasoning concepts. They also suggested the need to investigate other means to facilitate the development of more advanced reasoning.

The same need for enhanced clinical reasoning of occupational therapy program graduates “demanded by today’s health care environment,” identified by Neiswander (1998), prompted a study of clinical reasoning in Hong Kong. Liu, Chan, and Hui-Chan (2000) used the Canadian Occupational Performance Measure (COPM) (Law et al., 1991) to analyze therapists’ clinical reasoning (novice and expert). At the same time, they did a review of the content of the occupational therapy curriculum from which they graduated. The 12
subjects were recruited from among the Hong Kong OT program's graduates and were grouped into 'senior' and 'junior' groups based on years of practice. Clinical reasoning abilities were assessed for each participant using data from the therapists' administration of step one of the Canadian Occupational Performance Measure (COPM) with five clients who had had a stroke. Additionally, post-assessment interviews of the therapists (protocol analyst) were done. Data were analyzed using thematic content analysis of the interview sessions, which had been audio taped and transcribed. Percent agreement was done to compare the coding of the two raters for inter rater reliability. Analysis of the curriculum was done by classifying the subjects of courses into four areas: background-related subjects, theory subjects, clinical subjects, and fieldwork practice. (Li et al., 2000).

Findings included differences in the types of reasoning used by 'senior' versus 'junior' therapists. While both groups were found to use conditional reasoning, senior therapists did so more than the junior therapists and junior therapists were found to use procedural reasoning while senior therapists did not. The researchers suggested that based on their findings, the amount of fieldwork in the curriculum of this program should be increased and that "practice-related contextual
problem-based learning" should be added to the curriculum. (Liu et al., 2000)

Royeren, Mu, Barret and Luebben (2000) offered a more
quantitative analysis of clinical reasoning. This study identified the
need for a more in-depth investigation of the clinical reasoning
process as well as the development of ways to evaluate it. Therefore,
the "Self-Assessment of Clinical Reflection and Reasoning (SACRR)," a
questionnaire with Likert-scale items was developed to evaluate
clinical reflection and reasoning in clinicians. The questionnaire items
on the SACRR were subjected to "informal pilot testing in various
continuing education settings" as well as reviewed by practicing
clinicians for content and construct validity. The data was further
subjected to examination for validity and reliability in a repeated
measures study using 30 first semester occupational therapy students.
Results were analyzed using Cronbach's alpha to evaluate internal
consistency of the items as well as a Spearman correlation for the
ranking. The SACRR was found to have "acceptable psychometric
properties" for a pilot investigation. (Royeren et al., 2000)

In the same article, the authors reported that the SACRR
consequently was used in a follow-up repeated measures study
requiring self-assessment of clinical reflection and reasoning of
Therapists following a two-day workshop on clinical reasoning. According to the self-reporting mechanism of the SACRR, a "significant difference" existed between pretest and posttest scores, thus suggesting "intervention can enhance clinical reflection and reasoning." The authors also suggested "an intervention using case-based instruction coupled with didactic instruction is an effective method for increasing reflection and reasoning in therapists" (Royeen et al., 2000, p. 111). Limitations of this study included threats to validity due to choice of items, the stability of the instrument, and limited generalizability of the findings due to the use of a convenience sample in this investigation (Royeen et al., 2000).

Scaffa and Wooster (2000) also used the SACRR to "measure changes in clinical reasoning thought processes and behaviors" (p. 334) in 48 undergraduate occupational therapy students who were enrolled in a problem-based learning (PBL) course. The course used cases whose content crossed various practice areas. Pretest and posttest responses on the SACRR were subjected to analysis using the Wilcoxon Signed Rank Test. 11 of the 26 SACRR items were found to have "statistically significant improvement", and the overall scores were also found to exhibit improvement at a statistically significant level (p < .01). Conclusions suggested by these authors included
justification of the resources necessary to develop and deliver PBL courses and materials, as well as linking specific activities to the themes identified in the item analysis. Further study of the use of PBL strategies was urged.

Although the SACRR is a more quantitative tool, it is limited because it is a subjective self-measurement of clinical reasoning and relies on the individual’s feelings about his/her performance. It does not provide examples or categories against which to actually score clinical reasoning performance.

Current clinic-based studies in Clinical Reasoning

In 2001, Unsworth studied the clinical reasoning of novice and expert clinicians at an Australian rehabilitation facility, using an ethnographic approach that was similar to Mattingly and Fleming’s Clinical Reasoning Study in Boston in the late 1980s. Five clinicians wore a miniature head-mounted video camera attached to a recorder carried in a waist pouch while treating six different clients, yielding six data sets. Each therapist was recorded doing an evaluation, intervention and discharge planning session, for a total of 18 sessions (one novice therapist provided two data sets). The resulting videotapes were transcribed and analyzed using codes based on Mattingly and
Fleming’s reasoning categories (procedural, conditional and interactive). Unsworth’s ethnographic analysis also looked for common phases, patterns, themes and relationships between variables.

Chi-square analysis of the results was performed, and yielded four outcomes: 1) the experts had a higher frequency of instances of reasoning than novices; 2) the experts and novices both used similar percentages of reasoning in assessment and treatment, but experts used a higher percentage of reasoning in discharge planning; 3) the novices used more procedural reasoning than experts, but experts used more “combined” reasoning strategies; and 4) the experts used more conditional reasoning or combined it with interactive reasoning in assessment and discharge planning as opposed to the novices who used procedural or a combination of procedural and conditional reasoning.

Qualitative analysis supported these findings and additionally seemed to indicate, “while the novices provided therapy at an acceptable level, the experts offered a more flexible, client-centred and confidently presented therapy programme” (Unsworth, 2001). The findings of this study have limited generalizability because of the small sample size as well as the authors’ reliance on the subjects’ memories of their thought processes as a measure of reasoning.
In 2005, Unsworth replicated her 2001 study in three rehabilitation centers, with 13 experienced therapists (Unsworth, 2005). The same methods of videotaping and review were used, with transcripts generated and coded using not only Mattlingly and Fleming’s categories of procedural, interactive and conditional reasoning, but also Schell and Cerreto’s (1993) pragmatic reasoning. Unsworth interpreted narrative reasoning as “a way of expressing the other forms of reasoning” (p. 35); the author therefore did not code it separately. The therapists in this study were all experienced with more than four years practice in OT.

Findings from this study were analyzed using the same coding methods as the 2001 study, and essentially confirmed the findings of the 2001 study. Here, the therapists used all of the categories and often “mixed” them, thus creating seven “modes” of reasoning: “(1) procedural, (2) interactive, (3) conditional, (4) procedural and interactive, (5) procedural and conditional, (6) interactive and conditional and (7) procedural, interactive and conditional.” Unsworth’s work supported the work done by Mattlingly and Fleming in the area of physical rehabilitation.
Summary of Current Knowledge about Clinical Reasoning in Occupational Therapy

Types of clinical reasoning

The types of clinical reasoning identified in the Clinical Reasoning Study by Mattingly and Fleming (1991) have been supported in studies conducted with therapists and clients in physical disability settings (Creighton et al, 1995; Unsworth, 2001a). With the addition of pragmatic reasoning (Schell & Cervero, 1993) as a category, they are as follows:

a. **Procedure**: the same as Rogers' (1983) scientific and diagnostic reasoning; the identification of problems and implementation of treatment strategies focused on the client's disease or disability (Neistadt, 1994). Schell and Cervero (1993) suggest that scientific reasoning is "insufficient by itself to adequately explain the complexity of clinical practice" (p. 606).

b. **Interactive**: the thoughts and means used by an occupational therapist to get to know a person and engage the intervention process (Schwartzberg, 2002).

c. **Contextual**: understanding and using information about intervention relative to the client's life contexts and the
influence of the disability on the person's future (Fleming, 1994).

d. **Pragmatic**: broader than conditional reasoning, concerned with both present and future contextual issues of the client and also the temporal and personal context of the therapist, and the culture of the practice environment (Schell & Cervero, 1993).

e. **Narrative**: (identified by Mattingly, 1991 and discussed by Schell and Cervero, 1993); story making and story telling, about and with the client.

The qualitative studies mentioned in the above section verify the importance of these strategies or categories during the therapy process (assessment, intervention and discharge planning) in varying combinations and percentages. Most of the studies urge further investigation to verify their findings, broaden the client populations studied and develop strategies to promote all the types of reasoning in both students and practicing clinicians.

Additionally, Rogers' Eleanor Clark Slagle lecture identified the importance of the "artistry" of clinical reasoning (Rogers, 1983). She identified the differences between experts and novices as "not merely
thinking faster but thinking differently. Subsequent studies of the levels of clinical reasoning in occupational therapy have been assimilated from the research done with nurses (Benner, 1984; Dreyfus and Dreyfus, 1986). The table in Appendix B lists Benner’s levels of clinical reasoning as they have been applied to occupational therapists by various authors as cited in the literature.

Levels of clinical reasoning: from novice to expert

Differentiation among the levels has been the focus of some of the research done in the area of clinical reasoning. The studies of Strong et al. (1995), Liu et al. (2000) and Unsworth (2001a) all indicated significant differences between reasoning strategies of experts and students/novices in occupational therapy in assessment, intervention and discharge planning activities. This research indicates the use and dependence by novice therapists on primarily procedural/scientific reasoning based on information learned in school and its rigid application. Such reasoning is less efficient and less inclusive of the client’s individual needs and contexts.

In 1996, Neistadt pointed out the need for students to progress more quickly to the competent therapist stage so that they are "able to alter their procedures as needed for specific situations and prioritize..."
client problems" (p. 681). The demand for shorter stays and less therapy that has characterized health care since the late 1990s continues to exert pressure on educators to seek out strategies to promote faster acquisition of more advanced reasoning.

Appendix B contains a summary of the levels of clinical reasoning in the occupational therapy literature.

Need for the study

Previous studies of the levels of clinical reasoning used in occupational therapy are based on the levels of reasoning used in nursing, as identified by Benner (1984) and relying on the Dreyfus & Dreyfus model of skill acquisition (1980). These levels, from novice to expert, have been identified and examined at each end by occupational therapy researchers (Shang et al., 1995; Liu et al., 2000 and Unsworth, 2001a). But the researchers have failed to distinguish among examples of reasoning at the intermediate levels or the content of reasoning at each level. A framework of identified essential elements would allow clarification of differences in reasoning at each level as well as a means to identify strategies that each level of practitioner uses.
Both the original work by Benner and subsequent use of Benner's levels by Beranmy suggest that competency is not achieved until after two or three years of practice in the profession (nursing or occupational therapy). Creighton et al. chose to look at the decisions made by proficient occupational therapists in choosing activities for clients with spinal cord injuries, but the "proficient" category was undefined except for amount of experience, which varied from eight years of experience to two and one-half years, and the specific amount of time spent on the spinal cord injury team (1995).

Understanding performance associated with each level of clinical reasoning may have larger implications for the field of occupational therapy. As Beranmy (1996) pointed out, supervision of level 3 fieldwork by therapists who are themselves at a novice or advanced beginner level of clinical reasoning (less than 2 years) may not be desirable. Additionally, Benner (1984), in speaking of nurses at the proficient level, suggests that the performance of expert or proficient nurses deteriorates if they are made to follow explicit or formal rules or models (analogous to care paths or clinical pathways). If this is true for occupational therapists as well, development of clinical reasoning beyond the level of "competent" may be limited in such settings. The impact of the contextual factors on clinical reasoning
performance therefore requires explicit definitions of performance at each level.

Analysis of the reasoning ability of clinicians in a given setting may also enhance the productivity and effectiveness of treatment. Using the levels to match therapists to clients based on perceived difficulty of cases may produce better outcomes for both clients and therapists. In a study in England, Fortune and Ryan (1996) described the use of a caseload weighting system that was being used relative to the perceived abilities of therapists as well as their other responsibilities and learning needs. This concept may be applicable in other settings, and again supports a practical need for supervisors to identify the levels of reasoning evidenced by therapists in practice.

Rationale for the Study as Proposed

Detailed analyses of the elements which lead to clinical reasoning by experts in both clinical and educational settings were conducted in this study. Such analysis required agreement among expert members of the profession, that is, agreement about what constitutes evidence of clinical reasoning at any level. A proposed future study based on the results of this study hopes to examine agreement about the kinds of reasoning expected of entry-level
practitioners relative to that of competent practitioners. Research that explores the elements of occupational therapy reasoning that remain consistent despite treatment or discharge context should also be pursued. The first step in this analysis was the development of a measurement tool for clinical reasoning.

The literature suggests that analysis of clinical reasoning might best be done by using a case study that can be analyzed by novices and experts and therapists functioning at levels in between (Strong et al., 1995; Royeen et al., 2000). In developing this measurement device, the use of a consistent data set of clinical client facts to analyze elements of clinical reasoning is necessary. Two multimedia case studies (case studies offered in a CD-based format that are inclusive of diagnostic, interactive and narrative client information) developed for use in the Master of Science in Occupational curriculum at Seton Hall University offer the complexity and variety of information needed to elicit multiple levels of clinical reasoning. The case studies were submitted to a panel of experienced physical disabilities occupational therapists for content validity. According to DeFoy and Grillon (1998), review by experts is an acceptable assurance of content validity.

The next step in the analysis process was the development of consensus about the elements in the case study that should be
reflected in an occupational therapy intervention plan by clinicians at any level. A commonly used technique identified in the literature used specifically to develop consensus is the Delphi technique. First developed in the 1950s by the Rand Corporation for generating predictions, the Delphi has been adapted for use in health care, especially in nursing (Haxton, Keeney & McKenna, 2000). Delphi is uniquely suited to eliciting consensus from varied experts who are not necessarily geographically close, and in gathering ideas from those experts into an agreed-upon outcome. In this study, the Delphi is especially useful because the project integrates the opinions of educational and clinical experts in occupational therapy, potentially resulting in awareness on the part of both these groups of each other’s perceptions of clinical reasoning.

Delphi Technique

The Delphi technique is a process, rooted in a series of questionnaires that elicit controlled feedback, resulting in reliable consensus of opinion from a group of experts (Powell, 2003). Two elements are critical: 1) Identification of the “experts,” and the 2) development of the first questionnaire. Final consensus is developed
through resubmission of the rounds to the participants for ranking and rating.

To substantiate the use of Delphi technique in this study, a clear definition of the experts was necessary. Kennedy (2004) underscores the issues of communication, revision and explication of opinions anonymously without the interference of group dynamics. She suggests that the quality of the study rests on the design, the sample and the process by which consensus is identified. (p. 505).

Chochoik et al. (1999) and Windle (2004) suggest that four characteristics distinguish the use of Delphi: 1) anonymity, 2) iteration with controlled feedback, 3) statistical group response, and 4) expert input. While the need for anonymity is not considered central to this study, the use of Delphi to generate consensus across the profession, especially between educators and practitioners, is likely to minimize the friction that often characterizes attempts to generate agreement. Further, when used electronically (as originally proposed), the Delphi technique enables the sampling of experts from across different geographic locations in a short time period.

Qualitative analysis of the answers to open ended questions on the first questionnaire were tabulated and summarized for use in a second questionnaire which transposed the information into a series of
statements. The second and third rounds support the findings of the first
round by using surveys that include the findings of the preceding
rounds, so that respondents could review their answers relative to those
of the other experts. According to Hasson et al. (2000), the use of three
rounds may be better than the four rounds suggested in earlier Delphi
literature, as sample fatigue and respondent loss could become a
limiting factor on meaningful outcomes.

Overview and significance of the proposed study

The development of consensus regarding clinical reasoning in
occupational therapy is vital to both internal and external validation of
the importance of occupational therapy as a profession. As a
profession, the Occupational Therapy community should identify what
is agreed upon as the expected performance of an experienced
(more than 2 years) clinician as well as how an “expert” clinician in the
profession is defined. These definitions then allow practitioners to self-
assess their reasoning ability and pursue professional development
designed to achieve the next level, identifying elements of each less
advanced level as well as the relationship to intervention strategies:
also provides a guide to individual therapists’ self-generated effort to
progress to a proficient or expert level. The acquisition of competency
that encompasses reasoning as well as advanced methods of specific treatment techniques can also be assessed, given consensus on the level.

Additionally, analysis of clinical reasoning in occupational therapy is critical to the enhancement of teaching strategies in occupational therapy education as well as further post-professional clinical reasoning development. Identifying strategies to enhance progression to more sophisticated or refined reasoning is also likely to be instrumental in identifying activities or strategies beneficial for novice therapists to refine skills.
Chapter III

METHODOLOGY

This study involved a non-experimental survey design (Depauw & Gittel, 2005) to elicit consensus among occupational therapy experts about indicators of clinical reasoning relative to client content in two validated multimedia case studies. To that end, a two-step process was used. First, clinical occupational therapy experts in rehabilitation verified content validity of the two multimedia case studies. These experts determined the extent to which the case studies represented reasonable information about clients and the similarity to actual clinical case content encountered by practicing occupational therapists.

Second, a Delphi survey technique (Tufafi & Hiltz, 1995) that incorporated electronic communication as well as traditional postal and/or handwritten responses was utilized. Study materials including the multimedia cases, directions and links to on-line survey forms for each round were posted on a secure Web site. Both elements of the study were submitted to the IRB of Seton Hall University for review prior to initiating this research, and received approval on July 26, 2005.
Participants

The Delphi Survey is identified as a tool for generating consensus among a group holding diverse views. (Turoff & Hiltz, 1995). For the purpose of this study, the experts required for the Delphi process were solicited from three different groups of occupational therapists. Group 1: the authors, are individuals who have published on clinical reasoning in refereed occupational therapy publications; Group 2: clinical experts, and Group 3: faculty, experienced occupational therapy educators. These three groups ensured a representative distribution of opinion regarding what constitutes clinical reasoning among clinicians, theorists and educators in occupational therapy practice and education.

Criteria for inclusion were willingness to participate in three to four rounds of the Delphi study; Internet access; and the participant's technological ability to access the survey on-line. Criteria for exclusion included individuals who graduated from Seton Hall University's Master of Occupational Therapy program and individuals having neither access to the Internet or access limited to dial-up connections only.
The first group of Delphi respondents, individuals who published on the topic of clinical reasoning in refereed occupational therapy publications, were contacted by letter (Appendix D) via USPS mail and e-mail. This list included authors from five states and one foreign country. All have published in the American Journal of Occupational Therapy, as well as in publications outside of the United States; all were referenced in the literature review of this study. Of the 17 individuals contacted, eight agreed to participate in the study. At the end of the first round, one respondent indicated that time constraints precluded her further participation in the study. This left seven active participants in the author group (Group 1) who completed all rounds of the study.

Group 2: 'Clinical experts’ were solicited from the American Occupational Therapy Association’s list of practitioners who hold Board Certification in Neurorehabilitation (BCN), which was posted on the AOTA Web site (AOTA, 2003). Individuals who hold this designation have a minimum of five years experience with clients with a physical disability, have completed several professional educational activities (specialty courses or acquisition of certifications) and have successfully taken the AOTA Specialty Certification examination for neurorehabilitation. These individuals are identified in the study as BCN respondents.
Potential participants for Group (2) were contacted by letter (Appendix D) via USPS mail and e-mail. An e-mail inquiry was sent to the state Occupational Therapy Association of the last known state of residence of AOTA members with a BCN, requesting that the e-mail be forwarded to the BCN-designated therapist. This method yielded at least four eligible individuals willing to participate. Other individuals with a BCN credential known to the researcher were contacted directly, and were requested to forward the request to other BCN occupational therapists. Recruitment of Group (2) BCN participants generated seven participants; however, two BCN therapists who initially agreed to participate were unable to participate in all rounds due to time constraints and illness. The five individuals who completed all rounds of the study were from four states and one from an overseas military posting.

Group (3), faculty who are experienced educators were solicited via e-mail letter to occupational therapy educational program directors (Appendix D) of randomly selected educational programs among the 150 active, accredited, occupational therapy schools listed on the AOTA Web site. The poor response rate (four respondents) further necessitated a participant recruitment posting on the AOTA faculty reserve which yielded two more respondents who
met the criteria for the study. These six final respondents represent six different states as well as different educational institutions.

Powell (2003) suggested that the success of a Delphi study depends on the combination of two aspects of the study: panel size and expertise of the participants. Six participants in each category were initially solicited, for a total of eighteen in the sample. Although the participants were self-selected, an effort was made to contact as broad a geographic distribution as possible. Recruitment continued for each cohort until minimum numbers of participants in each category were reached for the first round of the study. According to Powell (2003), representativeness in a Delphi study is more a function of the qualities of the experts, rather than the number of participants. Although a balance of six in each category would have been optimal, it was appropriate to proceed with the study, even though the numbers were not equally balanced. The final distribution of respondents consisted of five BCN individuals, six faculty members and seven authors.
Procedures

Delphi Survey Technique

The Delphi technique has been used since the 1970's in nursing, physical therapy and occupational therapy (DeFoy, 1990; Partney & Watkins, 2000; Powell, 2002). The technique is often used to establish consensus without the interference of group dynamics or the limitations of geography. The process begins with an open-ended questionnaire designed to elicit individual opinions and ideas which are subsequently combined to generate more defined categories. This approach was particularly suited to combine the different viewpoints of clinicians and educators, as it elicited opinions using an anonymous and non-political method.

Respondents were first asked to review the content of the two content validated multimedia case studies that were posted on a secure website. These cases could be viewed throughout the Delphi process by respondents. A link to a survey site (Formsite.com) which hosted a survey designed for this Delphi round was embedded in the case study site, and information regarding site access was separately e-mailed to the respondents. Each respondent’s activity was tracked.
using an identifier code to ensure complete participation in all rounds of the survey process. Each iteration of the survey was linked to the study site; participants could submit only one completed survey for each round. On completion of the study, information from the Formsite.com Web site was printed as a hard paper copy as well as stored digitally on a removable flashdrive and archived in the researcher’s office in a securely locked location.

The first round questionnaire (Appendix E) was generated using the Practice Framework [AOTA, 2002] categories arranged into a table by sections; the resulting questionnaire was posted on the Internet on a secure Web site. Two respondents had difficulty with the Web-based connection to the cases, and requested CD-ROM versions of the cases so that they could be viewed on the respondents’ local computer systems. To ensure uniformity across the study, all respondents were mailed two CD-ROMS, each containing one full version of either Case One (Joe Remora) or Case Two (Mary Price) that ran automatically when loaded into a CD-ROM drive. No problems were reported with the CD versions.

Initial results of the first round open-ended questionnaire were analyzed using the Practice Framework as a guide (e.g., this round identified some items that were indicative of “Activities of Daily Living”
(see Appendix A for definitions that accompany the Practice Framework (AOTA, 2007)). Respondents' comments for Round 1 were organized into a preliminary matrix reflective of the case study content according to the Practice Framework, and then resubmitted to the respondents for further comment (Round 2). Table 1 is an edited example of how information was summarized into the Round 2 questionnaire. The full questionnaire with the tables for all sections is listed in Appendix E. Numbers to the left of each percentage represent the raw number of responses generated from the open-ended questions.

Table 1. Example of results from Round 1 as listed in Round 2 survey.

<table>
<thead>
<tr>
<th>Practice Framework</th>
<th>General</th>
<th>Care</th>
<th>Case Two</th>
</tr>
</thead>
<tbody>
<tr>
<td>Category</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Activities of Daily Living</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(overall)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Bathing/showering</td>
<td>10 (59%)</td>
<td>5 (29.4%)</td>
<td>6 (35.2%)</td>
</tr>
<tr>
<td>2. Bowel/bladder</td>
<td>2 (11.7%)</td>
<td>2 (11.7%)</td>
<td>1 (5.8%)</td>
</tr>
<tr>
<td>management</td>
<td>1 (5.8%)</td>
<td>1 (5.8%)</td>
<td>-</td>
</tr>
<tr>
<td>3. Dressing</td>
<td>2 (11.7%)</td>
<td>1 (5.8%)</td>
<td>1 (5.8%)</td>
</tr>
<tr>
<td>4. Eating</td>
<td>1 (5.8%)</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>5. Feeding</td>
<td>2 (11.7%)</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>6. Functional Mobility</td>
<td>2 (11.7%)</td>
<td>2 (11.7%)</td>
<td>3 (17.6%)</td>
</tr>
<tr>
<td>7. Personal Device Care</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>8. Personal Hygiene &amp; Grooming</td>
<td>2 (11.7%)</td>
<td>2 (11.7%)</td>
<td>-</td>
</tr>
<tr>
<td>9. Sexual Activity</td>
<td>2 (11.7%)</td>
<td>1 (5.8%)</td>
<td>2 (11.7%)</td>
</tr>
<tr>
<td>10. Sleep/Rest</td>
<td>1 (5.8%)</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>11. Toilet Hygiene</td>
<td>1 (5.8%)</td>
<td>2 (11.7%)</td>
<td>1 (5.8%)</td>
</tr>
</tbody>
</table>
The third Delphi round asked respondents to choose to either include or exclude (or use ‘neither’ to indicate neutral) those items in the matrix where consensus had not been reached.

Treatment of Data

Delphi Survey Results

The most critical analysis of the Delphi survey was the first round, the open-ended questionnaire results of Round 1 as they were analyzed and organized into a table. The table was organized according to the categories of the Practice Framework (e.g., Activities of Daily Living, contexts, performance patterns). Using the Practice Framework definitions, findings were analyzed to identify agreement about specific common components of the cases. Descriptive statistics, in the form of percentages of agreement about inclusion or exclusion of each category, were used to report the findings of the first and second iterations to the respondents.

After Round One responses were received, it become clear that respondents had to have a specific way to indicate whether they were referring to Case One or Case Two. Some chose to submit two
separate response sheets while others indicated differences in the text response. The difficulty of discerning whether respondents believed that a category should be included generally or if the response was related to one case and not the other impacted the development and format of the subsequent rounds. The use of columns that were labeled for each case (Round Two) and the use of a totally different response table (Round Three) greatly enhanced the clarity of the intent of the respondents.

Round One data was summarized into a table format and posted on the study Web site. This second survey was labeled “Round Two Delphi”. Respondents were asked to review the findings of Round One and indicate agreement that each identified category should be addressed for each case study as well as indicate the level of importance that the respondent attached to each category for each case, Case One and Case Two. This survey was also sent via post to all respondents in a paper format. Eleven of the respondents used the online format; seven returned paper forms by mail. Data from the paper forms was manually entered by the researcher into corresponding online format for each paper response.
The level of agreement of the respondents was analyzed according to consensus levels as suggested in the Delphi literature. The levels for agreement for this study are presented in Table 2.

Table 2: Agreement and Consensus levels.

<table>
<thead>
<tr>
<th>Number of responses</th>
<th>Percentage</th>
<th>Consensus level</th>
</tr>
</thead>
<tbody>
<tr>
<td>14-18</td>
<td>77.8% - 100%</td>
<td>Strong consensus</td>
</tr>
<tr>
<td>12-13</td>
<td>66.7% - 72.2%</td>
<td>Weak consensus</td>
</tr>
<tr>
<td>11-10</td>
<td>61.1% - 65.6%</td>
<td>Majority</td>
</tr>
<tr>
<td>9-8</td>
<td>50% - 44.4%</td>
<td>Plurality</td>
</tr>
<tr>
<td>7-6</td>
<td>38.9% - 33.3%</td>
<td>No trend</td>
</tr>
<tr>
<td>1-2</td>
<td>5.5% - 11.1%</td>
<td>Consensus for exclusion</td>
</tr>
</tbody>
</table>

Categories that were identified by more than 13 of the 18 respondents generated over 75% agreement and thus were identified as having strong consensus. Those items rated by 12 or 13 respondents (66.7% to 72.2%) as important were felt to have a weaker consensus, but still enough consensus for inclusion. Items which were marked as important by 50% - 61.1% (nine and ten respondents) were categorized as a majority choice. As mentioned above, items chosen by only one or two respondents (included by 5.5% to 11.1% and NOT chosen by 88.9% - 94.4% of the respondents) met the criteria for consensus for exclusion. Those items where responses were fairly evenly split between inclusion-exclusion and neither were felt to have no weight either way.
The third and final round of the Delphi sought to improve the consensus on those categories where consensus for inclusion or exclusion was unclear. Respondents received paper copies of the round as well as e-mail notification that the Round Three survey had been posted on the study website. The respondents were given tables that reported the categories where agreement of more than 75% indicated inclusion of a category, or where fewer than three responses (11.1%) indicated exclusion. Categories that did not yield clear consensus were listed in tables that cited the level of agreement from Round Two. Respondents were requested to choose inclusion, exclusion, or a neither response for that category. All eighteen respondents completed Round Three for a 100% response rate.

Translation of responses into data

Round One responses varied from short phrases that referred only to headings of the Practice Framework to lengthy text responses that were based upon very specific client information presented in each multimedia case. Respondents' answers were analyzed using the defining terms that accompanied the Practice Framework (AGTA, 2002). Categories were marked as included if mentioned in the respondent's replies. This analysis yielded a numerical count and
percentage of Practice Framework terms that were included in each response for each category for each of the two cases (1384 responses for each round).

Subsequent rounds of the Delphi were analyzed by using a simple count of responses. Although some respondents did add comments on response sheets or sent e-mail comments regarding Web site format, data was restricted to included items in Round Two. Excluded items were identified in Rounds One and Two by non-selection by respondents, and by specific choice of the category of “exclude” in Round Three. The answer “neither” was included in Round Three for those categories which the respondents believed would require more information from the client in the case for a decision of either inclusion or exclusion.
Chapter IV

RESULTS

Demographics

Of the eighteen respondents, sixteen were female and two were male. The respondents included nine individuals who possessed Ph.D.s, one who possessed a clinical doctorate (OTD), six who possessed Master degrees and two who possessed Bachelor degrees in Occupational Therapy. Three respondents practiced occupational therapy outside of the United States (Australia, England, and Puerto Rico). The American therapists resided in ten different states across the country. Overall, the respondents' years of experience ranged from 11 years to 38 years with a mean of 23 years (with a standard deviation of 8.94) in the field. Six of the respondents hold the designation FAOTA, denoting status as a "Fellow" of the American Occupational Therapy Association.

The eighteen respondents included seven individuals who have written in occupational therapy literature about clinical reasoning; five who are BCN-certified, and six who hold full-time faculty positions in entry-level occupational therapy educational programs. Two
Individuals who initially agreed to participate were unable to do so when the first round was disseminated due to other obligations and illness.

Findings

The 88 categories of the Practice Framework were delineated into eight sections to facilitate response generation by the respondents and for data management from round to round. The figures in this chapter present the responses by section. Data that correspond to the graphs can be found in Appendix F.

Data regarding the Practice Framework categories was divided into eight sections of the Practice Framework for each case and each round. Figures in this chapter are arranged in chronological order from Round 1 to Round 3 to show the progression towards consensus for each section. A fourth figure for each section illustrates the overall percentages of agreement for all categories in the section.

The Practice Framework document (Appendix A) itself is broken into sections entitled Areas of Occupation, Performance Skills, Performance Patterns, Context or Contexts, Activity Demands and Client Factors. The section entitled “Areas of Occupation” is further broken down into Activities of Daily Living, Instrumental Activities of Daily Living.
Education, Work, Play, Leisure and Social Participation and comprises 40 of the 88 categories in this study. For both ease of responses and data management, the “Areas of Occupation” was further divided into sections entitled ADL, IADL and other areas of occupation.
Delphi Technique Results for Case One (Joe Remora):

Areas of Occupation: ADL

Activities of Daily Living (ADL), as defined by the Practice Framework include "activities that are oriented toward taking care of one's own body" (AOTA, 2002, p. 629).

Figure 1. Frequency of inclusion scores for ADL categories for Case One Round 1.

Figure 1 displays the number of respondents who indicated that a category from the ADL section of the Practice Framework should be addressed as evidence of clinical reasoning in any occupational therapy intervention plan. The answers were counted as inclusive if the response matched or was consistent with the terms in the definition of the category as delineated in the Practice Framework.
Figure 2: Frequency of inclusion/neither scores for ADL categories for Case One Round 2.

Round 2 survey data is presented in the following tables show the response levels for Round 1 and solicited close-ended answers for Round 2. Respondents were asked to review the findings relative to the case studies, indicate if they still agreed that the category should be addressed, and specifically, whether the category should be addressed for Joe (Case One), Mary (Case Two), both or neither (see Appendix E).

Differences were noted when results were collected; Web-based responses required each item to be completed and forced a choice; the paper responses required written responses but allowed some
items to be left blank. Paper forms were entered manually by the researcher into the Web-based format. Of the eighteen respondents, only seven chose a paper format.

Items left unanswered for the seven paper responses required review of the first round open-ended answers. Choices were extrapolated from each respondent's commentary about the item in Round 1; if no discussion was evident, the category was marked neither.
In Round 3, eight of the ADL categories were chosen by more than 50% of the respondents for inclusion. Categories in the ADL section that were selected include Activities of Daily Living (overall), Bathing/Showering, Bowel/Bladder management, Dressing, Functional Mobility, Personal Hygiene and Grooming, Sexual Activity and Toilet Hygiene. Four other ADL categories (Eating, Feeding, Personal Device Care and Sleep/Rest) were excluded from this case by more than 50% of the respondents.
Agreement for either inclusion or exclusion in all categories of ADL for Case One exceeded 75% in all categories except sleep/rest.

**Occupational performance areas: IADL**

The next section of the Practice Framework addressed Instrumental Activities of Daily living (IADL) categories. Again, in the Practice Framework, IADL’s are defined as “activities that are oriented toward interacting with the environment and that are often complex—generally optional in nature (i.e., may be delegated to another).” (AOTA, 2002, p. 620).
Figure 5 illustrates the number of respondents who indicated that a category from the IADL section of the Practice Framework should be addressed as evidence of clinical reasoning in any occupational therapy intervention plan. These responses were counted as inclusive if the open-ended response of a respondent matched or was consistent with the definition of the category delineated in the Practice Framework.

In Figure 5, only the category IADL (overall) is mentioned in the narrative answers by more than 50% of respondents in Round 1.
Figure 6. Frequency of inclusion/neither scores for IADL categories for Case One Round 2.

Round 2 surveys presented respondents with tables showing the response levels for Round 1 and solicited restricted answers for Round 2. Respondents were asked to review the findings relative to the case studies, indicate if they still agreed that the category should be addressed, and specifically if the category should be addressed for Joe (Case One), Mary (Case Two), both or neither (see Appendix E).

Figure 6 indicates that in Round 2, the category Community Mobility elicited 100% agreement for inclusion (18 of the 18 respondents). This figure also indicates the respondents’ increased agreement about the exclusion of some IADL categories, as indicated by the darker bars on the right side of each category, such as Care of Others, Child Rearing or Shopping.
By Round 3, respondents agreed on inclusion of four IADL categories, and exclusion of six IADL categories. Figure 7 indicates the rate as it relates to the 50% level of agreement (9/18). Figure 8 more clearly indicates those items where agreement was greater than 75%.
Figure 8. Percentage agreement for inclusion or exclusion for IADL categories Case One Round 3. Strong consensus exists in categories with > 75% agreement.

Agreement for inclusion in the categories of IADL overall, Community Mobility and Safety Procedures/Emergency responses exceeded 75%; the categories of Care of Others, Care of Pets and Shopping also reached more than 75% agreement regarding exclusion. The categories entitled Financial Management and Meal Preparation and Cleanup did not show sufficient agreement among the respondents for a conclusion of either inclusion or exclusion at any level.

The next section relates to the remaining categories in the Areas of Occupation section of the Practice Framework.
Other areas of occupation: Education, Work, Play, Leisure, Social participation.

The final 15 categories in the section Areas of occupation are displayed below. Altogether, the ADL, IADL, and other areas of occupation relate to those kind of activities in which individuals engage as part of their daily lives.

Figure 9: Frequency of inclusion scores for Other Areas of Occupation categories for Case One Round 1.

Figure 9 displays the number of respondents who indicated that a category from the Other Areas of Occupation section of the Practice Framework should be addressed to evidence clinical reasoning in any occupational therapy intervention plan, the answers were counted as
inclusive if the response matched or was consistent with the terms in the definition of the category as delineated in the Practice framework.

For the remaining categories of this section of the Practice Framework, more than 50% (9/18) of the respondents indicated inclusion of three categories in the first round: Work (overall), Leisure (overall), and Social participation.

![Diagram showing frequency of inclusion or neither scores for Other Areas of Occupation for Case One Round 2.]

Figure 10. Frequency of inclusion/norther scores for Other Areas of Occupation for Case One Round 2.

Agreement about the inclusion of nine categories in this section following Round 2 is shown in Figure 10. More than 75% of respondents indicated inclusion of Leisure (overall), Leisure exploration, Leisure
Participation, Social Participation and the related categories of Community, Family and Peer/Friend; since agreement >75% was reached at this point, further selection of these categories in Round 3 was unnecessary. 100% agreement was reached about the inclusion of Job Performance during this round as well. None of the inclusion categories were noted as “neither” in this round with the exception of Leisure Exploration, which was selected by one respondent; thus, there are no darker bars on the graph in Figure 10.

![Graph](image)

Figure 11. Frequency of responses to inclusion, exclusion or neither in the other areas of occupation categories for Case One Round 3.
Figure 11 demonstrates an increase in agreement in five categories marked for exclusion (Education, Employment Interests and Pursuits, Employment Seeking and Acquisition, Retirement Preparation and Adjustment, Volunteer Exploration and Volunteer Participation) by the respondents with levels of more than 50%.

![Final consensus percentages Case One](image)

As shown in Figure 12, eight categories were agreed upon for inclusion as well as three for exclusion with responses > 75% for the
section of Areas of Occupation, the category of Retirement Preparation had a low response rate (only 14), so the 9 responses which appear as 50% (on the scale of 0-100 participants) were actually 64%, thus suggesting a majority level of consensus. The category of Play also received only 15 responses, but the responses were evenly split among include (six responses), and exclude (seven responses), and therefore do not have a level of agreement necessary to suggest consensus. Only one respondent indicated a "neither" response.
Performance Skills: Motor Skills, Process Skills and Communication/Interaction Skills

The section of the Practice Framework entitled “Performance Skills” refers to “features of what one does, not what one has, related to observable elements of action that have implicit functional purposes.” [AOTA, 2002, p. 421].

![Figure 13. Frequency of inclusion scores for Performance Skills categories for Case One Round 1.]

Figure 13 displays the number of respondents who indicated that a category from the Performance Skills section of the Practice Framework should be addressed as evidence of clinical reasoning in...
any occupational therapy intervention plan. Three categories were identified by respondents for inclusion relative to this case in the section of Performance skills: Motor Skills (overall), Mobility and Energy.

![Case One Round 2](image)

**Figure 14.** Frequency of inclusion/neither scores for performance skills Case One Round 2.

More than 10 categories of performance skills were selected by respondents for inclusion in Round 2. Two (Mobility and Energy) reached 100% agreement and therefore consensus in this round.
The third round responses for the categories in the section of the Practice Framework entitled "Performance Skills" demonstrated agreement > 75% for eight categories for inclusion (see Figure 16) and two excluded categories. Three more categories (Knowledge, Temporal Organization and Communication/Interaction Skills - overall) were agreed to be appropriate for exclusion. The categories of Motor Skills; Coordination and Communication/Interaction skills - Relations" did not achieve agreement for either inclusion or exclusion as demonstrated in Figure 16.
Figure 16: Percentage agreement for inclusion or exclusion for Performance skills categories Case One Round 3. Strong consensus exists in categories with > 75% agreement.

No agreement was reached for the Motor skill category of coordination or the Communication/Interaction skill category of Relations.
Performance Patterns: Habits, Routines and Roles

This section of the Practice Framework relates to "patterns of behavior related to daily life activities that are habitual or routine." (AOTA, 2002, p. 623.)

Figure 17 displays the number of respondents who indicated that a category from the Performance Patterns section of the Practice Framework should be addressed as evidence of clinical reasoning in any occupational therapy intervention plan.
More than 50% of respondents indicated the inclusion of overall Habits, Routines and Roles in their narrative responses in the first round.

![Performance Patterns](image)

**Figure 16.** Frequency of inclusion/exclusion scores in Performance Patterns categories for Case One Round 2

More than 50% of respondents indicated the inclusion of Habits (overall), Routines and Roles in this round.
In the third round, more than 75% of respondents agreed on inclusion for the categories Habits (overall), Routines and Roles. All respondents (18/18) agreed that the category of Dominating Habits should be excluded.
The three categories (Habits overall, Routines and Roles) which respondents identified in the first round generated very strong agreement by the third round for inclusion. No agreement for exclusion or inclusion was generated for either Useful or Impoverished Habits.
Contexts

According to the definitions in the Practice Framework, "context (including cultural, physical, social, personal, spiritual, temporal and virtual) refers to a variety of interrelated conditions within and surrounding the client that influence performance." (AOTA, 2002, p. 623).

Figure 21. Frequency of inclusion scores for Contexts categories Case One Round 1.

Figure 21 displays the number of respondents who indicated that a category from the Contexts section of the Practice Framework should be addressed as evidence of clinical reasoning in any occupational therapy intervention plan.
Respondents indicated agreement about inclusion of Physical, Social and Personal contexts in their open-ended responses. Other contexts were not mentioned; one respondent indicated in this round that there was no mention of Spirituality in any of the case narrative.

![Case One Round 2](image)

*Figure 22. Frequency of inclusion/neither scores for Context categories Case One Round 2.*

Round 2 of the Delphi demonstrated agreement for inclusion on all of the categories in this section. Round 3 and percentage figures demonstrate the strength of agreement for inclusion in these categories. Note agreement was > 50% in all categories even in the second round.
In the third round, inclusion of two categories (Contexts-overall and Social context) was agreed upon by 100% of the respondents for Case One.
Figure 24. Percentage of agreement for inclusion or exclusion for context categories Case One Round 3. Strong consensus exists in categories with >75% agreement.

All of the categories in the Context section of the Practice Framework were selected by the respondents for inclusion.

**Activity Demands**

The Practice Framework (AOTA, 2002) defines Activity Demands as "the aspects of an activity, which include the objects, space, social demands, sequencing or timing, required actions, and required body functions and body structure needed to carry out the activity." (p. 624).
Figure 23. Frequency of inclusion scores for Activity Demands categories for Case One Round 1.

Respondents showed agreement on five of the categories in the Activity demands section of the Practice Framework in Round 1. Figure 25 displays more than 50% agreement for the categories of Objects and their Properties, Space Demands, Required Actions, Required body Functions and Required Body Structures.
Figure 26. Frequency of inclusion/neither scores for Activity Demands categories Case One Round 2

Round 2 responses strengthened agreement for inclusion in all Activity Demands categories.
Figure 27. Frequency of responses to inclusion, exclusion or neither in categories of Activity demands for Case One Round 3.

In Round 3 of this section, respondents indicated that all categories of Activity Demands should be included. Figure 28 also shows that all categories were selected for inclusion by >75% of the respondents. All categories of the Practice Framework in the Activity Demands section would be included by any of the respondents.
Client Factors

The final section of the Practice Framework used in this study is Client Factors, and is defined as:

Those factors that reside within the client and that may affect performance in areas of occupation. Client factors include body functions and body structures. Knowledge about body functions and structures is considered when determining which functions and structures are needed to carry out an occupation/activity and how the body functions and structures may be changed as
a result of engaging in an occupation/activity. Body functions are the ‘physiological functions of body systems’; body structures are ‘anatomical parts of the body such as organs, limbs and their components’. (AOTA, 2002, p. 624).

![Graph showing frequency of inclusion scores for Client factors categories in Case 1 Round 1.]

Figure 29: Frequency of inclusion scores for Client factors categories in Case 1 Round 1.

Strong agreement in this section on Round 1 was limited to inclusion of neuromusculoskeletal and movement-related functions and exclusion of voice and speech functions. 50% of the respondents...
mentioned inclusion of mental functions and sensory functions and pain.

Figure 30. Frequency of inclusion/neither scores for Client Factors: Case One Round 2.

Figure 30 indicates stronger agreement in the previously selected categories and adds agreement for inclusion of three more Client Factor categories: Body Functions categories (overall), Genitourinary and Reproductive Functions and Skin and Related Structures Functions.
Figure 31. Frequency of responses to inclusion, exclusion or neither in Client factors: Case One Round 3.

100% agreement for exclusion was reached for voice and speech functions for Case One in Round 3.
In the section of the Practice Framework entitled Client Factors, respondents reached strong agreement (greater than 75%) on inclusion of the overall categories of Body Functions, Mental Functions, Sensory Functions and Pain, Neuromusculoskeletal and Movement-related functions and Skin and Related Structures Functions. Exclusion was suggested for the category of Voice and Speech functions by >75% of the respondents. No agreement was reached for Cardiovascular and Digestive categories.
Delphi Technique Results for Case Two: Mary Price

Occupational performance areas: ADL

Activities of Daily Living (ADL) as defined by the Practice Framework include “activities that are oriented toward taking care of one’s own body” (AOTA, 2002, p. 630).

Figure 33. Frequency of inclusion scores for ADL categories for Case Two Round 1.

Figure 33 displays the number of respondents who indicated that a category from the ADL section of the Practice Framework should be addressed as evidence of clinical reasoning in any occupational therapy intervention plan. The answers were counted as inclusive if the
response matched or was consistent with the terms in the definition of the category as delineated in the Practice Framework.

In this round for Case Two, overall ADL showed strong agreement for inclusion.

Figure 34. Frequency of inclusion/nor scores for ADL categories for Case Two Round 2.

The category of Functional Mobility reached 100% agreement for inclusion in Round 2, and therefore was presented in Round 3 in the data table rather than as a choice.
Round 3 data showed agreement >75% for inclusion for ADL overall, Dressing, Functional Mobility and Toilet Hygiene. Categories excluded by >75% of respondents for this case were Bowel/Bladder Management, Eating, Feeding and Personal Device Care. No agreement was reached for Personal Hygiene and Grooming.
As in Case One, the data from Round 3 was converted into percentages to determine the strength of consensus for each category, whether included, excluded or neither.
Occupational performance areas: IADL

The next section of the Practice Framework addressed Instrumental Activities of Daily living (IADL) categories. IADLs are "activities that are oriented toward interacting with the environment and that are often complex – generally optional in nature (i.e., may be delegated to another)." (AOTA, 2002, p. 620).

Figure 37: Frequency of inclusion scores for IADL categories for Case Two Round 1.

Figure 37 indicates that for this case, only the general category of IADL (overall) was chosen by > 50% of the respondents in Round 1.
Figure 38. Frequency of inclusion/neither scores for IADL categories for Case Two Round 2.

Respondents indicated agreement for inclusion of IADL (overall), Community Mobility, Meal Preparation and Cleanup, Safety Procedures and Emergency Responses and Shopping for Case Two in this round.
The third round of the Delphi yielded agreement of the respondents on all categories in this section of the Practice Framework. Three of the categories – Care of Pets, Child Rearing and Communication Device Use – were excluded by 100% of the respondents; the respondents also agreed unanimously to include Community Mobility for Case Two.
Figure 40. Percentage agreement for inclusion or exclusion of IADL categories for Case Two Round 3. Strong consensus exists in categories with > 75% agreement.

Strong agreement of > 75% by respondents for inclusion of five IADL categories was reached as well as exclusion of five IADL categories. 12 respondents selected the category of Home Establishment and Maintenance for inclusion (see table F39 in Appendix F); it was excluded by four respondents and marked “neither” by two. No agreement was reached about the category of Health Management and Maintenance.
Other areas of Occupation: Education, Work, Play, Leisure, Social participation.

The final 15 categories in the section Areas of Occupation are displayed below. All together, the ADL, IADL, and other Areas of Occupation relate to those kind of activities in which individuals engage as part of their daily lives.

![Case Two Round 1](image)

Figure 41. Frequency of inclusion for Other areas of occupation categories Case Two Round 1.

In Round 1 for this section of the Practice Framework, respondents identified three categories for inclusion for Case Two. Figure 41 displays:
inclusion of Work (overall), Leisure (overall) and Social participation (overall).

![Graph showing frequencies of inclusion and neither for various categories](image)

**Figure 42.** Frequency of inclusion/neither scores for other areas of occupation categories Case Two Round 2.

Round two responses indicated inclusion of nine categories by more than 50% of the respondents. Furthermore, 100% (18/18) indicated that the category of Job Performance should be included for this case.
In the third and final round, nine of the other areas of occupation categories (Work-overall, Job Performance, Leisure-overall, Leisure Exploration, Leisure Participation, Social Participation-overall, Community, Family and Friend/Peer) were chosen by > 50% of the respondents for inclusion. Four categories (Employment Interests and Pursuits, Employment Seeking and Acquisition, Volunteer Exploration and Volunteer Participation) were excluded from Case Two by > 50% of the respondents.
Agreement of 100% for inclusion was reached in the categories of Job Performance, Social Participation with Family and Social Participation with Peers/Friends. Strong agreement (>75%) was also reached for the categories of Leisure (overall), Leisure Participation and Leisure Exploration as well as Social Participation (overall). Respondents strongly indicated exclusion of the categories of Employment Seeking and Acquisition and Volunteer Participation for this case. No
agreement was reached for the categories of Retirement Preparation and Adjustment or Play.

Performance Skills: Motor skills, Process Skills and Communication / Interaction Skills

The section of the Practice Framework entitled “Performance skills” refers to “features of what one does, not what one has, related to observable elements of action that have implicit functional purposes.” (AOTA, 2002, p. 621).

Figure 45. Frequency of inclusion scores for Performance skills categories for Case Two Round 1.
Figure 45 displays the results of Round 1 regarding Performance skills categories. In Round 1, > 50% of the respondents indicated that both the Mobility and Energy categories should be included in any occupational therapy intervention plan for Case Two.

![Case Two Round 2](image)

Figure 46. Frequency of inclusion/neither scores for Performance skills categories for Case Two Round 2.

Eight categories of Performance Skills were selected by respondents for inclusion in Round 2 (Motor Skills-overall, Posture, Mobility, Strength and Effort, Energy, Process Skills-overall, Organizing Space and Objects and Adaptation).
Categories identified by > 50% of respondents in Round 3 for inclusion in this section include Posture, Process skills (overall), and Organizing space and objects. Respondents (> 50%) agreed that Coordination, Communication/Interaction skills (overall) and Relations should be excluded relative to Case Two.
Agreement for inclusion of the category of Mobility reached 100%. Other categories agreed for inclusion by respondents were Motor skills (overall), Strength and Effort, Energy (in both Motor Skills and Process Skills categories) and Adaptation. Respondents agreed strongly that the category of Information Exchange in this section of the Practice Framework for Case Two should be excluded. No agreement was reached regarding the categories of Knowledge.
Temporal Organization or Physicality (in Communication/interaction skills).

Performance Patterns: Habits, Routines and Roles
This section of the Practice framework relates to “patterns of behavior related to daily life activities that are habitual or routine.” (ACTA, 2002, p. 523.)

Figure 49. Frequency of inclusion scores for Performance patterns categories for Case Two Round 1.

The categories of Routines and Roles were noted for inclusion in the narrative responses of Round 1 for Case Two.
Figure 40. Frequency of inclusion/neither scores for Performance patterns categories for Case Two Round 2.

Respondents (> 50%) suggested the inclusion of the categories of Habits (overall), Routines and Roles in Round 2.

Figure 51. Frequency of responses to inclusion, exclusion or neither in Performance patterns categories for Case Two Round 3.
Habits-impo\-ver\-ished was excluded by > 50%. Habits-Dominating (>
75%) was also excluded as a category that was relevant to Case Two.

Figure S2: Performance patterns categories and final percentage of consensus for Case Two.

Agreement for either inclusion or exclusion > 75% for four of the six
categories in this section of the Practice Framework for this case. No
agreement was reached for the category of Habits-Useful for this case.
Contexts

According to the definitions in the Practice Framework, “context (including cultural, physical, social, personal, spiritual, temporal and virtual) refers to a variety of interrelated conditions within and surrounding the client that influence performance.” (AOTA, 2002, p. 623).

Figure 53. Frequency of inclusion scores for Context categories for Case Two Round 1.

Figure 53 indicates that > 50% of respondents indicated agreement about inclusion of Physical, Social and Personal Contexts in their open-ended responses.
The second round of the Delphi demonstrated agreement for inclusion on all of the categories in this section, with the exception of Virtual Context. Round 3 percentage figures demonstrate the strength of agreement for inclusion in these categories. Note agreement was more than 50% in all categories except the Virtual Context category.
The category of Virtual in the Context section did not achieve agreement for inclusion or exclusion in Round 3 for Case Two, as demonstrated in Figure 55. There were eight responses indicating inclusion, six which indicated exclusion and four which did not indicate to either include or exclude this category for this case.
Figure 56. Percentage agreement for inclusion or exclusion for Context categories Case Two Round 3. Strong consensus exists in categories with >75% agreement.

Case two responses for this section of the Practice Framework did reach agreement of >75% about the inclusion of Context (overall), Physical, Social, Personal, Spiritual and Temporal categories and slightly weaker agreement (>72.2%) about the inclusion of Cultural context.
Activity Demands

The Practice Framework (ACTA, 2002) defines activity demands as “the aspects of an activity, which include the objects, space, social demands, sequencing or timing, required actions, and required body functions and body structure needed to carry out the activity.” (p. 624).

Figure 57, Frequency of inclusion scores for Activity demands categories for Case Two Round 1.

Figure 57 demonstrates that respondents showed agreement of five of the categories (Objects and Their Properties, Space Demands, Required Actions, Required Body Functions and Required Body
Structures in the Activity Demands section of the Practice Framework even in Round 1.

![Case Two Round 2 Diagram]

Figure 58. Frequency of inclusion/neither scores for Activity demands categories for Case Two Round 2.

Note that in Round 2 for this case, all categories in the Activity Demands section of the Practice Framework were included by ≥ 50% of the respondents. None of the categories were disputed in this round for Case Two.
Figure 59: Frequency of responses to inclusion, exclusion or neither in the Activity demands categories for Case Two Round 3.

In the final round (Figure 59), all categories continued to exhibit > 50% agreement for inclusion. Figure 60 further indicates that the categories of Sequence and Timing did not achieve strong agreement (> 55%), but did have enough majority agreement for inclusion. Required Actions reached 72.2% agreement for inclusion.
Client Factors

The final section of the Practice Framework used in this study is client factors, and is defined as:

Those factors that reside within the client and that may affect performance in areas of occupation. Client factors include body functions and body structures, knowledge about body functions and structures, is considered when determining which functions and structures are needed to carry out an occupation/activity.
and how the body functions and structures may be changed as a result of engaging in an occupation/activity. Body functions are the 'physiological functions of body systems'; body structures are 'anatomical parts of the body such as organs, limbs and their components. (AOTA, 2002, p. 624).

![Case Two Round 1](image)

Figure 6.1. Frequency of inclusion scores for client factor categories for Case Two Round 1.

The open-ended responses from Round 1 related to Case Two indicated inclusion of Neuromusculoskeletal and Movement-Related Functions for Case Two.
Figure 62. Frequency of inclusion/neither scores for Client factor categories for Case Two Round 2.

Round 2 for Case Two additionally indicated >50% agreement about the inclusion of Body Function categories (overall), Sensory Functions and Pain, and Body Structure categories. Exclusion of Voice and Speech functions was indicated in this round by a choice of neither by nine respondents.
Figure 63. Frequency of responses to inclusion, exclusion or neither in Client factors categories for Case Two Round 3.

Figure 64. Percentage agreement for inclusion or exclusion for Client factors categories for Case Two Round 3. Strong consensus exists with >75% agreement.
Agreement about all of the Client Factors categories was strong with the exception of Mental Functions. Four categories (Body Function overall, Sensory Functions and Pain, Neuroniusculoskeletal and m
Movement-Related functions and Body Structure categories were all selected by > 75% of the respondents. Five categories (Cardiovascular, etc.; Voice and Speech functions; Digestive, etc.; Genitourinary and Reproductive functions; and Skin and Related structures functions) were also strongly excluded for this Case Two.
Chapter 5

DISCUSSION

The purpose of conducting the Delphi study rounds was to gather data about experts' opinions regarding the content of two specific multimedia case studies in order to explore clinical reasoning in a systematic way. The content of the cases was reviewed using the categories of the Practice Framework to elicit experts' opinions about content inclusion or exclusion, and convert the opinions into consensus levels. The consensus levels provide the basis for a scoring tool (in the form of a matrix) which can then be developed using the selected categories as evidence of clinical reasoning.

Formation of Consensus

Tuoroff and Hiltz (1998) suggested that one of the misconceptions of the Delphi is that it is a method for generating a quick consensus. From start to finish, this process took approximately 11 months. The study concluded once participation by the 16 respondents for all three rounds was achieved. It did, however, allow for individuals of diverse backgrounds and views to "combine opinion into group consensus"
(Hasson, 2000, p. 1010). Clearer inclusion criteria for participants that defined a level of technological expertise might have identified respondents with a higher ability to use the on-line format. This might have accelerated the process, but conversely might have prohibited the participation of the experts who asked for a paper survey and CD materials.

In the first round, individual responses suggested a wide interpretation of the task. Some respondents appropriately answered the request to 'identify the section of the Practice Framework that you feel would be evidence of clinical reasoning by any occupational therapist for the clients in these case studies' by using just the broad terms taken directly from each section, producing a list of categories. In contrast, other respondents produced responses with great written detail related to the narrative aspects of the cases; they specifically were about the categories to be included in Case 1 and Case 2. Another respondent reacted to the case in a highly unstructured manner, commenting on elements in each case that she felt demanded her attention ('commuting on train to NYC will not be feasible in the long run').

While the reception of such varied responses made analysis of the first round difficult, using the Practice Framework definitions as a basis
One purpose of the study was to provide a valid basis for comparison of expert opinions and the development of consensus relative to evidence of clinical reasoning through the use of the multimedia case studies. The other identified purpose of this study was to "generate consensus-based evidence in the form of identified case elements". This evidence was gathered as "the opinions of expert occupational therapists about what areas should be addressed by any therapist, regardless of level of expertise." The use of the Practice Framework items allowed for a comparison of the expert opinions in that it forced the experts to identify the case elements using uniform terms, and then to choose which terms should be addressed. Thus, there 18 respondents used the same language and the same two cases to define what they considered to be the categories which occupational therapists should address.
Interpretation of Findings

For Case One (Joe Remora), there was strong agreement (>75%) about the inclusion of 51 categories. Three more categories were included by < 75% agreement needed for strong consensus, but represented the opinions of 12 of the 18 respondents. Another two categories were identified by ten respondents. In total, 56 categories were selected for inclusion with more than 51% agreement which was identified in the literature (McKenna, 1994) as the basic level of consensus. The listing of these categories in a scoring tool (in a matrix format) is representative of the experts’ opinions that these categories should be addressed in any treatment plan for Case One by any occupational therapist. Exclusion of the 21 categories identified by the respondents as not indicative of clinical reasoning in this case further determines what categories should appear in the scoring tool. The eleven categories that did not reach majority (51-64%) agreement for inclusion or exclusion are not listed on the scoring matrix, as there is not sufficiently strong support for their inclusion as being indicative of good clinical reasoning.
In Case Two, 42 categories were included by > 75% of the respondents. Eight more categories were included by > 65% respondents, and two more by more than half of the respondents. The scoring matrix for this case includes 52 of the 88 categories of the Practice Framework. 25 items were excluded from this case and therefore are not included on the scoring matrix for Case Two. The scoring matrix does not include the eleven items that were not agreed upon.

Individuality and Generalizability of the Responses

As noted above, there were differences in the number of categories chosen by respondents for inclusion for each of the cases. This was not unexpected, as the narrative content of the cases was different for both diagnostic and medical information as well as occupationally relevant life choices and activities identified by each of the protagonists in each case. The content of the cases, especially in the open-ended responses of the first round, are the basis for the differences in what categories were selected by the respondents for each case.
Differences in the categories selected for inclusion related to the client limitations and occupational choices described in the narratives of each case. For example, in the section of the Practice Framework for ADL, two categories were selected for inclusion for Case One (Joe Remora): Bowel/Bladder Management, and Personal Hygiene and Grooming. The experts in this study excluded Bowel/Bladder Management for Case Two (Mary Price) and would consider, based on the information in the case, that intervention to address this issue for this client would not be reflective of good clinical reasoning. The same would be true of intervention to address Personal Hygiene and Grooming for Case Two; the implication of such intervention for the diagnosis of total hip replacement (THR) in a managed care environment is that it could lead to denial of reimbursement for occupational therapy services for this client.

Explicit differences were seen in other sections of the cases. While selection of the category “Health Management and Maintenance” would be important for Case One, where Joe Remora has an ongoing long-term condition, the need for this category for the second case would be only temporary, relating to healing of the hip fracture. One might question the inclusion of the categories of Home Establishment and Maintenance, Meal Preparation and Cleanup and Shopping for
Case Two and not Case One. This discrepancy raises the question whether the choice was made based on the diagnostic and occupational needs of the client in the cases or whether such decisions reflect a gender bias about the activities one might expect each to do. Similarly, the presence of a wife in Case One may also have some impact on the choices made by the respondents; in contrast, Mary Price, the protagonist in Case Two, lives alone.

Respondents' choices for inclusion in the Other Areas of Occupation, Performance Skills, Performance Patterns and Activity Demands sections were uniform across the two cases. One notable difference is the inclusion of Virtual Context for Case One and not for Case Two. This reflects that the case content was individualized. At one point in the narrative for Case Two, Mary declares that she does not like computers or on-line communication; Joe, in Case One, is a regular member of several virtual communities.

Not surprisingly, categories selected for inclusion differed most in the area of Client Factors. Functional categories related to physiology and pathophysiology identified for each of the cases were closely and appropriately related to case information. Intervention plans that did not address the specific impact of these functions for each of the
clients in these cases can be seen as missing important information and would not be considered reflective of good clinical reasoning.

Clearly each case requires its own scoring tool which reflects the opinions of the experts relative to the inclusion of case-specific categories. To generalize the matrix to both cases could potentially lead one to ignore the specific needs of each client and would not necessarily reflect appropriate clinical reasoning as identified by the experts. Since the purpose of this study was to use the expertise of the respondents to generate agreement about the information in each case that would guide an intervention plan, a generalized matrix would not offer enough specificity for scoring clinical reasoning.

Limitations of the Study

Occupational Therapy Practice Framework Issues

The Occupational Therapy Practice Framework replaced the Uniform Terminology III document published in 1994. The Practice Framework, although published initially in 2002, is a work in progress and an ongoing activity of the American Occupational Therapy Association’s Commission on Practice. It represents agreement by
practitioners, educators and experts as well as representatives of the profession from each state about the best way for occupational therapists to share a common understanding and vocabulary relative to the domain and process of occupational therapy services. Use of the Practice Framework was determined to be the most updated set of terms familiar to all respondents and thus was appropriate for this study.

Interestingly, the Practice Framework was not embraced equally by all the respondents in this study. One respondent was concerned about her participation in the study as she felt her “clinical reasoning would fall outside of the Practice Framework model”. Another respondent stated frankly that she would answer questions as she was able, but did not like the Practice Framework categories. At one point in Round 2, a prominent participating author suggested that some of the components were “redundant.”

The items for which consensus was not found may reflect respondents’ dissatisfaction with the Practice Framework terminology rather than lack of agreement regarding inclusion or exclusion of a category. It was also interesting to note that despite the complaints from the U.S. respondents, the non-U.S. respondents did not express difficulty using the Practice Framework terms. This difference may be
related to the understanding of the terms that were taken from the International Classification of Functioning, Disability and Health from the World Health Organization by the Practice Framework authors (AO1A, 2002, p. 637).

Some respondents did make comments about the Practice Framework that indicated an unwillingness or discomfort with the categories. Despite those differences of opinion, respondents came together and indicated overall 87.5% agreement on the inclusion or exclusion of the 88 categories that were used in this study, which according to the literature (Hasson, 2000, McKenna, 1994) is considered strong consensus.

The Size of the Delphi Cohort

The 18 respondents in this study, as described in the demographic section of the Results Chapter are consistent with the type of experts described in the Delphi literature. Powell (2002) notes that “experts should be chosen for their work in the appropriate area and credibility with the target audience” (p. 379). She also quotes Murphy et al. (1998) in her assertion that “there is very little empirical evidence on the effect of the number of participants on the reliability or validity of consensus processes (p. 378).”
The expertise of this cohort is its strength, the combination of authors and faculty tapped the resources of the occupational therapy profession in the dimensions where clinical reasoning is most often discussed, taught and researched. The addition of clinical expertise in the form of board-certified in neurorehabilitation therapists promoted the inclusion of clinical reasoning used in ongoing “real life” practice.

One concern about the expertise of this cohort does arise when examining their credentials (which in a Delphi study, remain available only available to the researchers). Clinical reasoning literature in occupational therapy has been generated by a small number of authors. Some of the respondents who are ‘author experts’ may have influenced the development of reflection and awareness of clinical reasoning in the remainder of the respondent pool via their writing. Thus, the pool of experts could be said to be limited to those who share similar views about clinical reasoning in occupational therapy.
Number of Delphi Rounds

The literature addressing the use of the Delphi technique emphasizes that the expertise and methodology of the technique should be based on the desired outcome. The desired outcome in this study was to collect the opinions of the experts. The decision to use three rounds instead of four for this study was based on both the literature and the time constraints of the respondents. Continuing the study beyond three rounds would have increased the time commitment of the respondents for a minimal return of data. This inference is consistent with both Hasen (2000) and Powell (2003), who point to the need to balance time, expenses and possible participant fatigue with data returns. The high rate of consensus (87.5% for each case) achieved after Rounds 2 and 3 of this study suggests that data saturation had been reached and further consensus through a fourth round would not have substantively affected the overall outcomes or the final iteration of the matrix.
Use of Only Two Cases

Development of additional case studies would likely enhance the ability of the proposed tool to evaluate differences in clinical reasoning. At this time, only two multimedia cases exist. The definitions for the categories in the Practice Framework allowed for qualitative analysis of the open-ended responses of Round 1. Cases which presented similar diagnostic information but different narrative aspects may further determine levels of clinical reasoning and so, should be developed.

The purpose of this study, to explore consensus regarding case study information within the Practice Framework language for later use in the assessment of clinical reasoning generated 1584 data points in each round for each case. The detail in the multimedia cases, similar to the detail in a live case, allowed respondents to make decisions regarding inclusion or exclusion of specific categories. Shorter cases or less detailed presentations would not have been able to offer information for all 88 categories.
Chapter VI

SUMMARY AND CONCLUSIONS

The strength of the Delphi technique rests on the design of the study and the expertise of the experts as well as interpretation of consensus. (Kennedy, 2004). The individuals who participated in this study had a wealth of experience, with a mean of 23 years of professional activity. Even the least experienced individuals had 11 years of experience and demonstrated interest in furthering their expertise beyond that acquired in entry-level education.

In an exploratory study of the differences between experts' and novices' perceptions of clinical reasoning, Strong et al. (1995) suggest that "it would be interesting to compare the clinical reasoning skills of these experts with those of the students in a particular case" (p. 122). This suggestion exemplifies the purpose of this study: the exploration of what should be addressed in an intervention plan, regardless of the level of expertise of the therapist.

The hypothesis of gaining consensus about the categories of the Practice framework was confirmed by the data from the two cases
that reached a level of 87.5% agreement across each of the cases. The categories that did not reach consensus at any level for either inclusion or exclusion might be said to be possible areas for an occupational therapist to address in an intervention plan, but the lack of agreement indicates that few experts saw these areas as very important to the occupational therapy intervention outcome. Recall that the selections made by the respondents are offered as indicators that show clinical reasoning.

It, as Benorrty (1997) and Cohn and Czycholl (1991) indicated, clinical reasoning can only be studied inferentially, then only analysis of the results of clinical reasoning provide data to evaluate it. The most concrete outcome of clinical reasoning is intervention on behalf of a client. Occupational therapy intervention plans address the needs of clients; in this study, the needs of Joe Remora and Mary Price have been identified by experts using the categories and terminology of the Practice Framework. These components can then be included in a matrix. A distinctly different scoring matrix (Appendix G) particular narrative of each case allows for evaluation and analysis of intervention plans developed by students or therapists for these clients. This analysis can facilitate development of course content or fieldwork.
experience to meet the needs of the student or facilitate professional
development plans for practicing therapists.

Development and use of the matrix for each case can also result in
grading criteria for the strength of the reasoning process. For instance,
the grading criteria may include: no evidence of clinical reasoning if a
category is absent in an intervention plan; minimal evidence of clinical
reasoning is evident if the category is mentioned as problematic but
solutions are not suggested; and strong evidence of clinical reasoning
is evident if the category is mentioned and addressed in the
intervention plan. Students and clinicians can address their own
knowledge and expertise level using these grading criteria; with this
assessment, students and clinicians can identify strengths and areas of
improvement to be addressed in professional development plans.

Directions for Further Research

This study has provided data for the development of two scoring
tools to further investigate clinical reasoning in occupational therapists.
At present, the grading of the tool would simply indicate the presence
or absence of the categories in intervention plans done by students or
therapists. (Such a process is described above.)
A future project might use the cases and the matrices to compare intervention plans of therapists who have either been identified by their peers as experts, or therapists who have worked with a given population for several years. Correlation of these groups may assist in new understanding about the levels of reasoning (similar to those identified by Benner [1984] for nursing) displayed by occupational therapists with various types and amount of experience.

Another area for future research related to the findings of this study involves the use of exemplars. Benner (1994) used clinical examples of the type of reasoning displayed by nurses at each level of clinical reasoning (novice through expert) and for each type of reasoning. To date, no such exemplars exist for occupational therapy. Exemplar cases developed for occupational therapy would then require both content validation and analysis similar to the Delphi analysis in this study.

The use of specifically tailored scoring matrices for continuing education and professional development could be expanded with further validation of each matrix relative to specific cases. While this study used the expertise of a variety of esteemed experts from a wide geographic distribution, a similar process could be done in a focus group with recognized at a conference, or as part of an in-house
activity at a clinical site with local experts. Such matrices may be useful in facilitating the acquisition of clinical reasoning skills for a particular client population by new employees in a given setting. Self-reflection and/or mentoring activities which utilize a contrast and compare method of case-based intervention plans might also offer a practical hands-on method of professional development in such a setting.

As part of the final indicated that they found the cases informative and more like client narratives than traditional text cases. Respondents asked for a broader scope of cases to include pediatrics, mental health and other physical rehabilitation diagnoses. The development of more cases – format, content and delivery method – is another area of research that can build on the results of this study and can integrate data and the methods generated by this study.

Development of more cases and the evaluation tools to accompany them is important to the development, analysis and assessment of clinical reasoning in students by educators. Advanced cases offering complexity in contexts, client information or available treatment resources could also aid in the further development of advanced reasoning in more experienced occupational therapists.
References


Appendix A - Occupational Therapy Practice Framework

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(included with permission)
OCCUPATIONAL therapy is an evolving profession. Over the years, the study of human occupation and its components has enlightened professionals about the rich concepts and language that undergird occupational therapy practice. In addition, occupational therapists' roles and contributions to society have expanded to include new areas of focus. The "Occupational Therapy Practice Framework: Domain and Process" (© 2008 American Occupational Therapy Association; © 2014 American Occupational Therapy Association) outlines new roles and responsibilities for occupational therapists and is based on a thorough review of research and practice. This document is intended to be a resource for occupational therapists to use in their professional practice and to guide the development of new roles and responsibilities. The framework is designed to be a living document, allowing for continuous evaluation and revision as new knowledge and best practices emerge. The "Occupational Therapy Practice Framework: Domain and Process" is a comprehensive guide that provides a framework for occupational therapists to use in their practice, education, and research. It is a tool for occupational therapists to use in their daily practice, and it is intended to be a resource for occupational therapists to use in their professional development.
descriptions of the process will assist readers in understanding how occupational therapy and occupational therapy assessment apply their knowledge and skills in helping people adapt and resume daily life activities that support function and health.

The Occupational Therapy Practice Framework: Domain and Process begins with an explanation of the profession's domain. Each section of the framework is fully described. An introduction to the occupational therapy process follows with key aspects that highlight important points. Each section of the process is then, specifically described. Numerous resources are included, including appendices, a glossary, references, a bibliography, and the background of the development of the Frameworks are supplied at the end of the document.

Domain

The Domain of Occupational Therapy

"A profession's domain is concerned with those areas of human experience in which practitioners of the profession offer assistance to clients." (Moller, 1991, p. 51). Occupational therapists and occupational therapy assistants focus on enabling people to engage in daily life activities that they find meaningful and purposeful. Occupational therapy's domain arises from the profession's interest in human beings' ability to engage in everyday life activities. The broadness of the occupational therapy domain and its mission to capture the breadth and meaning of "everyday life activities" is occupational therapy. The profession, as used in this document, is defined in the following way:

"everyday life: named, organized, and given value and meaning by individuals and a culture. Occupation is something that people do to satisfy themselves, including looking after themselves. "Occupation" and 'daily life' are continuing to be social and economic forces of social communications. Law, Paludan, Hepworth & Townend, 1991, p. 3).

Occupational therapists and occupational therapy assistants practice expertise in this knowledge of occupation and how engaging in occupation can be used to affect human behavior and the effects of human and disability. When working with clients, occupational therapists and occupational therapy assistants direct their effort toward helping clients perform. Performance changes are directed to support engagement in meaningful occupations that subsequently affect health, well-being, and the environment.

The purpose of providing occupational therapy intervention may involve the intrapersonal use of occupation as a "means" to assist in changing function. The "ends" of the occupational therapy intervention process occurs with the client's intrapersonal satisfaction in meaningful occupations.

Both terms, "occupation" and "activities," are used by occupational therapists and occupational therapy assistants in conducting participation in daily life activities. Occupations are generally viewed as "activities having unique meaning and purpose in a person's life. Occupations are central to a peron's identity and competence, and they influence how one spends time and makes decisions. The realm activity describes a general-level human action that is goal directed (Blau, 2001). A person may participate in activities or achieve a goal, but these activities do not assume a place of central importance in meaning for the person. For example, many people participate in the activity of gathering, but not all of those individuals would describe gathering as an "occupation" that has central importance and meaning for them. Those who are gathering as an activity may argue that gathering is a chore or task that must be done as part of home and yard maintenance but that are not the same that they particularly enjoy doing it from which they derive significant personal satisfaction or fulfillment. Those who experience gathering as an occupation would ourselves as "gardeners," gaining out of their identity from their participation. They would achieve a sense of competence by their accomplishments in gathering and would report a sense of satisfaction and fulfillment as a result of engaging in this occupation. Occupational therapists and occupational therapy assistants work with both occupation and activity and recognize their importance and influence on health and well-being. They believe that the meaning and daily related to occupation such units has a distinct meaning and that individual experiences each differently. In this document, the terms are often used together to acknowledge their relationship yet recognize their different meanings.

The domain of occupational therapy frames the arena in which occupational therapy evaluation and intervention occur. To make the domain more understandable to readers and serve as a foundation, this section of the domain has been illustrated in Figure 1. As the top of the part is the overarching environment of the environment in which occupational therapy evaluation and intervention interest is placed. The other terms used in the figure identify the various aspects of the domain that occupational therapy evaluation and intervention address and address the process of providing services. The three terms at the bottom of the figure (team, activity demands, and core functions) identify areas that influence performance and potential. The three terms at the middle of the figure (performance skills, performance patterns) describe the observable performance that
the individual continues when engaging in a range of occupations. No one aspect explained in the previous figure is considered more important than another. Occupational therapists are trained to assess all aspects and to apply their knowledge to an intervention process that leads to engagement in occupations to support participation in contexts or settings. Occupational therapists work with clients in this process to support an occupational therapy plan. The discussion that follows provides a brief exploration of each term in the figure. Tables included in the appendix provide definitions and definitions of areas.

**Figure 1.** Discourse of Occupational Therapy. This figure explains the change of occupational therapy and its relation to allow people to participate in their daily activities with all of its aspects. This aspect is required to be understood as an important part of daily life.

**Engagement in Occupation:**

Engagement in occupation in support participation in contexts is the focus and central objective of occupational therapy intervention. Engagement in occupation is seen as naturally supporting and leading to participation in contexts.

When individuals engage in occupations, they are committed to performance as a result of self-choice, environment, and meaning. The term expresses the profession's belief in the importance of arising and maintaining the individual's desire, passion, and needs during the evaluation and intervention process. Engagement in occupation includes both the subjective (emotional or psychological) aspects of performance and the objective (physically observable) aspects of performance. Occupational therapists and occupational therapy assistants understand engagement from the dual and holistic perspectives and address all aspects of performance (physical, cognitive, social, and contextual) when providing intervention designed to support engagement in occupations and in daily life activities.

Occupational therapists and occupational therapy assistants recognize that health is supported and maintained when individuals are able to engage in occupations and to activities that allow them to participate in home, school, workplace, and community life situations. Occupational therapists and occupational therapy assistants assist individuals to feel that they are able to perform daily life activities with meaningful participation in engagement in occupations that allow participation in desired roles and life situations in homes, schools, workplaces, and communities. The World Health Organization (WHO), in its efforts to broad-
on the understanding of the effects of disease and disability on health, has recognized that health can be affected by the
inability to carry out routines and participate in life situ-
tions as well as by problems that arise with body structure
and function (WHO, 2001). Occupational therapy focuses
on engagement in occupations or support participatory
competencies within this perspective.

Occupational therapists and occupational therapy
practitioners recognize that engagement in occupation occurs
in a variety of contexts (cultural, physical, social, personal,
emotional, spiritual, virtual). They also recognize that
the individual's experience and performance cannot be
understood or addressed without understanding the many
circumstances in which occupations and daily life activities
occur.

Performance in Areas of Occupation

Occupational therapists and occupational therapy practition-
ers view engagement in the broad range of human occupa-
tional activities and activities that make up daily life. When oc-
cupational therapists and workers work with an individual,
group, or a population to promote engagement in occupa-
tions and daily life activities, they take into account all of
the many types of occupations in which an individual,
group, or population might engage. These human activities
are used in contexts called "areas of occupation."—
aspects of daily living, emotional expression of daily life,
education, work, play, leisure, and social participation.

(See Appendix, Table 1.)

Occupational therapists and occu-
pational therapy assistants under the supervision of an
occupational therapist use their expertise to address perfor-
mance issues in or on all areas that are affecting the person's
ability to engage in occupations and in environments. Addressing
performance issues in areas of occupation requires knowledge of what performance skills are needed and
what performance patterns are used.

Performance Skills

Skills are small units of performance. They are features of
what we do (e.g., bezels, choices, games) versus underly-
ing capacities or body functions (e.g., joint mobility, mo-
ment, visual acuity). "Skills" are overwhelmingly features of
action that have implied functional purposes (Gibbs &
Fathauer, 1996, p. 1119). For example, when observing a
person writing out a check, you would notice skills of grip-
ing and manipulating objects and initiating and responsi-
ving the waves of the activity to complete the writing of the
check.

Expression of a performance skill occurs when the pre-
factor, the context, and the demand of the activity come
together in the performance of the activity. Each of these
factors influences the expression of a skill and may support
or hinder access to skill performance.

When occupational therapists and occupational therapy
practitioners have established competencies under the
supervision of occupational therapists, educate performance,
they specifically identify the skills that are effective or inef-
flective during performance. They use skill observations
and adaptive assessments to outline the following skills:

- Motor skills—observed in the three areas and contexts
with task objects and environments. Aspects of manual
skill include posture, mobility, coordination, strength and
effects, and energy. Examples of specific manual perfor-
mance skills include manipulating the body, bending, and
manipulating objects.

- Process skills—observed in the three contexts and modi-
fying actions while completing a task. Aspects of process
skills include energy, knowledge, temporal organization,
organizing procedural objects, and adaptability. Examples
of specific process performance skills include maintaining,
attention to a task, covering appropriate tools and materials
for the task, logically organizing workforce, and reac-
commodating and modifying the method of task completion
in response to a problem.

- Communication/interaction skills—observed in the three
contexts and involves intentions and needs and immediates
social influence to act together with people. Aspects of
communication/interaction skills include physiological
information exchange, and values. Examples of specific
communication/interaction performance skills include
gesturing to indicate intentions, asking for information,
xpressing effect, or offering a way to establish rep-
with others.

Effective performance (i.e., effective execution of perform-
ance skills) depends on client factors (body functions,
body structure), activity attributes, and the context.
However, the presence of underlying client factors (body
functions and structures) does not inherently ensure the
effective execution of performance skills (See Appendix,
Table 2) for complete list of performance skills).
Contex

Context refers to a variety of interrelated conditions within and surrounding the client that influence performance. These contexts can be cultural, physical, social, personal, situational, environmental, and virtual. Some contexts are external to the client (e.g., physical, social, social norms, virtual contexts), while others are internal to the client (e.g., personal, spiritual). While they may have external surfaces, they hold internal values that have been internalized (e.g., culture). Contexts may include time dimensions (e.g., within a temporal context, the time of day, within a personal context, time spent), and space dimensions (e.g., within a physical context, the size of room in which activity occurs). When the occupational therapist and occupational therapy assistant are preparing to understand performance skills and patterns, they consider the specific contexts that surround the performance of a particular occupation or activity. In this process, the therapist and assistant consider all the different contexts, knowing that some of them may not be influencing the particular skills and patterns being addressed. (See Appendix, Table 5 for a description of the different kinds of contexts that occupational therapists and occupational therapy assistants consider.)

Activity Demands

The demands of the activity in which a person engages will affect skill and expected outcomes of performance. Occupational therapists and occupational therapy assistants apply their analysis skills to determine the demands that an activity will place on any performer and how these demands will influence skill acquisition. (See Appendix, Table 5 for a complete list of activity demands.)

Client Factors

Performance can be influenced by factors that reside within the client. Occupational therapists and occupational therapy assistants consider the various factors that influence development and performance and how these factors influence the client's abilities and disability affect these factors. The occupational therapist and occupational therapy assistant recognize that client factors influence the ability to engage in occupations and that engagement in occupations can also influence client factors. They apply their understanding of the interaction and use it throughout the intervention process. Client factors include the following:

- Body functions—"physiological functions of body systems (including psychological functions" (World Health Organization, 2001, p. 19). (See Appendix, Table 6 for complete list.) The occupational therapist and occupational therapy assistant understand the relationship of each client's body functions to knowledge about body functions to evaluate related client body functions that may be affected by an activity.
- Body structures—"anatomical part of the body such as organs, limbs, and their components" (World Health Organization, 2001, p. 10). (See Appendix, Table 6.) Occupational therapists and occupational therapy assistants cannot or do not supervise the use of an occupational therapy assistant to apply knowledge about body structures to determine which body structures are needed to carry out an occupation or activity.

The combination of client factors addressed in Table 6 is based on the International Classification of Functioning, Disability and Health proposed by the WHO (2011). The classification was selected because it incorporates wide experience and presents a common language that is understood by mental health providers. The classification includes all client areas that occupational therapists and assistants address and consider during evaluation and intervention.

Process

The Process of Occupational Therapy Evaluation, Intervention, and Outcome

Many professionals use the process of evaluating, intervening, and carrying out intervention outcomes that is outlined in the framework. However, occupational therapists focus on occupation through the process to ensure effective application and use of the process unique. The process of occupational therapy services delivery begins by evaluating the client's occupational needs, problems, and contexts. Understanding the client as an occupational being for whom someone engaged in meaningful and productive activities is central for health and wellbeing is a perspective that is unique to occupational therapy. Problems and concerns that are addressed in evaluation and intervention are often framed uniquely from an occupational perspective, based on occupational therapy domains, and are defined as problems or goals in the occupational performance. During intervention, the focus remains on occupations, and efforts are directed toward learning and improving engagement in occupations. A variety of therapeutic activities, including engagement in visual occupations and in daily living activities, are used in intervention.

Framework Proposed Organisation

The Introduction to the Occupational Therapy Practice Framework process is organized into short broad sections that describe the process of service delivery, briefly overview of the process as it is applied within the profession's domain is outlined in Figure 1.

Figure 1 schematically illustrates how these sections we relate to one another and how they were intended against the o
lobbicular therapeutic relationship between the client and
the occupational therapist and occupational therapy
assistants.

To help the reader understand the process, key
elements highlight important points about the process
modified below.

The process outlined is dynamic and interactive in
nature. Although the parts of the Framework are described
in a linear manner, in reality, the process does not occur in
a sequential, step-by-step fashion. The arrows in Figure 3
that connect the boxes indicate the interactive and
innovative nature of the process. The process, however, does
take into account the occupational profile. An understanding
of the client's concerns, problems, and goals is the cornerstone
of the process. The factors that influence occupational per-
formance (skills, performance patterns, concerns or
complaints, activity demands, stress factors) continually
interact with one another. Because of these dynamic inter-
actions, these factors are frequently reevaluated simul-
taneously throughout the process in their influence on performance
is adjusted.

Context is an unceasing, underlying, unspoken
influence on the process of service delivery. Context
varies from one client to another, both the client's
performance and the process of delivering
services. The physical setting (e.g., the physical setting, social
and virtual context) provides resources that support or
inhibit the client's performance (e.g., presence of a willing
 caregiver) as well as the delivery of services (e.g., limits
placed on length of intervention in an inpatient hospital
setting). Different settings (i.e., inpatient, acute, long-term,
home) provide different supports and resources for service
delivery. The client's internal emotional and spiritual
context affects service delivery by influencing personal
beliefs, preferences, and expectations. The cultural context,
which exists outside of the person but is internalized by
the person, also affects beliefs, behaviors, and norms that
are affected how and when services may be delivered. Note
dis in Figure 3, context is depicted as surrounding and underlaying
the process.

The term clinician is used to mean the entity
that receives occupational therapy services. Clients may
be

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Figure 3: Framework Collaborative Process Model. This diagram of
the framework depicting client practice and interaction nature
is the service delivery process.
competitors as its individuals, including individuals who may be involved in supporting or caring for the client (e.g., caregivers, friends, parents, employees, spouses); (b) individuals within the context of a group (e.g., a family, a team); or (c) individuals within the context of a population (i.e., an organization, a community). The definition of clients is consistent with The Guide to Occupational Therapy Practice (Mooney, 1999) and is indicative of the profession's growing understanding that people may be served not only as individuals, but also as members of a group or a population. The actual terms used for individuals, who are served will vary by practice setting. For example, in a hospital, the person might be referred to as a "patient," whereas in a school, he or she might be called a "student." Clients may be served as individuals, groups, or populations. Although the term "client service" is common within the profession, the term "client" refers to the person who is served rather than to the group or population in which the client is a member (i.e., organization, community). When providing interventions other than those in a one-on-one model, the occupational therapist and occupational therapy assistants are seen as agents who help clients engage in occupations rather than as those who personally provide task support. Often, they use education and communication to intervene. When occupational therapists and occupational therapy assistants are collaborating with clients to provide services to the group or population level, an important piece of the puzzle is that although interventions may be directed to a group or population (i.e., organization, community), the individuals within these entities are the ones who are being evaluated and served. The values, needs, occupational roles, or problems, and performance patterns and skills of individual members of the group or population (i.e., organization, community) are examined in an aggregate, and information is compiled to determine group or population occupational issues and solutions.

A client-centered approach is used throughout the Framework. The Framework incorporates the values of client-centered evaluation and intervention by recognizing that all interventions must be focused on client priorities. The very nature of occupations in occupations— which is universally experienced by individuals involved and important active participation by the client—means that the client must be an active participant in the process. Clients identify what occupations and activities are important to them and determine the degree of engagement in each occupation. In addition, in some circumstances, the client's ability to create a description of the present or desired occupations or environment may be limited because of either the nature of the client's problems (e.g., amnesia, depression) or the stage of development (e.g., infancy). When this occurs, the occupational therapist and occupational therapy assistant must then view a broader view of the client and work in partnership with others such as family or significant others who would have knowledge and insight about the client's desires. By involving the family or significant others, the occupational therapist and assistant can better understand the client's daily living environments, stage of development, and current contexts. Inclusion of others in these circumstances allows the client to be represented in intervention planning and implementation.

The entire process of service delivery begins with a collaborative relationship with the client. The collaborative relationship continues throughout the process and affects all phases of the process. The central importance of this collaboration is visualized in Figure 3.

The Framework is based on the belief that the occupational therapist, occupational therapy assistant, and the clients bring unique resources to the Framework process. Occupational therapists and occupational therapy assistants bring knowledge about how engagement in occupations affects health and performance. They also bring knowledge about disease and disability and couple this information with their clinical reasoning and theoretical perspectives to critically observe, analyze, diagnose, and interpret client performance. Therapists and assistants combine their knowledge and skills to modify the factors that influence engagement in occupations to improve and support performance. Clients bring knowledge about their lives experiences and their hopes and dreams for the future. Clients share their priorities, which are based on what is important to them, and collaborate with the therapist and assistant in defining the intervention process to those priorities.

"Engagement in occupation" is viewed as the overarching outcome of the occupational therapy process. The Framework emphasizes occupational therapy's unique contribution to health by identifying "engagement in occupation to support participation" as the end goal of the occupational therapy process. The profession recognizes that in some areas of practice (e.g., acute rehabilitation, hand therapy), occupational therapy interventions may focus primarily on performance skills or on client factors (i.e., body function, body structure) that will enable engagement in occupations here in the continuum of care.

Evaluation Process

The evaluation process with the clients all that follows. Because occupational therapy is concerned with performance in daily life and how performance affects recovery.
OCCUPATIONAL PROFILE

An occupational profile is defined as information that describes the client's occupational history and experiences, patterns of daily living, interests, values, and needs. The profile is designed to provide an understanding of the client's perspectives and background. Using a client-centered approach, information is gathered to understand what is currently important and meaningful to the client (e.g., the present and needs to do) and to identify past experiences and attitudes that may affect the understanding of current issues and problems. During the process of collecting this information, the client's priorities and desires are considered in order to promote participation in life activities that are meaningful to them. These priorities and desires typically include activities that are personally important and enjoyable, as well as those that are socially significant. The occupational profile is a valuable tool for identifying areas of strength and opportunities for growth. It is a dynamic and ongoing process that requires ongoing evaluation and adaptation to changing circumstances. The occupational profile is used to inform treatment planning and to guide the development of individualized programs. It is a comprehensive and holistic approach to assessing and understanding the client's occupational functioning. The occupational profile is a valuable tool for occupational therapists and other health professionals in promoting the client's participation in meaningful and purposeful activities, thereby enhancing their quality of life.
Next, profile data are gathered, the therapist reviews the information and develops a working hypothesis regarding possible reasons for identified problems and concerns and identifies the client's strengths and weaknesses. Outcome measures are periodically selected.

Analysis of Occupational Performance
Occupational performance is defined as the ability to carry out activities of daily life, including activities in the arena of occupational activities of daily living (ADLs) such as basic activities of daily living (BADLs) and personal activities of daily living (PADLs), instrumental activities of daily living (IADLs), education, work, play, leisure, and social participation. Occupational performance results in the accomplishment of the selected occupations in an efficient and successful manner through a dynamic interaction among the client, the context, and the activity occurring or developing skills and patterns of occupational performance leads to engagement in one or more occupations (adapted in part from Law et al., 1995, p. 16).

When occupational performance is assessed, the performance skills and patterns used in performance are identified, and other aspects of engaging in occupation (e.g., client factors, activity demands, context or setting) are evaluated. The analysis focuses on identifying facilitators as well as barriers in various aspects of engagement in occupations and in daily life activities. Analyzing occupational performance requires an understanding of the client and dynamic interactions among performance skills, performance patterns, client context or setting, and client factors rather than of any one factor alone.

The information gathered during the occupational profile guides the client's needs, problems, and protective factors decisions during the analysis of occupational performance. The profile information forms the therapist's selection of the specific occupational performance that must be further analyzed and influences the selection of specific assessment measures that are used during the analysis process.

Process. Using available evidence and absorptions of clinical reasoning (scientific, practical, empirical), the therapist when we are more frame of reference to guide further collection of evaluation information. The following are some taken:

- Synthesize information from the occupational profile to focus on specific areas of performance and their context that must be addressed.
- Observe the client's performance in defined occupational activities, noting effectiveness of the performance skills and performance patterns. The client's performance and specific measures to examine performance skills and patterns as appropriate.

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• Select assessment as needed to identify and measure specific client needs or concerns, activity demands, and client factors that may influence performance skills and performance patterns.
• Interpret the assessment data to identify what supports performance and what hinders performance.
• Develop and select hypotheses that show the client's occupational performance strengths and weaknesses.
• Create goals in collaboration with the client that address the identified problems. Confirm the consultation for use.
• Different personal innovation approaches to approaches based on best practice and evidence.

Intervention Process
The intervention process is divided into three subphases: intervention plan, intervention implementation, and intervention review. During the intervention process, information from the evaluation step is integrated with theory and frame of reference, and evidence and is coupled with clinical reasoning to develop a plan and carry out. The plan guides the actions of the occupational therapist and occupational therapy assistant and is based on the client's profile. Interventions are aligned due to add to add performance skills, patterns, resources, or contexts, activity demands, and client factors that are limiting performance. Periodic reviews throughout the process allow for feedback in the plan modifications. Again, collaboration with the client is vital in this process to ensure effectiveness and success. All interventions are ultimately oriented toward achieving the overarching outcome of empowerment in occupations to support participation.

Intervention Plan
An intervention plan is developed as a plan that is developed based on the results of the evaluation process and individual occupational therapy assessment and identifies the client's identified expected outcomes. An intervention plan is developed collaboratively with the client (including, in some cases, family or significant others) and is based on the client's goals and priorities.

The design of the intervention plan is affected by:
- The client's goals, values, and beliefs.
- The health and well-being of the client.
- The client's performance skills and performance patterns as they are influenced by the environment among the context or setting, activity demands, and client factors.
- The setting or circumstance in which the intervention is provided (e.g., care setting, organization, purpose, setting, requirements, or applicable regulations).
Interventions are designed to foster engagement in occupation and, as activities to support participation in life. The selection and design of the intervention plan and goals are directed toward addressing the client's current and potential problems related to engagement in occupation or activity.

Process: Intervention planning includes the following steps:

1. Develop the plan. The occupational therapy develops the plan. The occupational therapy assistant, based on established competencies and under the supervision of the occupational therapy, may contribute to the plan's development. The plan includes the following:
   - Objective and measurable goals with a time frame
   - Occupational therapy intervention approach or approach based on theory and evidence (see Appendix, Table 7)
   - Client's preferences
   - Usable or access
   - Maintenance
   - Modality
   - Progress
   - Mechanism for service delivery
   - Who will provide intervention
   - Types of intervention
   - Frequency and duration of service

2. Consider potential discharge needs and plans.

3. Select outcome measures.

4. Make accommodation of referral to others if needed.

Intervention Implementation

Intervention is the process of putting the plan into action. Intervention implementation is defined as the skilled process of enacting change to the client's occupational performance, leading to empowerment in occupation or, as activities to support participation. Intervention implementation is a collaborative process between the client and the occupational therapist or assistant.

Interventions may be focused on changing the manner or context, activity demands, client factors, performance skills, or performance contexts. Occupational therapy and occupational therapy assistants anticipate that change in one factor may influence other factors. All factors that affect performance are intertwined and influence one another in a continuous dynamic process that results in performance in desired areas of occupation. Because of this dynamic interrelationship, dynamic assessment occurs throughout the implementation process.

Process: Intervention implementation includes the following steps:

1. Determine and carry out the type of occupational therapy intervention or interventions to be used (see Appendix, Table 7).
   - Therapists: use of self
   - Therapeutic use of occupations or activities
   - Occupation-based activity
   - Purposeful activity
   - Preparatory materials
   - Consumables
   - Education process

2. Monitor client's response to intervention based on ongoing assessment and measurement.

Intervention Review:

Intervention review is defined as a continuous process for evaluating and revising the intervention plan, the effectiveness of delivery, and the progress toward targeted outcomes. This process includes collaboration with the client (including, in some cases, family, significant others, and other service providers). Feedback and review may lead to change in the intervention plan. The intervention review process may be carried out differently in a variety of settings.

Process: The intervention review includes the following steps:

1. Reevaluate the plan and how it is carried out with the client relative to achieving targeted outcomes.
2. Modify the plan as needed.
3. Determine the need for continuation, discontinuation, or referral.

Outcomes Process

Outcomes are defined as important dimensions of health that are achieved through interventions, including ability to function, health promotion, and satisfaction with care (adapted from Engberg for Planning Aid, 2001). The important dimension of health that occupational therapy and occupational therapy assistants target in the profession's reasoning is engagement in occupation to support participation. The two concepts included in this outcome are defined as follows:

- Engagement in occupation—The commitment made to performance in occupations or activities as the result of self-determination, resistance, and meaning, and includes the objective and subjective aspects of carrying on occupations and activities that are meaningful and purposeful in the process.

- Participation—"involve oneself in a life situation" (WHO, 2001, p. 10).

Engagement in occupation to support participation is the broad measure of intervention that is designed to foster performance is desired and needed occupations or activities. When clients are actively involved in pursuing their occupa-
An Overview of the Occupational Therapy Practice Process

TABLE 16 in the Appendix summarizes the process that occurs during occupational therapy service delivery. The rows placed between the Occupational Profile and Analysis of Occupational Performance evaluation substeps identifies the relationship between those two. Moreover, a similar notation occurs among each of the steps and substeps. The process is not linear but, instead, is fluid and dynamic, allowing the occupational therapist and occupational therapy assistant to initiate or stop at any point while continually reflecting and changing as needed, plus to accommodate new developments and insights along the way.

Acknowledgments

The Commission on Practice (COP) would like to thank and acknowledge all those who participated in the revisited and current process associated with the development of the Occupational Therapy Practice Framework: Domain and Process. The COP has found this process to be flexible and enriching. Every person's input has been carefully reviewed and considered. Often, small comments repeated by many can lead to significant direction and change. The COP hopes that all those who contributed to this process will continue to do so as this future document will encourage others to participate. The profession is richer for this process.

The COP would like to thank the following individuals for their significant contributions to the direction and final content of the document: Carolyn Burton, MD, OTR/L; Elizabeth Currier, PhD, OTR/L, FAOTA; Patricia A. Davis, MA, OTR/L; Wendell Davis, PhD, OTR/L, FAOTA; Anne G. Fehn, PhD, OTR/L, FAOTA; Gail S. Field, OTR/L; Martha Fyock, OTR/L, FAOTA; Mary Ives, OT, OTR/L, FAOTA; Nita J. Kline, SCP, OTO, OTR/L; Marca M. Losos, PhD, OTR/L, FAOTA; Mark B. Hendon, PhD, OTR/L, FAOTA; Greg Kohanski, DrPh, OTR/L, FAOTA; Paula Koftrain, PhD, OTR/L, FAOTA; Mary Lay, PhD, OTR/L; Linda L. Lockhard, OTR/L, FAOTA; Anna Nadeau, PhD, OTR/L, FAOTA; Perdita A. Meyers, EdD, OTR/L, FAOTA; David Nelson, PhD, OTR/L, FAOTA; Marta Puszczewicz, OTR/L, KAT/STM; L. Paul, PhD, OTR/L, FAOTA; Barbara Schall, PhD, OTR/L; Jennifer Schiidt, PhD, OTR/L, Winde Schmoc, CCA; Debra Schrier, MS, OTR/L; V. Judith Thoresson, MCA Linda Holdeman Thompson, MD, OTR/L, FAOTA; Amy L. Wald, OTR/L, Wendy Wood, PhD, OTR/L, FAOTA; Boston University OTR Student mentored by Kevin Jacob, EdD, OTR/L, FAOTA; and the University of Kansas Occupational Therapy Education Faculty.

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TABLE 1. ACTIVITIES OF OCCUPATION

<table>
<thead>
<tr>
<th>ACTIVITIES OF OCCUPATION</th>
<th>Numbers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total number of activities</td>
<td>191</td>
</tr>
</tbody>
</table>

(Appendix page)
TABLE 1. AREAS OF OCCUPATION

<table>
<thead>
<tr>
<th>Area</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Home</td>
<td>Day-to-day living, eating, and household management activities.</td>
</tr>
<tr>
<td>Work</td>
<td>Employment-related tasks, including physical and cognitive demands.</td>
</tr>
<tr>
<td>Play</td>
<td>Recreational activities, including hobbies and leisure time.</td>
</tr>
</tbody>
</table>

TABLE 2. PERFORMANCE BARRIERS

- Lack of knowledge or skills
- Limited access to resources
- Physical limitations or disabilities
- Economic constraints
- Social isolation or discrimination

TABLE 3. OBSTACLES TO FUNCTIONING

- Lack of adequate support systems
- Insufficient funding or resources
- Lack of accessible and inclusive environments
- Limited access to healthcare services
- Stigma and discrimination towards individuals with disabilities
<table>
<thead>
<tr>
<th>TABLE 2: PERFORMANCE METRICS (Continued)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Number of Events</strong></td>
</tr>
<tr>
<td>-------------------------------------------</td>
</tr>
<tr>
<td><strong>Number of Participants</strong></td>
</tr>
<tr>
<td>-------------------------------------------</td>
</tr>
<tr>
<td><strong>Number of Observers</strong></td>
</tr>
<tr>
<td>-------------------------------------------</td>
</tr>
<tr>
<td><strong>Number of Sessions</strong></td>
</tr>
<tr>
<td>-------------------------------------------</td>
</tr>
<tr>
<td><strong>Number of Locations</strong></td>
</tr>
<tr>
<td>-------------------------------------------</td>
</tr>
<tr>
<td><strong>Number of Cameras</strong></td>
</tr>
<tr>
<td>-------------------------------------------</td>
</tr>
<tr>
<td><strong>Number of Equipment Items</strong></td>
</tr>
<tr>
<td>-------------------------------------------</td>
</tr>
<tr>
<td><strong>Number of Activities</strong></td>
</tr>
<tr>
<td>-------------------------------------------</td>
</tr>
<tr>
<td><strong>Number of Tasks</strong></td>
</tr>
<tr>
<td>-------------------------------------------</td>
</tr>
<tr>
<td><strong>Number of Observations</strong></td>
</tr>
<tr>
<td>-------------------------------------------</td>
</tr>
<tr>
<td><strong>Number of Ratings</strong></td>
</tr>
<tr>
<td>-------------------------------------------</td>
</tr>
<tr>
<td><strong>Number of Comments</strong></td>
</tr>
<tr>
<td>-------------------------------------------</td>
</tr>
<tr>
<td><strong>Number of Questions</strong></td>
</tr>
<tr>
<td>-------------------------------------------</td>
</tr>
<tr>
<td><strong>Number of Surveys</strong></td>
</tr>
<tr>
<td>-------------------------------------------</td>
</tr>
<tr>
<td><strong>Number of Reports</strong></td>
</tr>
<tr>
<td>-------------------------------------------</td>
</tr>
<tr>
<td><strong>Number of Evaluations</strong></td>
</tr>
<tr>
<td>-------------------------------------------</td>
</tr>
<tr>
<td><strong>Number of Assessments</strong></td>
</tr>
<tr>
<td>-------------------------------------------</td>
</tr>
<tr>
<td><strong>Number of Evaluators</strong></td>
</tr>
<tr>
<td>-------------------------------------------</td>
</tr>
<tr>
<td><strong>Number of Participants Involved</strong></td>
</tr>
<tr>
<td>-------------------------------------------</td>
</tr>
<tr>
<td><strong>Number of Observers Involved</strong></td>
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<tr>
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<tr>
<td><strong>Number of Sessions Involved</strong></td>
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<tr>
<td><strong>Number of Cameras Involved</strong></td>
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<tr>
<td>-------------------------------------------</td>
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<tr>
<td><strong>Number of Equipment Items Involved</strong></td>
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<tr>
<td>-------------------------------------------</td>
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<tr>
<td><strong>Number of Activities Involved</strong></td>
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<tr>
<td>-------------------------------------------</td>
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<tr>
<td><strong>Number of Tasks Involved</strong></td>
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<tr>
<td>-------------------------------------------</td>
</tr>
<tr>
<td><strong>Number of Observations Involved</strong></td>
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<td>-------------------------------------------</td>
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<tr>
<td><strong>Number of Ratings Involved</strong></td>
</tr>
<tr>
<td>-------------------------------------------</td>
</tr>
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<tr>
<td>-------------------------------------------</td>
</tr>
<tr>
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</tr>
<tr>
<td>-------------------------------------------</td>
</tr>
<tr>
<td><strong>Number of Surveys Involved</strong></td>
</tr>
<tr>
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<td><strong>Number of Reports Involved</strong></td>
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<tr>
<td>-------------------------------------------</td>
</tr>
<tr>
<td><strong>Number of Evaluations Involved</strong></td>
</tr>
<tr>
<td>-------------------------------------------</td>
</tr>
<tr>
<td><strong>Number of Assessments Involved</strong></td>
</tr>
<tr>
<td>-------------------------------------------</td>
</tr>
<tr>
<td><strong>Number of Evaluators Involved</strong></td>
</tr>
</tbody>
</table>

### COMMUNICATION AND INFORMATION NETWORKS

- Telecommunication:
- Computer networks:
- Ethernet:
- Wi-Fi:
- Bluetooth:
- Zigbee:
- NFC:
- RFID:
- Satellite communication:
- Optical fiber:
- 5G:
- 6G:
- Quantum communication:

### PHYSICAL BASES ON ELECTRICAL SIGNALS

- Voltage:
- Current:
- Resistance:
- Capacitance:
- Inductance:

### SYSTEMS

- Open systems:
- Closed systems:
- Hybrid systems:

### DESIGN AND APPLICATIONS

- Design principles:
- Design process:
- Design methodologies:

### EVALUATION AND TESTING

- Testing procedures:
- Quality assurance:
- Reliability:
- Maintainability:
- Safety:

### STANDARDS AND REGULATIONS

- International standards:
- National standards:
- Regulatory frameworks:

### CASE STUDIES

- Example 1:
- Example 2:
- Example 3:

### REFERENCES

- [Reference 1](#)
- [Reference 2](#)
- [Reference 3](#)
### TABLE 4. CONTEXT OF CONTENTS

<table>
<thead>
<tr>
<th>Context</th>
<th>Question</th>
<th>Answer</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical</td>
<td>Location factors and equipment, including the accessibility to and format of the content.</td>
<td>Quality, format, accessibility, usability, design, and technical aspects.</td>
</tr>
<tr>
<td>Mental</td>
<td>Adaptability and expressiveness of the content, including the medium, style, and tone.</td>
<td>Relatability with the subject, quality, originality, and coherence.</td>
</tr>
<tr>
<td>Spiritual</td>
<td>The influence of the content on the user, including its emotional and spiritual impact.</td>
<td>Spirituality of the content, emotional and spiritual impact, and long-term influence.</td>
</tr>
<tr>
<td>Temporal</td>
<td>The content's relevance and its impact on the user, including its current and future relevance.</td>
<td>Relevance of the content, current and future impact, and potential for growth.</td>
</tr>
<tr>
<td>Virtual</td>
<td>The content's presentation and its influence on the user, including the user's experience and engagement.</td>
<td>Virtual presentation, user experience, engagement, and user feedback.</td>
</tr>
</tbody>
</table>

Note: The context of contents is influenced by the user's environment and their personal experiences, which can vary significantly. Therefore, the answer to the question may vary based on the user's individual circumstances and preferences.
### Table 5: Activity Demands

<table>
<thead>
<tr>
<th>Activity Demands</th>
<th>Dimension</th>
<th>Example</th>
</tr>
</thead>
<tbody>
<tr>
<td>Static and static</td>
<td>Force, velocity, and acceleration with the systems reacting and</td>
<td>• Static strength, static balance, flexibility</td>
</tr>
<tr>
<td>Physical methods</td>
<td>the system</td>
<td>• Static strength, static balance, flexibility</td>
</tr>
<tr>
<td>Static and static</td>
<td>Torque, rotation, and displacement with the systems reacting and</td>
<td>• Static strength, static balance, flexibility</td>
</tr>
<tr>
<td>Physical methods</td>
<td>the system</td>
<td>• Static strength, static balance, flexibility</td>
</tr>
<tr>
<td>Dynamic and dynamic</td>
<td>Force, velocity, and acceleration with the systems reacting and</td>
<td>• Dynamic strength, dynamic balance, flexibility</td>
</tr>
<tr>
<td>Physical methods</td>
<td>the system</td>
<td>• Dynamic strength, dynamic balance, flexibility</td>
</tr>
<tr>
<td>Dynamic and dynamic</td>
<td>Torque, rotation, and displacement with the systems reacting and</td>
<td>• Dynamic strength, dynamic balance, flexibility</td>
</tr>
<tr>
<td>Physical methods</td>
<td>the system</td>
<td>• Dynamic strength, dynamic balance, flexibility</td>
</tr>
</tbody>
</table>

### Table 6: Client Factors

<table>
<thead>
<tr>
<th>Client Factors</th>
<th>Selected Identification Terms and Occupational Therapy Domain</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical factors</td>
<td>• Gait, posture, balance, range of motion, strength, coordination, sensory perception</td>
</tr>
<tr>
<td>Cognitive factors</td>
<td>• Attention, memory, problem-solving, processing speed, decision-making, language, social skills, creativity, abstract thinking</td>
</tr>
<tr>
<td>Emotional factors</td>
<td>• Mood, anxiety, depression, stress, coping strategies, self-esteem, self-efficacy, social support, relationship skills</td>
</tr>
<tr>
<td>Environmental factors</td>
<td>• Home environment, work environment, community environment, leisure environment, family environment</td>
</tr>
</tbody>
</table>

(Continued)
<table>
<thead>
<tr>
<th>Category</th>
<th>Characteristics (continued) from 7th and 8th Edition of the DSM-IV-TR</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sensory</td>
<td>Tactile, visual, auditory, olfactory, gustatory, kinesthetic, gustatory</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Sensory</th>
<th>Thresholds and Sensations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Visual</td>
<td>Thresholds to light, color, movement, shapes, sizes</td>
</tr>
<tr>
<td>Auditory</td>
<td>Thresholds to sound, pitch, intensity, duration</td>
</tr>
<tr>
<td>Tactile</td>
<td>Thresholds to touch, pressure, vibration, temperature, pain</td>
</tr>
<tr>
<td>Olfactory</td>
<td>Thresholds to smell</td>
</tr>
<tr>
<td>Gustatory</td>
<td>Thresholds to taste</td>
</tr>
<tr>
<td>Kinesthetic</td>
<td>Thresholds to movement, muscle stretch, position</td>
</tr>
<tr>
<td>Gustatory</td>
<td>Sensations to taste</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Sensory</th>
<th>Perceptual Functions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Visual</td>
<td>Vision, depth perception, color vision, visual field</td>
</tr>
<tr>
<td>Auditory</td>
<td>Hearing, sound localization, pitch perception</td>
</tr>
<tr>
<td>Tactile</td>
<td>Touch, pressure, vibration, pain</td>
</tr>
<tr>
<td>Olfactory</td>
<td>Smell, odor detection</td>
</tr>
<tr>
<td>Gustatory</td>
<td>Taste, flavor perception</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Sensory</th>
<th>Motor Functions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Visual</td>
<td>Visual-motor integration, eye-hand coordination</td>
</tr>
<tr>
<td>Auditory</td>
<td>Auditory-motor integration, speech-production</td>
</tr>
<tr>
<td>Tactile</td>
<td>Tactile-motor integration, muscle tone, strength</td>
</tr>
<tr>
<td>Olfactory</td>
<td>Olfactory-motor integration, smell identification</td>
</tr>
<tr>
<td>Gustatory</td>
<td>Gustatory-motor integration, taste recognition</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Sensory</th>
<th>Cerebral Functions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Visual</td>
<td>Vision, visual memory, visual imagination</td>
</tr>
<tr>
<td>Auditory</td>
<td>Hearing, auditory memory, auditory imagination</td>
</tr>
<tr>
<td>Tactile</td>
<td>Tactile, motor memory, movement imagery</td>
</tr>
<tr>
<td>Olfactory</td>
<td>Olfactory, olfactory memory, olfactory imagination</td>
</tr>
<tr>
<td>Gustatory</td>
<td>Gustatory, gustatory memory, taste imagery</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Sensory</th>
<th>Sensory Integration</th>
</tr>
</thead>
<tbody>
<tr>
<td>Visual</td>
<td>Vision, visual memory, visual imagination</td>
</tr>
<tr>
<td>Auditory</td>
<td>Hearing, auditory memory, auditory imagination</td>
</tr>
<tr>
<td>Tactile</td>
<td>Tactile, motor memory, movement imagery</td>
</tr>
<tr>
<td>Olfactory</td>
<td>Olfactory, olfactory memory, olfactory imagination</td>
</tr>
<tr>
<td>Gustatory</td>
<td>Gustatory, gustatory memory, taste imagery</td>
</tr>
</tbody>
</table>

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<table>
<thead>
<tr>
<th>Client Factors</th>
<th>Consultations (Suggestion and後Measurement in the 4th Phase) in 2nd Initial</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Validity, Validity, Validity</td>
<td>Consultations (Suggestion and後Measurement in the 4th Phase) in 2nd Initial</td>
</tr>
<tr>
<td>Digestive Function, Nutritional Function and Involutional Factors</td>
<td>Consultations (Suggestion and後Measurement in the 4th Phase) in 2nd Initial</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### TABLE 6. CLIENT FACTORS

<table>
<thead>
<tr>
<th>Client Category</th>
<th>Consultations (Suggestion and後Measurement in the 4th Phase) in 2nd Initial</th>
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<tbody>
<tr>
<td>• Validity, Validity, Validity</td>
<td>Consultations (Suggestion and後Measurement in the 4th Phase) in 2nd Initial</td>
</tr>
<tr>
<td>Digestive Function, Nutritional Function and Involutional Factors</td>
<td>Consultations (Suggestion and後Measurement in the 4th Phase) in 2nd Initial</td>
</tr>
</tbody>
</table>

Note: The tables and figures are designed for an integrated consultation of the Six-Phase System. The 4th Phase is particularly emphasized to facilitate in-depth information and support for consultation (texts, tables, and figures).
<table>
<thead>
<tr>
<th>Approach</th>
<th>Signs of improvement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cognitive-behavioral therapy (CBT)</td>
<td>- Alter cognitive distortions (e.g., thoughts about guilt, shame, worthlessness)</td>
</tr>
<tr>
<td></td>
<td>- Modify dysfunctional beliefs and attitudes (e.g., perfectionism, helplessness)</td>
</tr>
<tr>
<td></td>
<td>- Improve coping strategies (e.g., relaxation techniques, problem-solving skills)</td>
</tr>
</tbody>
</table>

| | Modification of environmental stimuli (e.g., reducing stressors, improving living conditions) |
| | - Modify sleep patterns to improve overall well-being |
| | - Modify physical activity levels to enhance mood and energy |

| | Adolescents' concerns (e.g., academic, social, emotional) |
| | - Modify peer relationships, including peer norms and expectations |
| | - Improve social skills and communication strategies |

| | Client's concerns (e.g., Work, family, health) |
| | - Modify vocational goals and aspirations |
| | - Improve family functioning and relationships |
| | - Enhance physical health and well-being |

The American Psychological Association (1982) | Original text reference | 637
TABLE II. TYPES OF OCCUPATIONAL THERAPY INTERVENTIONS

**Therapeutic Use of Self**
- A patients potential use of the self to engage, manage, challenge and grow is part of the therapeutic process and the foundation for the therapeutic relationship.

**Functioning of Occupations and Activities**
- Occupations and activities support the specific needs and lifestyle goals of an individual.
- Occupations may be arranged into activity and activity performance, and activities into meaningful, purposeful and purposeful activity.

**Occupational therapy approach**
- Supportive therapy: a method to engage patients in a goal-directed activity and to facilitate their self-care and functional skills.

**Proposed method**
- A proposed method to engage patients in goal-directed activity and to facilitate their self-care and functional skills.

**Preparatory method**
- A preparatory method to engage patients in goal-directed activity and to facilitate their self-care and functional skills.

**Interim Evaluation**
- An interim evaluation of the engagement and activity and the goal and role of the patient.

**Final Evaluation**
- A final evaluation of the engagement and activity and the goal and role of the patient.

**Appendix**
- An appendix to provide additional information.

---

**Note:**
- The data provided is a summary of the types of occupational therapy interventions suggested by therapists and are not exhaustive.

---

**Table II. Types of Outcomes**

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Task-oriented</td>
<td>Focused on achieving specific tasks or goals.</td>
</tr>
<tr>
<td>Goal-oriented</td>
<td>Focused on achieving specific goals or outcomes.</td>
</tr>
<tr>
<td>Activity-oriented</td>
<td>Focused on enhancing active participation in specific activities.</td>
</tr>
</tbody>
</table>

---

**Table II. Types of Outcomes**

<table>
<thead>
<tr>
<th>Type of Outcome</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Task-oriented</td>
<td>Focused on achieving specific tasks or goals.</td>
</tr>
<tr>
<td>Goal-oriented</td>
<td>Focused on achieving specific goals or outcomes.</td>
</tr>
<tr>
<td>Activity-oriented</td>
<td>Focused on enhancing active participation in specific activities.</td>
</tr>
</tbody>
</table>

---

**Appendix**
- An appendix to provide additional information.

---

**Note:**
- The data provided is a summary of the types of occupational therapy interventions suggested by therapists and are not exhaustive.
### TABLE 10. OCCUPATIONAL THERAPY PRACTICE FRAMEWORK PROCESS SUMMARY

<table>
<thead>
<tr>
<th>Intervention Components</th>
<th>Information Components</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Agenda Setting</strong></td>
<td><strong>Agenda Setting</strong></td>
</tr>
<tr>
<td>- Importance of the client</td>
<td>- Importance of the client</td>
</tr>
<tr>
<td>- Time for shared decision-making</td>
<td>- Time for shared decision-making</td>
</tr>
<tr>
<td>- Needs assessment and prioritization</td>
<td>- Needs assessment and prioritization</td>
</tr>
<tr>
<td>- What is the client’s expectation?</td>
<td>- What is the client’s expectation?</td>
</tr>
<tr>
<td>- What are the family’s expectations regarding outcomes?</td>
<td>- What are the family’s expectations regarding outcomes?</td>
</tr>
<tr>
<td>- Goals of Occupational Therapy</td>
<td>- Goals of Occupational Therapy</td>
</tr>
<tr>
<td>- Significant transitions from the therapeutic process</td>
<td>- Significant transitions from the therapeutic process</td>
</tr>
<tr>
<td>- What are the client’s expectations in regard to outcomes?</td>
<td>- What are the client’s expectations in regard to outcomes?</td>
</tr>
<tr>
<td>- Metaphor and metaphor application</td>
<td>- Metaphor and metaphor application</td>
</tr>
<tr>
<td>- How effective are the metaphors and metaphors in promoting goal attainment?</td>
<td>- How effective are the metaphors and metaphors in promoting goal attainment?</td>
</tr>
<tr>
<td>- What is the client’s understanding of the metaphors?</td>
<td>- What is the client’s understanding of the metaphors?</td>
</tr>
<tr>
<td>- What are the client’s expectations regarding outcomes?</td>
<td>- What are the client’s expectations regarding outcomes?</td>
</tr>
<tr>
<td>- Different types of metaphors and metaphor application</td>
<td>- Different types of metaphors and metaphor application</td>
</tr>
<tr>
<td>- Metaphor and metaphor application</td>
<td>- Metaphor and metaphor application</td>
</tr>
<tr>
<td>- Metaphor and metaphor application</td>
<td>- Metaphor and metaphor application</td>
</tr>
<tr>
<td>- Metaphor and metaphor application</td>
<td>- Metaphor and metaphor application</td>
</tr>
<tr>
<td>- What is the client’s expectation regarding outcomes?</td>
<td>- What is the client’s expectation regarding outcomes?</td>
</tr>
</tbody>
</table>

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Glossary

Activity
- of daily living (ADL): (see use of exceptions)
- Activities that we engaged toward adapting one's own body (adapted from Rogers & Wolman, 1996, pp. 181-202).
- See Appendix, Table 1, for definitions of errors.
- ADL is also referred to as basic activities of daily living (BADLs) and personal activities of daily living (PALS).
- Mental: thinking
- Physical: feeding
- Functional mobility
- Personal hygiene care
- Personal hygiene and personal hygiene
- Social: social
- Sleep
- Task efficiency

Activity (activities)
- A term that describes a class of human actions that are goal directed.
- Activity demands

The power of an activity, which include the object, space, social aspects, performance timing, required actions and required understanding body functions and body structures needed to carry out the activity. (See Appendix, Table 2, for definitions of these aspects).

Adaptation (as used in 5 categories; see Appendix, Table 3)
- A change a person makes in how he responds to an unusual challenge.
- The change is implemented when the individual's complete response procedures are found inadequate for producing some degree of mastery or the challenge (Schulz & Schlda, 1997, p. 674).

Adaptation (as used in performance skills; see Appendix, Table 2)
- Ability to adapt to circumstances, correct time and benefit by learning from the consequences of errors that arise in the course of task performance (Fisher, 2003).

Area of occupation

Various kinds of life activities in which people engage, including the following categories: ADL, IADL, education, work, leisure, and social participation. (See Appendix, Table 4, for definitions of errors.)

Anomalous
"...shall be used to refer to specific needs or circumstances that are used during the evaluation process" (KOTA, 1997, pp. 107:1-107).

Body functions: (i) client role, including physical, cognitive, perceptual aspects
- "The physiological functions of body systems including physiological functions" (WHO, 2001, p. 10). (See Appendix, Table 6, for categories.)

Body structure: (client factor)
- "Anatomical part of the body such as organs, limbs and their components (this support body function)" (WHO, 2002, p. 10). (See Appendix, Table 6, for categories.)

Client
- (a) Individual (including others involved in the individual's life who may have a body or behavior indirectly such as carers, teachers, parents, employers, support, (b) groups, or (c) populations (i.e., organizations, communities).

Client-centered approach
- An orientation that stresses the desire and priorities of clients in designing and implementing interventions (adapted from Pease, 2000, p. 41).

Client factor
- These factors that exist within the client and that may affect performance in areas of occupation. Client factors include body functions and body structure. (See Appendix, Table 6, for categories.)

Client satisfaction
- The client's affective response to his or her perceptions of the process and benefits of receiving occupational therapy services (adapted from Mason-Jones, Kavander, & Vroman, 1999, pp. 67-89).

Communication/satisfaction skills (a performance skill)
- Refers to communicating intentions and needs as well as coordinating social behavior to act together with people (Kefiff, 1999; Kefiff, 1999; Kefiff, 1999; Kefiff, 1999; Kefiff, 1999; Kefiff, 1999; Kefiff, 1999; Kefiff, 1999; Kefiff, 1999; Kefiff, 1999).

Context of care
- Refers to a variety of interrelated conditions and behaviors and the surrounding the client's life style. (See Appendix, Table 4, for definitions of errors.)

Cultural (a context)
- "Cultural beliefs, family patterns, behavioral standards, and expectations accepted by the society in which the individual is a member. Includes cultural aspects such as (a) livest
effect access to resources and affirm personal rights. This includes opportunities for education, employment, and economic support” (AOTA, 1994, p. 1054).

Dynamic assessment

Describe a process used during intervention implementation to ensure the hypotheses generated through the evaluation process allows for evaluation of change and intervention effectiveness during intervention. Assesses the interactions among the person, environment, and activity as understood from the client’s lens and expression activities. May lead to adjustments in intervention plans adapted from Smedley & Ferguson, (1998, p. 62).

E

Education (or area of occupation)

Includes activities needed for being a student and participating in a learning environment. (See Appendix, Table 1, for definition of agent.)
- Formal educational participation
- Informal general educational needs or interest expression (beyond formal education)
- Informal personal educational expression

Engagement in occupation

This term recognizes the communicative role of performance in occupations as activities in the lives of individuals, communities, and society, and meaning and adding to the productive and creative aspects of being involved in and guiding the occupation and activities that are meaningful and purposeful to the person.

Evaluation

"Still be used in order to the proposed observing and interpreting data necessary for intervention. This includes planning for and documenting the evaluation process and results” (AOTA, 1995, p. 1072).

G

Goal

"The result of achievement toward which effort is directed" (Random House Webster, College Dictionary, 1999).

H

Habits (performance pattern)

"Atmospheric behavior that is integrated into many complex patterns that enable people to function on a day-to-day basis" (Norton & Green, 1998, p. 809). Habits can either support or interfere with performance in areas of occupation. (See Appendix, Table 3, for description of types of habits.)

Health

"A complex mix of physical, mental, and social well-being and not just the absence of disease or infirmity" (WHO, 1946, p. 29).

Health care

A condition in which you successfully and subjectively perceive occupation (adapted from McCall, Law, & Stewart, 1995, p. 5).

Identity

A comprehensive definition of the self and includes an interpersonal aspect (e.g., self image and relationships, such as family, work, occupational therapy), an awareness of possibility or potential (what we might become), and a value system (whether our occupation and provide a stable basis for choices and decisions). — Identity can be likened to the somewhat vague idea that includes the self-esteem and self-image, but also important social and is influenced by the larger social world in which we find ourselves" (Christensen, 1999, pp. 948-949).

Independence

"Having adequate resources to accomplish everyday tasks" (Christensen & Egan, 1997, p. 592). "The patient's sense of independence is the ability to self-determine activity performance regardless of who actually performs the activity" (AOTA, 1998, p. 1051).

Instrumental activities of daily living (IADL (or area of occupation))

Activities that are oriented toward interacting with the environment and that we when complex, IADL, are evaluated in nature, that is, may be categorized into whether (adapted from Ripley & Haas, 1984, p. 181-182). (See Appendix, Table 1, for definition of area.)
- Use of objects (including selecting and supervising care given)
- Use of phone
- Child raising
- Communication device use
- Communication mobility
- Financial management
- Health management and maintenance
- Home establishment and management
- Meal preparation and serving
- Safety procedures and emergency response
- Shopping
- Interests

"Disposition to find pleasure and satisfaction in occupation and the self-knowledge of one experiences of occupa-
Introduction approach

A critical process for identifying and reviewing the interventions plan and the effectiveness of implementation, and the progress toward targeted outcomes.

Intervention review

A continuous process for reviewing and revising the interventions plan, the effectiveness of implementation, and the progress toward targeted outcomes.

Interventions

Items or types of interventions

- Therapeutic use or off
- Therapeutic use of occupational therapy interventions
- Cancellation process
- Education process

Level of an area of occupation

A predefined activity that is (involvement orientated) or engaged in during daily functioning, that is time oriented or idiosyncratic, or both (Pihlorn & Pihlorn, 1997, p. 259). (See Appendix, Table 4, for definitions of areas.)

Least involvement

Least participation

Motor skills in performance skill

Skills in movement and interacting with task, object, and environment. A. Fish, personal communication, July 9, 2003.
Social (a context)

Availability and expectation of significant individuals, such as spouse, family, and caregivers. Also include larger social groups which are influential in establishing norms, role expectations, and social sanctions (MOTA, 1994, p. 51).

Social participation (as area of occupation)

"Biographical patterns of behavior that characterize and expected of an individual in a given situation within a social system" (MOTA, 1996, p. 340). (See Appendix, Table 1, for definitions of area).

Contingency

• Family
• Peer, friend

Spiritual (a context)

The existential or ideological view of a person's life that which inspires and motivates the individual.

T
temporal (a context)

"Location of occupational performance in time" (Nevins & Conger, 1988, p. 291).

V

Values

A coherent set of convictions that guide significant or mundane individual actions to perform accordingly" (Kissel, Boswell, Burke, Helkert, & Nagy, 1999, p. 46).

Virtual (a context)

Environment in which occupational actions are based on always or occasionally and are absent of physical context.

W

Wellness

The condition of being in good health, including the appreciation and the enjoyment of health. Wellness is more than a lack of disease symptoms; it is a sense of mental and physical balance and function. (Giger, Occupational Therapy, 1997).

Work (as area of occupation)

Include activities needed for engaging in productive employment or volunteer activities (MOTA, 1996, p. 341). (See Appendix, Table 1, for definitions of area)

• Employment and productivity
• Job performance
• Requirement preparation and adjustments
• Volunteer employment
• Volunteer participation

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1995, 49, 101-120.
References


The revised edition of the first edition of "Operational Terminology" was titled the "Operational Terminology: Product Output Reporting System and Uniform Terminology for Reporting Occupational Therapy Services" (OCTAS). It was published in 1979. It was revised and updated to reflect changes in the field and to incorporate new terminology and concepts. The revised edition was released in 1989. The revision process involved input from occupational therapists and other stakeholders to ensure that the terminology accurately reflected the current state of the field.

The revised edition was widely used in the field of occupational therapy and became a standard reference for therapists, researchers, and educators. It was also used as a basis for developing similar terminologies in other fields.

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during which each official document can be updated and revised as needed. Theorem of content exposed to reviewers included the following:

- Terms defined in the department were unclear, incoherent, or confusing.
- Terms that should have been in the documents were missing.
- Too much emphasis was placed on performance comparisons.

- The concept of occupation was not included.
- Terms were used that were unfamiliar to external reviewers (i.e., performance comparisons, performance outcomes).
- Considerations should be given to using terminology proposed in the revision of International Classification of Functioning, Disability and Health (ICF).
- The document is being used inappropriate to design curriculum.
- The role of therapy application in clinical reasoning is being minimized by using UT-III as a recipe for practice.

The COP recognized that the practice environment had changed significantly since the last revision and that the profession's understanding of its user context and service delivery process had further evolved. The recently published Guide to Occupational Therapy Practice (1999) outlined many of these contemporary shifts, and the COP carefully reviewed this document. In light of these changes, and the feedback received during the review process, the COP decided that practice-needed had changed and that it was time to develop a different kind of assessment. The Occupational Therapy Practice Framework: Domain and Processes was developed in response to these needs and changing conditions.

Guidelines of the Framework in the Revised UT-III and the ICF

The Framework updates, revises, and incorporates the primary elements (performance areas, performance comparisons, performance outcomes) outlined in the revised UT-III. In some cases, the nature of these elements were updated to reflect shifts in thinking and to create more obvious links with terminology outside of the profession. Feedback from the review indicated that the use of occupational therapy terminology often made it more difficult for others in understand what occupational therapy colleagues. The ICF language is also seen as important to incorporate. The following chart shows how terminology has evolved by comparing terminology used in the Framework, the revised UT-III, and the ICF documents.

<table>
<thead>
<tr>
<th>Framework</th>
<th>Revised UT-III</th>
<th>p. 42</th>
</tr>
</thead>
<tbody>
<tr>
<td>Domain:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Environment: Health, social, and environmental conditions, and personal and contextual factors that influence the context in which occupational therapy services are provided.</td>
<td>Environment: Health, social, and environmental conditions, and personal and contextual factors that influence the context in which occupational therapy services are provided.</td>
<td>Not specified.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Section of occupations: health (1999) with activities in which therapy, apply, and the learning categories.</th>
<th>ICF, ICF, question, work, play, leisure, and social participation.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Therapy-occupation (p. 101-102)</td>
<td>Web and technology-related, body-mind, and communication</td>
</tr>
</tbody>
</table>

Aspects and considerations—
- Adaptability—How easy it is until practice is in (therapy) p. 10 |
- Modification—Enhancement to the patient's p. 18-19 |
- Environment: physical, social, and emotional conditions, communication, social and living skills, personal and social participation, and environmental, social and emotional conditions. Adaptability and regulation capacities from UT evolve from all sections of occupations, activities and values, and rehabilitation services for the patient.

(Endnotes)

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COMPOSITION OF TERMS

COMPOSITION OF TERMS

1. **Performance**—arrangement of actions, or tasks, executed by an organism or an organism with an organism, such as in plant and animal behavior or in the behavior of robots and machines.

2. **Performance components**—refers to specific, measurable, and observable elements of performance, such as physical or cognitive abilities, as well as the interaction of these components with other components.

3. **Activity**—the process of producing a product or service by applying the performance components to a specific task or task set.

4. **Activity components**—refers to the specific, measurable, and observable elements of activity, such as the physical or cognitive abilities required to perform the activity.

5. **Adaptation**—the process of adjusting to changes in the environment or in the performance or activity components.

6. **Recognition**—the process of identifying and distinguishing between different performance or activity components.

7. **Feedback**—the process of receiving information about the performance or activity components and using this information to adjust the performance or activity components.

8. **Decision**—the process of making a choice or selecting a course of action based on the performance or activity components and the feedback received.

9. **Learning**—the process of acquiring new knowledge, skills, or abilities through experience and practice.

10. **Retention**—the process of maintaining the acquired knowledge, skills, or abilities over time.

11. **Transfer**—the process of applying the acquired knowledge, skills, or abilities to new situations or contexts.

12. **Assessment**—the process of evaluating the performance or activity components and the effectiveness of the adaptation and feedback processes.

13. **Evaluation**—the process of judging the performance or activity components and the effectiveness of the adaptation and feedback processes.

14. **Performance components**—refers to specific, measurable, and observable elements of performance, such as physical or cognitive abilities, as well as the interaction of these components with other components.

15. **Activity**—the process of producing a product or service by applying the performance components to a specific task or task set.

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18. **Recognition**—the process of identifying and distinguishing between different performance or activity components.

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24. **Assessment**—the process of evaluating the performance or activity components and the effectiveness of the adaptation and feedback processes.

25. **Evaluation**—the process of judging the performance or activity components and the effectiveness of the adaptation and feedback processes.

26. **Performance components**—refers to specific, measurable, and observable elements of performance, such as physical or cognitive abilities, as well as the interaction of these components with other components.

27. **Activity**—the process of producing a product or service by applying the performance components to a specific task or task set.

28. **Activity components**—refers to the specific, measurable, and observable elements of activity, such as the physical or cognitive abilities required to perform the activity.

29. **Adaptation**—the process of adjusting to changes in the environment or in the performance or activity components.

30. **Recognition**—the process of identifying and distinguishing between different performance or activity components.

31. **Feedback**—the process of receiving information about the performance or activity components and using this information to adjust the performance or activity components.

32. **Decision**—the process of making a choice or selecting a course of action based on the performance or activity components and the feedback received.

33. **Learning**—the process of acquiring new knowledge, skills, or abilities through experience and practice.

34. **Retention**—the process of maintaining the acquired knowledge, skills, or abilities over time.

35. **Transfer**—the process of applying the acquired knowledge, skills, or abilities to new situations or contexts.

36. **Assessment**—the process of evaluating the performance or activity components and the effectiveness of the adaptation and feedback processes.

37. **Evaluation**—the process of judging the performance or activity components and the effectiveness of the adaptation and feedback processes.

(Continues)
References


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Adopted by the Representative Assembly 2/20/91

Appendix B:

Levels of Clinical Reasoning Table
<p>| - | Use “context-free” applications of theory. |  |
| - | Learn to identify what is normal and what is not, but generally does not consider other aspects of a disability. | Slater &amp; Cohn 1991, p 1040 | Benamy, 1996, p 26 |
| - | May need help understanding and recognizing phenomena. |  |
| - | Have difficulty prioritizing information. |  |
| - | Use situational thinking but still has difficulty prioritizing; attends only to the behavior that is observable. | Slater &amp; Cohn 1991, p 1040 | Benamy, 1996, p 26 |
| - | Do not see the impact of deficits on overall functioning. |  |
| - | May misdirect energy; need help to select the most effective treatment and the most pressing functional needs of a client. |  |</p>
<table>
<thead>
<tr>
<th>Proficient Therapists</th>
<th>Expert Therapists</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Demonstrate flexibility to alter treatment plans and has a clearer sense of the client’s contexts both currently and anticipated.</td>
<td>• Organize treatment from client cues rather than from treatment protocols.</td>
</tr>
<tr>
<td>• Use prospective story telling to promote desired outcomes; uses familiar patterns and integrates both for treatment.</td>
<td>• Make clinical decisions that “just feel right.”</td>
</tr>
<tr>
<td>• Identifies what typical events to expect; recognizes when the expected picture does not materialize.</td>
<td>• Have intuitive grasp of the situation, may use rules as part of the “background.”</td>
</tr>
<tr>
<td>• Employ unusual methods or novel solutions, given the freedom and support to do so.</td>
<td>• Demonstrate substantial technical skill without breaking up the interaction with the patient.</td>
</tr>
</tbody>
</table>
Appendix C.
Validation Study

(© Torcivia, 2005)
Validity Study of Multimedia Cases

It was necessary to have clinical occupational therapy experts in rehabilitation verify the content validity of two multimedia case studies. These experts determined the extent to which the case studies represented reasonable information about clients and the similarity to actual clinical case content encountered by practicing occupational therapists.

Validation of Case Studies:

Two multimedia case studies developed by Torcivia, Picard and Younghouse (2000) were used for the analysis of elements of clinical reasoning in the second part of this study. The cases were originally developed for use during occupational therapy graduate courses and were based on several actual clinical cases treated by the developers. For this portion of the study, individuals (experts) who had clinical knowledge of the cases' patient populations were recruited and asked to review the cases and their content to ensure a valid foundation for consensus building.

Subjects: Occupational therapy department heads of the rehabilitation facilities within 100 miles of Seton Hall University were sent
a letter requesting the nomination of experienced occupational therapists to participate in a short on-line survey regarding the validity of the content of the case studies. These letters were followed up by phone calls to the facilities. Individuals who graduated from the Selcon Hall University Occupational Therapy Program or individuals who were unable to use the computer technology required to review the cases and answer the survey were excluded. This effort resulted in a convenience sample of six content experts.

Agreement of at least 75% of the participants on the correctness of the content was considered adequate to assure validity of the cases (Depoy and Girlin, 1998, p. 206). Modifications (additions, changes, or deletions) of information suggested by participants in the cases were undertaken if the change corrected any inconsistencies in the content of the case without changing the actual outcomes or format.

Results

Validity study: Table 1. represents the questions asked in the pilot study for content validity of the cases. Questions 2-4 were about the case content for Case One (Joe Remora). Questions 7-11 were about the case content for Case Two (Mary Price).
<table>
<thead>
<tr>
<th>Question Asked</th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>2. Was the scientific/procedural information in Case One (Joe Remora) correct?</td>
<td>4</td>
<td>2</td>
</tr>
<tr>
<td>3. Was the case content consistent across Case One (Joe Remora)?</td>
<td>5</td>
<td>1</td>
</tr>
<tr>
<td>4. Was the case (Case One) plausible/consistent with your experience?</td>
<td>5</td>
<td>1</td>
</tr>
<tr>
<td>5. Are these elements that you would add to this particular case (Joe Remora)? (Please list in the next question)</td>
<td>4</td>
<td>2</td>
</tr>
<tr>
<td>7. Was the scientific/procedural information in Case Two (Mary Price) correct?</td>
<td>6</td>
<td>0</td>
</tr>
<tr>
<td>8. Was the case content consistent across Case Two (Mary Price)?</td>
<td>4</td>
<td>2</td>
</tr>
<tr>
<td>9. Was this case (Case Two) plausible/consistent with your experience?</td>
<td>5</td>
<td>1</td>
</tr>
<tr>
<td>10. Are there elements that you would add to this particular case (Mary Price)?</td>
<td>3</td>
<td>3</td>
</tr>
</tbody>
</table>

Three respondents were contacted by phone to clarify their negative answers and to provide corrections to the case content. One respondent suggested that in the current healthcare environment, Occupational Therapy intervention in the second case would be implausible or at best minimal, as the individual in the case was “too good” to need services. When asked if the rest of the case was correct and consistent, she agreed that overall the case was correct and consistent with her experience.
Another respondent provided a detailed analysis of the first case, and contacted the researcher by phone with specific suggestions. She found several text inconsistencies: one with medications, one with transfer status and an “implausible finding” regarding the client’s premorbid ability to commute. At the completion of her conversation, she agreed that this case was very consistent with her experience and that with the corrections, the case would be correct. All of these suggestions were integrated into the case studies. With the corrections, both case studies now have better than 75% agreement suggesting good face validity.
Sample of solicitation letter (Seton Hall University IRB approved)

September 28, 2005

Dear Colleague,

My name is Elizabeth Toniolli, and I am a doctoral candidate in the Graduate Programs in Health Sciences at Seton Hall University as well as a faculty member in the Occupational Therapy program. I am seeking your assistance to identify individuals (yourself included) who can give me a few minutes to complete an online survey regarding the content of two, multimedia case studies. Your facility was selected as a center at which expertise in physical disability-related occupational therapy is available.

These case studies were developed about 4 years ago by myself and a colleague. The content of the case studies was based on information combined from cases each of us had previously treated. We have used them in training our graduate students; now I would like to use the cases in my dissertation research on clinical reasoning. Your assistance in validating the content of the cases would allow me to assert that the diagnostic content is correct and that the cases are plausible.

I would appreciate your assistance in the identification of occupational therapy practitioners (OTR-level, either masters or baccalaureate prepared) whom you consider experts, who have at least 5 years experience in physical disabilities, are willing to complete a short on-line survey, and have access to the Internet. The ability to competently use the Internet and high-speed access (cable or DSL) are important factors, due to the size of the multimedia files. Individuals who are graduates of the Seton Hall University Occupational Therapy Program are not eligible to participate in this study.

If you and/or other occupational therapists at your facility agree to participate, you will be asked to review the case studies, which will be posted on a secure Internet website, and then asked to complete a short survey regarding the content of each case study. Each individual will be given a password to access the case studies and the surveys. Participants’ identifying information (names and passwords) will be kept in a locked drawer in the investigator’s office and destroyed when the study is completed.

It is expected that the review process will take about 15-20 minutes; and the survey will take less than 10 minutes of each participant’s time.
To participate in this study, or to suggest individuals on your staff who might participate, contact me at toremia@ahs.org. Those individuals who are identified will be given a link to the website and a password. Participation is entirely voluntary; and a response to this solicitation will be considered consent.

Your assistance in this study is greatly appreciated, and will help contribute to the development of materials to study clinical reasoning in students and practitioners in the field of occupational therapy.

Sincerely,
Elizabeth M. Torcivia, MFA, OTR
Appendix D

Solicitation of Respondents
Dear Colleagues,

I am a doctoral candidate in the Graduate Programs in Health Sciences at Seton Hall University as well as an occupational therapist. I am contacting you to ask for your participation in a project which is part of my dissertation research. I have specifically contacted you because of your past research and authorship on clinical reasoning in our field.

I am investigating the development of clinical reasoning in occupational therapy practitioners and students, and have identified the need for consensus among experts in our field as to what constitutes evidence of clinical reasoning. To that end, I propose using two multimedia case studies as the basis for a Delphi survey of a variety of individual experts. Experts in my study will come from three areas of our profession: individuals who have discussed and published articles in our literature about clinical reasoning; individuals who have passed the exam for Board Certification in Neurorehabilitation; and educators who have significant experience in teaching OT practitioners of tomorrow in the areas of clinical reasoning or physical disabilities.

Delphi surveys have been used in our literature previously to examine the concept of mastery in clinical occupational therapy (see the article by Depoy, AJOT, May 1990). This project will use an electronic Delphi survey and will consist of 4 rounds of questions regarding evidence of clinical reasoning based on two specific case studies. Use of the Internet will allow for quicker and easier access for all the respondents, so consistent access to the Internet, familiarity with website browsing and a high-speed connection will be important. I expect that this will take about an hour of your time initially, and much less in the subsequent rounds. The entire project, although dependent on the speed of respondent’s replies, is expected to be completed within 6 weeks.

The study will be posted on a website to which you will be given access by a specific password. This site will host both the case studies and surveys; your attempts to access the site will be electronically tracked to ensure the participation of all respondents in all iterations. The first survey will be an online open-ended questionnaire, and will be completed after you have reviewed the case studies. The case studies will be available online throughout the entire process. Participation will be asked to identify components of the case studies that correspond to concepts in the Occupational Therapy Practice Framework (AOTA, 2002). It is anticipated that this component will be the most time-consuming, but it should not exceed two hours. Subsequent online questionnaires will be developed based on synthesis of the previous results, should take less than an hour to complete, and will ask for your ranking and/or agreement on the overall findings of the group. The final result will be a matrix of elements that you as the experts agree are essential indicators of clinical reasoning for these cases.
Participation in this study is entirely voluntary and is assumed when you respond to this inquiry. Initial contact should be in the form of an email addressed to terciviaj@atu.edu with ‘Delphi Study respondent’ in the subject line. You will receive a return email with the user and password information as well as directions and a link to access the website.

Your participation in this study will be kept confidential. All information about the participants in this study, including identifying information, passwords, and responses will be kept in a locked file drawer in the investigator’s office and will be destroyed at the completion of the study.

The development of tools to assess or self-assess clinical reasoning is important to our profession. The demands of the healthcare environment and the complexity of the reasoning required in our field necessitate such tools to ensure competency of practitioners as well as efficacy of professional development strategies. Please consider participation in this study as a contribution to our self-reflection about clinical reasoning in occupational therapy.

Sincerely,

Elizabeth M. Tercivia, MPA, OTR
Dear Colleague,

I am a doctoral candidate in the Graduate Program in Health Sciences at Siena Hall University as well as an occupational therapist. I am contacting you to ask for your participation in a project which is part of my dissertation research. Specifically, I would appreciate it if you would read the following request for participants and forward it to members of your faculty who have been teaching for more than 5 years and whose areas of expertise include clinical reasoning and/or physical disabilities.

I am investigating the development of clinical reasoning in occupational therapy practitioners and students, and have identified the need for consensus among experts in our field as to what constitutes evidence of clinical reasoning. To that end, I propose using two multimedia case studies as the basis for a Delphi survey of a variety of individual experts. Experts in my study will come from three areas of our profession: individuals who have discussed and published articles in our literature about clinical reasoning; individuals who have passed the exam for Board Certification in Neurorehabilitation; and educators who have significant experience in teaching OT practitioners of tomorrow in the areas of clinical reasoning or physical disabilities.

Delphi surveys have been used in our literature previously to examine the concept of mastery in clinical occupational therapy (see the article by Deppay, AOT, May 1990). This project will use an electronic Delphi survey and will consist of 4 rounds of questions regarding evidence of clinical reasoning based on two specific case studies. Use of the Internet will allow for quicker and easier access for all the respondents, so consistent access to the Internet, familiarity with website browsing and a high-speed connection will be important. I expect that this will take about an hour of your time initially, and much less in the subsequent rounds. The entire project, although dependent on the speed of respondent’s replies, is expected to be completed within 6 weeks.

The study will be posted on a website to which you will be given access by a specific password. This site will host both the case studies and surveys; your attempt to access the site will be electronically tracked to ensure the participation of all respondents in all iterations. The first survey will be an online open-ended questionnaire, and will be completed after you have reviewed the case studies. The case studies will be available online throughout the entire process. Participants will be asked to identify components of the case studies that correspond to concepts in the Occupational Therapy Practice Framework (AOTA, 2002). It is anticipated that this component will be the most time-consuming, but it should not exceed two hours. Subsequent online questionnaires will be developed based on synthesis of the previous results, should take less than an hour to complete, and will ask for your ranking and/or agreement on the overall findings of the group. The final result will be
a matrix of elements that you as the experts agree are essential indicators of clinical reasoning for these cases.

Participation in this study is entirely voluntary and is assumed when you respond to this inquiry. Initial contact should be in the form of an email addressed to torcivia@shs.edu with “Delphi Study respondents” in the subject line. You will receive a return email with the user and password information as well as directions and a link to access the website.

Your participation in this study will be kept confidential. All information about the participants in this study, including identifying information, passwords, and responses will be kept in a locked file drawer in the investigator’s office and will be destroyed at the completion of the study.

The development of tools to assess or self-assess clinical reasoning is important to our profession. The demands of the healthcare environment and the complexity of the reasoning required in our field necessitate such tools to ensure competency of practitioners as well as efficacy of professional development strategies. Please consider participation in this study as a contribution to our self-reflection about clinical reasoning in occupational therapy.

Sincerely,

Elizabeth M. Torcivia, MPA, OTR
Dear Colleague,

I am a doctoral candidate in the Graduate Programs in Health Sciences at Saint Mary University as well as an occupational therapist. I am contacting you to ask for your participation in a project which is part of my dissertation research. Specifically, I am contacting individuals who are experts by virtue of status as Board-Certified in Neurorehabilitation (BCN). Your expertise is valuable to our profession, and I am hoping you will be willing to use it to help develop consensus about clinical reasoning in our profession.

I am investigating the development of clinical reasoning in occupational therapy practitioners and students, and have identified the need for consensus among experts in our field as to what constitutes evidence of clinical reasoning. To that end, I propose using two multimedia case studies as the basis for a Delphi survey of a variety of individual experts. Experts in my study will come from three areas of our profession: individuals who have discussed and published articles in our literature about clinical reasoning; individuals who have passed the exam for Board Certification in Neurorehabilitation; and educators who have significant experience in teaching OT practitioners of tomorrow in the areas of clinical reasoning or physical disabilities.

Delphi surveys have been used in our literature previously to examine the concept of mastery in clinical occupational therapy (see the article by Depoy, AJOT, May 1990). This project will use an electronic Delphi survey and will consist of 4 rounds of questions regarding evidence of clinical reasoning based on two specific case studies. Use of the Internet will allow for quicker and easier access for all the respondents, to consistent access to the Internet, familiarity with website browsing and a high-speed connection will be important. I expect that this will take no more than 2 of your time initially, and much less in the subsequent rounds. The entire project, although dependent on the speed of respondent's replies, is expected to be completed within 6 weeks.

The study will be posted in a Blackboard™ site to which you will be given a specific password to access. This site will host both the case studies and surveys; your attempts to access the site will be electronically tracked to ensure the participation of all respondents in all iterations. Your anonymity will be protected by your invisibility to other participants; I will maintain a list of passwords and user identification in a locked file. The first survey will be an online open-ended questionnaire, and will be completed after you have reviewed the case studies. The case studies will be available online throughout the entire process. Participants will be asked to identify components of the case studies that correspond to concepts in the Occupational Therapy Practice Framework (AOTA, 2002). It is anticipated that this component will be the most time-consuming, but it should not exceed two hours. Subsequent online questionnaires will be developed based on synthesis of the previous results, should
take less than an hour to complete, and will ask for your ranking and/or agreement on the overall findings of the group. The final result will be a matrix of elements that you as the experts agree are essential indicators of clinical reasoning for these cases.

Participation in this study is entirely voluntary and is assumed when you respond to this inquiry. Initial contact should be in the form of an email addressed to torcivial@dshu.edu with “Delphi Study respondent” in the subject line. You will receive a return email with the user and password information as well as directions and a link to access the Blackboard™ site. Again, your participation is anonymous to other respondents. This study has been reviewed and approved by the Institutional Review Board of Seton Hall University.

The development of tools to assess or self-assess clinical reasoning is important to our profession. The demands of the healthcare environment and the complexity of the reasoning required in our field necessitate such tools to ensure competency of practitioners as well as efficacy of professional development strategies. Please consider participation in this study as a contribution to our self-reflection about clinical reasoning in occupational therapy.

Sincerely,

Elizabeth M. Torcivia, MPA, OTR
Appendix E

Survey Questionnaires
ROUND ONE QUESTIONNAIRE (posted on Formsite™)

Clinical Reasoning Delphi Study

This is the first part of this Delphi survey. For your convenience, I have broken responses up by sections in the Occupational Therapy Practice Framework (AOTA, 2002). Because I am seeking to understand what expert occupational therapists identify as essential client narrative information, there are no questions about intervention or outcomes.

Each section can be answered in text or list form.

1. Please identify the AREAS OF OCCUPATION that you feel would be evidence of clinical reasoning by any occupational therapist for the clients in these cases.

2. Please identify the PERFORMANCE SKILLS you feel would be addressed by any occupational therapist in these cases that would be evidence of his or her clinical reasoning.

4. Using the information from the cases, indicate what information about CONTEXT would be evidence of clinical reasoning.

5. Please specify what information about ACTIVITY DEMANDS would reflect evidence of clinical reasoning in these cases.
6. What are the CLIENT FACTORS in this case that any occupational therapist should address?

7. Is there other client information that you feel would be significant as evidence of clinical reasoning in developing interventions or outcomes for this case?

Figure 61. Round one questionnaire
ROUND TWO QUESTIONNAIRE (posted on Formsite and sent by postal mail)

March 17, 2006

Dear Dr. ,

Thank you again for your participation in Round One of my Delphi study on expert consensus regarding clinical reasoning. I apologize for the lengthy first round, but the very defining characteristics of “experts” are those that extend the time needed for completion by all the participants. Experts are busy, engaged individuals who, when they agree to participate in such an activity, do so completely and in much detail. I have finally received 17 full responses and feel that it is sufficient to go forward with the next round. Again, I would like to thank you all for the detail and obvious thought that went into all the responses. I have a wealth of data for this study and for my future as a researcher.

The responses, as expected, varied in both content and in approach to a very open-ended set of questions. I enjoyed the comments and emails that accompanied the responses, and will be glad to discuss them after the process is complete. Some participants chose to address the content in each case study separately, while some chose to give broad categorical responses that were coached in the language of the Practice Framework.

The purpose of the second round of the Delphi is provide you with group feedback on the elements that you, as the experts, felt should be addressed in these two cases. You will find an enclosed/attached questionnaire that reflects my attempt to compile and synthesize the comments and responses of the first round. This round is for you to review the identified components that were agreed to be important (this time, case-specifically). I then would like you to indicate that you continue to agree upon the important elements and, additionally, indicate how important you think these elements are.

One of the features of the Delphi process is the opportunity to receive group feedback and to be able to re-evaluate your responses in light of the group’s input. The grid indicates the number of responses (and percentage); that is how many individuals identified that element of the Practice Framework as being important to address for these cases.
The three columns to the right of the summary are for you to indicate whether, after seeing the responses of other participants, you still agree or disagree that the element is important to address. In the column labeled AGREE/IN, mark your choices for this round; that you agree that the section is important for either or both (or neither) of the cases. (J for Case One, M for Case Two, JM for both, N for neither).

The two columns to the right are for a Likert-type ranking of the importance of each element. Please indicate, using a scale of 1 (least desirable) to 5 (most desirable) how important this element would be to address for these cases. Any open-ended comments can be added below each section.

Some respondents were challenged by the electronic nature of this study, and I have revised my initial design to offer traditional paper surveys as well as an on-line version. I have again posted this round to the study website (http://pinge.shu.edu/~torcivel), but am also mailing a "hard" copy with a return envelope for your convenience. Please try to get them back within 10 days of your receipt. Please put your identifier at the top of each page (a reminder is next to your name at the top of this letter).

If you have questions regarding the survey or the process, please feel free to email me at torcivel@shu.edu or call me at 908-236-3586. I would appreciate responses no later than April 1, 2006 and will try to follow up with the third and final round quickly thereafter. The final round will consist of feedback from this round and a final ranking of the items.

I will also shortly be sending out invitations for a get-together in Charlotte for us to trade ideas. If all the rounds are complete, this will also be an opportunity for you to see some of the anonymous "raw" data from the first round. It's pretty interesting, and can perhaps provide a basis for some other lines of inquiry.

Again, I want to thank you for your participation in this study. Please feel free to contact me if you have any further questions.

Sincerely,

Elizabeth M. Torcivia, MPA, CTR
Assistant Professor, Occupational Therapy Dept.
School of Graduate Medical Education
Seton Hall University
South Orange, New Jersey 07079

Enclosed: Round two questionnaire, return envelope
ROUND TWO DELPHI

The following data represent analysis and compilation of expert responses to Round One questions.

The columns entitled "General" indicates the number of respondents who indicated that, in general, this subcategory of the OTPF would be important to address, given the information in the two case studies.

The columns entitled "Joe" or "Mary" reflect the number of responses that specifically indicated the need to address this subcategory for that specific case.

As outlined in the accompanying letter, please do the following:

- Review the findings relative to the case studies.
- Indicate in the 4th column if you still agree that this element should be addressed. In this column, place a "J" (case one) or "M" (case two) or "J/M" for both.
- Rate the importance of each item on a Likert scale in the 5th and 6th columns, from a 1 (least desirable) to 5 (most desirable).

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<th>Areas of Occupation responses</th>
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<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
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<td>Mary</td>
<td>Agree</td>
<td>Rate (Joe)</td>
<td>Rate (Mary)</td>
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<td>Activities of Daily Living (ADL)</td>
<td>10 (59%)</td>
<td>5 (29.4%)</td>
<td>6 (35.2%)</td>
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<td></td>
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<td>1. Bathing/showering</td>
<td>2 (11.7%)</td>
<td>2 (11.7%)</td>
<td>1 (5.8%)</td>
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<tr>
<td>2. Bowel/bladder management</td>
<td>1 (5.8%)</td>
<td>1 (5.8%)</td>
<td>-</td>
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<td></td>
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<tr>
<td>3. Dressing</td>
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<td>1 (5.8%)</td>
<td>1 (5.8%)</td>
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<td></td>
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<tr>
<td>4. Eating</td>
<td>1 (5.8%)</td>
<td>-</td>
<td>-</td>
<td></td>
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<tr>
<td>5. Feeding</td>
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<td>6. Functional Mobility</td>
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<td>2 (11.7%)</td>
<td>3 (17.6%)</td>
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<td>7. Personal Device Care</td>
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<td>-</td>
<td></td>
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<tr>
<td>8. Personal Hygiene &amp; Grooming</td>
<td>2 (11.7%)</td>
<td>2 (11.7%)</td>
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<td>9. Sexual Activity</td>
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<td>1 (5.8%)</td>
<td>2 (11.7%)</td>
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<td>10. Sleep/Rest</td>
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<td>11. Toilet Hygiene</td>
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<td>2 (11.7%)</td>
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(-) indicates no responses

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<th>Rate (Mary)</th>
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<td>2. Care of pets</td>
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<td>5. Community Mobility</td>
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<td>7. Health Management &amp; Maintenance</td>
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<td>-</td>
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<tr>
<td>8. Home Establishment &amp; Maintenance</td>
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<td>-</td>
<td>-</td>
<td>1 (5.8%)</td>
<td>-</td>
<td>-</td>
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<tr>
<td>9. Meal Preparation &amp; Cleanup</td>
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<td>-</td>
<td>2 (11.7%)</td>
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<td>-</td>
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<td>10. Safety procedures &amp; emergency</td>
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<td>5.8%</td>
<td>1 (5.8%)</td>
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<th>Rate (Mary)</th>
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(-) indicates no responses

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<td>3. Job performance</td>
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<td>2 (11.7%)</td>
<td>1 (5.8%)</td>
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<td>5. Volunteer exploration</td>
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<td>6. Volunteer participation</td>
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<th>Joe</th>
<th>Mary</th>
<th>Agree (1/M)</th>
<th>Rate (Joe)</th>
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<th>Mary</th>
<th>Agree (1/M)</th>
<th>Rate (Joe)</th>
<th>Rate (Mary)</th>
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<th>General</th>
<th>Joe</th>
<th>Mary</th>
<th>Agree (1/M)</th>
<th>Rank (Joe)</th>
<th>Rank (Mary)</th>
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<tbody>
<tr>
<td>3 (52.9%)</td>
<td>-</td>
<td>3 (17.5%)</td>
<td>2 (11.7%)</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>1. Community</td>
<td>2 (11.7%)</td>
<td>1 (5.8%)</td>
<td>-</td>
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<td>-</td>
<td>-</td>
</tr>
<tr>
<td>2. Family</td>
<td>2 (11.7%)</td>
<td>3 (17.8%)</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>3. Peer, friend</td>
<td>2 (11.7%)</td>
<td>1 (5.8%)</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td><strong>Performance Skills responses.</strong></td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>----------------------------------</td>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td><strong>Motor Skills</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Posture</td>
<td>5 (35.3%)</td>
<td>1 (5.8%)</td>
<td>1 (5.8%)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Mobility</td>
<td>6 (35.2%)</td>
<td>4 (23.3%)</td>
<td>2 (11.7%)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Coordination</td>
<td>4 (23.3%)</td>
<td>2 (11.7%)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Strength &amp; Effort</td>
<td>3 (17.6%)</td>
<td>3 (17.6%)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Energy</td>
<td>3 (17.6%)</td>
<td>3 (17.6%)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Process Skills</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Energy</td>
<td>2 (11.7%)</td>
<td>-</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Knowledge</td>
<td>2 (11.7%)</td>
<td>-</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Temporal Organization</td>
<td>2 (11.7%)</td>
<td>1 (5.8%)</td>
<td>-</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Organizing space &amp; objects</td>
<td>2 (11.7%)</td>
<td>2 (11.7%)</td>
<td>1 (5.8%)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Adaptation</td>
<td>3 (17.6%)</td>
<td>2 (11.7%)</td>
<td>3 (17.6%)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Communication/Interaction skills</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Physicality</td>
<td>1 (5.8%)</td>
<td>1 (5.8%)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Information exchange</td>
<td>3 (17.6%)</td>
<td>3 (17.6%)</td>
<td>1 (5.8%)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Relations</td>
<td>3 (17.6%)</td>
<td>-</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Performance Patterns responses:</td>
<td>General</td>
<td>Joe</td>
<td>Mary</td>
<td>Agree (J/M)</td>
<td>Rate (Joe)</td>
<td>Rate (Mary)</td>
</tr>
<tr>
<td>--------------------------------</td>
<td>---------</td>
<td>-----</td>
<td>------</td>
<td>-------------</td>
<td>------------</td>
<td>-------------</td>
</tr>
<tr>
<td>Habits</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Usefulness</td>
<td>7 (41.1%)</td>
<td>5 (29.4%)</td>
<td>2 (11.7%)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Impoverished</td>
<td>1 (5.8%)</td>
<td>-</td>
<td>1 (5.8%)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dominating</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Routines</td>
<td>16 (59%)</td>
<td>5 (28.4%)</td>
<td>6 (35.2%)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Roles</td>
<td>10 (59%)</td>
<td>5 (29.4%)</td>
<td>3 (17.6%)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Context Responses:</th>
<th>General</th>
<th>Joe</th>
<th>Mary</th>
<th>Agree (J/M)</th>
<th>Rank (Joe)</th>
<th>Rank (Mary)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Contexts</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cultural</td>
<td>3 (17.6%)</td>
<td>-</td>
<td>-</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physical</td>
<td>7 (41.1%)</td>
<td>7 (41.1%)</td>
<td>10 (38.8%)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Social</td>
<td>6 (35.2%)</td>
<td>7 (41.1%)</td>
<td>6 (35.2%)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Personal</td>
<td>6 (35.2%)</td>
<td>5 (29.4%)</td>
<td>6 (35.2%)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Spiritual</td>
<td>2 (11.7%)</td>
<td>2 (11.7%)</td>
<td>2 (11.7%)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Temporal</td>
<td>6 (35.2%)</td>
<td>1 (5.8%)</td>
<td>3 (17.6%)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Virtual</td>
<td>2 (11.7%)</td>
<td>3 (17.6%)</td>
<td>2 (11.7%)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Comments:
(-) indicates no responses

**Activity Demands responses**

<table>
<thead>
<tr>
<th>Activity Demands</th>
<th>General</th>
<th>Joe</th>
<th>Mary</th>
<th>Agree (J/M)</th>
<th>Rank (Joe)</th>
<th>Rank (Mary)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Objects and their properties</td>
<td>1 (5.8%)</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>2. Space demands</td>
<td>6 (35.2%)</td>
<td>5 (29.4%)</td>
<td>5 (29.4%)</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>3. Social demands</td>
<td>4 (23.5%)</td>
<td>5 (23.4%)</td>
<td>4 (23.5%)</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>4. Sequence and timing</td>
<td>4 (23.5%)</td>
<td>3 (17.6%)</td>
<td>2 (11.7%)</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>5. Required actions</td>
<td>7 (41.1%)</td>
<td>5 (29.4%)</td>
<td>6 (35.2%)</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>6. Required body functions</td>
<td>7 (41.1%)</td>
<td>4 (23.5%)</td>
<td>5 (29.4%)</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>7. Required body structures</td>
<td>7 (41.1%)</td>
<td>3 (17.6%)</td>
<td>3 (17.6%)</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
</tbody>
</table>

Comments: 

_________________________________________________________________________

_________________________________________________________________________
<table>
<thead>
<tr>
<th>Client Factors: Body Function</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
</tr>
</thead>
<tbody>
<tr>
<td>General</td>
<td>3 (17.6%)</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>1. Mental functions</td>
<td>5 (29.4%)</td>
<td>4 (23.5%)</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>2. Sensory functions &amp; pain</td>
<td>4 (25.9%)</td>
<td>5 (29.4%)</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>3. Neuromusculoskeletal &amp; movement-related functions</td>
<td>5 (29.4%)</td>
<td>7 (41.1%)</td>
<td>6 (35.2%)</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>4. Cardiovascular, hematological, immunological &amp; respiratory system functions</td>
<td>1 (5.8%)</td>
<td>2 (11.7%)</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>5. Voice &amp; speech functions</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>6. Digestive, metabolic &amp; endocrine system functions</td>
<td>-</td>
<td>3 (17.6%)</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>7. Genitourinary &amp; reproductive functions</td>
<td>1 (5.8%)</td>
<td>3 (17.6%)</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>8. Skin &amp; related structure functions</td>
<td>2 (11.7%)</td>
<td>2 (11.7%)</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Client Structures - Body structures</td>
<td>2 (11.7%)</td>
<td>2 (11.7%)</td>
<td>4 (23.5%)</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
</tbody>
</table>

Comments:
Round 2 Web Site Version:

The figures below are "screen shots" of the Web site version of Round 2, which was linked to the Formsite web site. The screen shots below are taken from the stored versions of the survey. Some have been edited (cropped) to delete repeated information. Original on-line forms were developed to proceed from page to page; minimal "scrolling" was required of respondents.

Figure E2. Screen shot of the on-line directions for the Round 2 survey.
Figure E3. Screen shot of table of AQL data from Round 1 for the online version of the Round 2 survey. Numbers in the columns relate to respondents’ inclusion of a category generally (non-specific to case information), related to information in Case One (Joe) or related to information in Case Two (Mary).
Figure E4: Screen shot of Areas of Occupation – ADL response grid, to be filled out by each respondent. Note that the entire version would only show to the red bar; a new webpage would display information beyond the page 2 break.
Figure E5. Screen shot of response table with IADL data from Round 1 for on-line version of Round 2 survey. Numbers in the columns relate to respondents’ inclusion of a category generally (non-specific to case information), related to information in Case One (Joe) or related to information in Case Two (Mary).
Figure E6. Screen shot of Areas of occupation - IADL response grid, to be filled out by each respondent.
Figure E4. Screen shot of response grid to be filled out by each respondent for the area entitled “Education”. Note that the page break for page three occurred here; the response grid below the page break appeared on a separate web page in the survey.
Figure E7. Edited partial screen shot of response grid to be filled out by each respondent for the area entitled "Work". (Edited to remove redundant material from other categories.)

Figure E8. Edited partial screen shot of both Play responses from Round 1 and response grid to be filled out by each respondent.
Figure E9. Edited partial screen shot of leisure categories responses from Round one and response grid to be filled out by each respondent.
Figure E10. Screen shot of Social Participation categories responses from Round 1 and response grid to be filled out by each respondent.
Figure 11: Screen shot of Performance Skills section of the Practice Framework with table of responses from Kouna 1 and response grid to be filled out by each respondent.
Figure E12. Screen shot of Process Skills section of the Practice framework with table of responses from Round 1 and response grid to be filled out by each respondent.
Figure E13. Edited partial screen shot of Communication/Interaction Skills section of the Practice Framework with response table which displays Round 1 responses and response grid to be filled out by each respondent.
Figure E.14. Screen shot of Performance Patterns section of the Practice Framework with response table which displays Round 1 responses and response grid to be filled out by each respondent.
Figure E15: Screen shot of Context section of the Practice Framework with response table which displays Round 1 responses and response grid to be filled out by each respondent.
### Figure E10
Edited partial screen shot of the beginning of page six in the online version of Round 2 of the Delphi. Included in this shot is the response table which displays the round 1 responses for the activity demands section of the Practice Framework.

### Table: Activity Demands Responses

<table>
<thead>
<tr>
<th>Activity Demands</th>
<th>First</th>
<th>Second</th>
<th>Third</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Physical activity</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>2. Memory retention</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>3. Social interaction</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>4. Executive function</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>5. Locomotor</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>6. Reading tasks</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>7. Required sensory</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
</tbody>
</table>

### Figure E17
Edited partial screen shot of the response grid for the Activity Demands section of the Practice Framework, to be filled out by each respondent.
### Client Factors Responses

<table>
<thead>
<tr>
<th>Factor</th>
<th>Mean</th>
<th>Std Dev</th>
<th>Median</th>
</tr>
</thead>
<tbody>
<tr>
<td>Client Access Scale</td>
<td>1.02</td>
<td>0.053</td>
<td>1.00</td>
</tr>
<tr>
<td>Working techniques</td>
<td>2.85</td>
<td>0.863</td>
<td>3.00</td>
</tr>
<tr>
<td>Testing techniques &amp; tools</td>
<td>2.85</td>
<td>0.863</td>
<td>3.00</td>
</tr>
<tr>
<td>Environment &amp; resources</td>
<td>5.01</td>
<td>0.14</td>
<td>5.00</td>
</tr>
<tr>
<td>Communication strategies</td>
<td>5.01</td>
<td>0.04</td>
<td>5.00</td>
</tr>
<tr>
<td>Information sharing</td>
<td>5.01</td>
<td>0.04</td>
<td>5.00</td>
</tr>
<tr>
<td>Support &amp; services</td>
<td>5.01</td>
<td>0.04</td>
<td>5.00</td>
</tr>
<tr>
<td>Team working &amp; coordination</td>
<td>5.01</td>
<td>0.04</td>
<td>5.00</td>
</tr>
<tr>
<td>Time &amp; flexibility</td>
<td>5.01</td>
<td>0.04</td>
<td>5.00</td>
</tr>
<tr>
<td>Flexibility &amp; adaptability</td>
<td>5.01</td>
<td>0.04</td>
<td>5.00</td>
</tr>
<tr>
<td>Project &amp; implementation</td>
<td>5.01</td>
<td>0.04</td>
<td>5.00</td>
</tr>
</tbody>
</table>

**Figure E18**: Screen shot of the Round 1 response table for the Client Factors section of the Practice framework.
**Figure E19.** Screen shot of final response grid for the Client Factors section of the Practice Framework, to be filled in by each respondent. Note the back button for the survey, this button was labeled “Submit.”
Round 3 Questionnaires [Sent by email and by U.S.P.S. to all respondents].

June 9, 2006

Dear Colleagues,

This is the final round for the Delphi Study in which you have so graciously participated. I received responses from ALL the participants in Round Two, and hope to do the same for this round. I am scheduled to go to WFOT in Sydney, Australia in mid-July, and would greatly appreciate having all the responses by July 1.

This round assumes two things— that by now, you are familiar enough with the cases that you won’t have to spend more than a few minutes reviewing them, if at all; and secondly, that you have already developed a sense of what you would want to address with each of the individuals in the cases. If that is true, then this round should only take you about 15 minutes. The final round of the Delphi is to improve consensus, specifically on the items that individual respondents omitted or where the responses were evenly split (indicated by items with an *).

The literature on the Delphi technique suggests that consensus varies from as high as 80% agreement to as low as 51% agreement among respondents (Hess et al., 2000). I have chosen a rate of 72% for strong consensus, and have also assumed that less than 12% agreement indicates that an element can be excluded.

I have had several comments from various individuals about the use of the OTPF as a tool, but I felt that it was common to all of you, and provides clear definitions of common occupational therapy terms. Please continue to use it as it makes sense to you, and again, feel free to add comments. What is most important are your responses in the section where I ask for you to indicate if you want to include or exclude an element; there is also an option for “neither” if you feel as if you can’t decide, or would seek more information before deciding to include it. Mark each item, please!

As before, I am mailing the survey and posting it on the website (http://pnsite.shu.edu/~terrelc/). I am also including a short demographic portion to this round so that I can report information about all of you as a group. Please know that all information is confidential, and that the specific information will be destroyed in the appropriate timeframe after the study is complete. I am the only person who knows who the individuals are that relate to each identifier. Furthermore, your responses are anonymous to my committee and to each other, should you decide you would like to see the finished product.
Again, I want to thank you for your participation, your understanding and patience, as well as your response on or before July 1. Please feel free to call or email me with any questions. Let me know if you would like a copy of the final findings, and please feel free to use the cases for your classes if they would be helpful.

Sincerely,

Elizabeth (Beth) Tocci-via, MPA, OTR (toccivel@shu.edu)
Assistant Professor, Occupational Therapy Department
School of Graduate Medical Education
Seton Hall University
South Orange, NJ 07079
973-275-2920
<table>
<thead>
<tr>
<th><strong>Delphi Study Demographic data sheet:</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Name_________________________________</td>
</tr>
<tr>
<td>Identifier_____________________________</td>
</tr>
<tr>
<td>City/State______________________________</td>
</tr>
<tr>
<td>Organization where you are employed_________</td>
</tr>
<tr>
<td>Years of practice as an OT______________</td>
</tr>
<tr>
<td>Highest Degree held in OT: Bachelor___ Master___ PhD___ OTD___</td>
</tr>
</tbody>
</table>

If you are not currently doing clinical practice, when was the last year that you engaged in client treatment, and in what setting did you practice?

(If you are an educator) Do you use multimedia materials in your teaching? Y___ N___

If so, please describe:__________________________________________________________

________________________________________________________________________

Would you be interested in a series of cases similar to the ones used in this study? What type of clients would you want to see?

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

Thanks for your time and participation!
Case One: Joe Remora

**Areas of Occupation**

Based on the consensus compiled from Round Two data, more than 75% of our panel of expert occupational therapists agree that the following elements should be addressed for this client:

<table>
<thead>
<tr>
<th>OTPF category</th>
<th># of responses</th>
<th>% of agreement for inclusion</th>
</tr>
</thead>
<tbody>
<tr>
<td>ADL: overall</td>
<td>15</td>
<td>83.3%</td>
</tr>
<tr>
<td>ADL: Bathing</td>
<td>15</td>
<td>83.3%</td>
</tr>
<tr>
<td>ADL: Functional mobility</td>
<td>18</td>
<td>100%</td>
</tr>
<tr>
<td>ADL: Sexual activity</td>
<td>14</td>
<td>77.8%</td>
</tr>
<tr>
<td>ADL: Toilet hygiene</td>
<td>18</td>
<td>100%</td>
</tr>
<tr>
<td>IADL overall</td>
<td>15</td>
<td>83.3%</td>
</tr>
<tr>
<td>IADL: Community mobility</td>
<td>18</td>
<td>100%</td>
</tr>
<tr>
<td>IADL: Safety procedures and emergencies</td>
<td>15</td>
<td>83.3%</td>
</tr>
<tr>
<td>Work: job performance</td>
<td>18</td>
<td>100%</td>
</tr>
<tr>
<td>Leisure: overall</td>
<td>14</td>
<td>77.8%</td>
</tr>
<tr>
<td>Leisure: Exploration</td>
<td>15</td>
<td>83.3%</td>
</tr>
<tr>
<td>Leisure: Participation</td>
<td>16</td>
<td>86.9%</td>
</tr>
<tr>
<td>Social Participation: overall</td>
<td>15</td>
<td>83.3%</td>
</tr>
<tr>
<td>Social Participation: Community</td>
<td>16</td>
<td>89.9%</td>
</tr>
<tr>
<td>Social Participation: Family</td>
<td>17</td>
<td>84.4%</td>
</tr>
<tr>
<td>Social Participation: Peer/Friend</td>
<td>15</td>
<td>83.3%</td>
</tr>
</tbody>
</table>

Exclusion of the following elements is based on selection of the element by less than 3 respondents (less than 12%)

<table>
<thead>
<tr>
<th>OTPF category</th>
<th># of responses</th>
<th>% of agreement (exclusion)</th>
</tr>
</thead>
<tbody>
<tr>
<td>ADL: Eating</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>ADL: Feeding</td>
<td>1</td>
<td>5.6%</td>
</tr>
<tr>
<td>ADL: Personal device care</td>
<td>2</td>
<td>11.1%</td>
</tr>
<tr>
<td>IADL: Care of others</td>
<td>1</td>
<td>5.6%</td>
</tr>
<tr>
<td>IADL: Child rearing</td>
<td>2</td>
<td>11.1%</td>
</tr>
<tr>
<td>IADL: shopping</td>
<td>2</td>
<td>51.1%</td>
</tr>
<tr>
<td>Work: volunteer exploration</td>
<td>1</td>
<td>5.6%</td>
</tr>
<tr>
<td>Work: volunteer participation</td>
<td>1</td>
<td>5.6%</td>
</tr>
</tbody>
</table>
Please review the following elements in which consensus is weak or absent and indicate in the right-hand column whether you would include the element, exclude the element or have no opinion (neither)

(* elements with little/no consensus)

<table>
<thead>
<tr>
<th>OTPE category</th>
<th># of responses</th>
<th>% of agreement</th>
<th>Include/exclude/neither</th>
</tr>
</thead>
<tbody>
<tr>
<td>ADL: Showering</td>
<td>7</td>
<td>38.9%*</td>
<td></td>
</tr>
<tr>
<td>ADL: Bowel/bladder management</td>
<td>12</td>
<td>96.7%*</td>
<td></td>
</tr>
<tr>
<td>ADL: Dressing</td>
<td>12</td>
<td>66.7%*</td>
<td></td>
</tr>
<tr>
<td>ADL: Personal hygiene and grooming</td>
<td>13</td>
<td>72.2%</td>
<td></td>
</tr>
<tr>
<td>ADL: Sleep/rest</td>
<td>5</td>
<td>27.8%</td>
<td></td>
</tr>
<tr>
<td>IADL: care of pets</td>
<td>4</td>
<td>22.2%</td>
<td></td>
</tr>
<tr>
<td>IADL: Communication, device use</td>
<td>6</td>
<td>33.3%</td>
<td></td>
</tr>
<tr>
<td>IADL: Health management &amp; maintenance</td>
<td>4</td>
<td>22.2%*</td>
<td></td>
</tr>
<tr>
<td>IADL: Home establishment &amp; maintenance</td>
<td>3</td>
<td>16.7%</td>
<td></td>
</tr>
<tr>
<td>IADL: Meal preparation and cleanup</td>
<td>5</td>
<td>27.8%</td>
<td></td>
</tr>
<tr>
<td>Education</td>
<td>3</td>
<td>16.7%</td>
<td></td>
</tr>
<tr>
<td>Work: overall</td>
<td>13</td>
<td>72.2%</td>
<td></td>
</tr>
<tr>
<td>Work: Employment interests &amp; pursuits</td>
<td>5</td>
<td>27.8%</td>
<td></td>
</tr>
<tr>
<td>Work: Employment seeking and acquisition</td>
<td>3</td>
<td>16.7%</td>
<td></td>
</tr>
<tr>
<td>Work: Retirement preparation &amp; adjustment</td>
<td>3</td>
<td>16.7%</td>
<td></td>
</tr>
<tr>
<td>Play</td>
<td>5</td>
<td>16.7%</td>
<td></td>
</tr>
</tbody>
</table>
In the area of Performance Skills

Based on the consensus compiled from Round Two data, more than 75% of our panel of expert occupational therapists agree that the following elements should be addressed for this client:

<table>
<thead>
<tr>
<th>OTPF category</th>
<th># of responses</th>
<th>% of agreement for inclusion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Motor skills: Mobility</td>
<td>18</td>
<td>100%</td>
</tr>
<tr>
<td>Motor skills: Strength and effort</td>
<td>16</td>
<td>88.9%</td>
</tr>
<tr>
<td>Motor skills: Energy</td>
<td>18</td>
<td>100%</td>
</tr>
<tr>
<td>Process skills: Adaptation</td>
<td>15</td>
<td>93.3%</td>
</tr>
</tbody>
</table>

Exclusion of the following elements is based on selection of the element by less than 3 respondents (less than 12%):

<table>
<thead>
<tr>
<th>OTPF category</th>
<th># of responses</th>
<th>% of agreement (exclusion)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Communication: physicality</td>
<td>2</td>
<td>11.1%</td>
</tr>
</tbody>
</table>

Please review the following elements where consensus is weak or absent and indicate in the right hand column whether you would include the element, exclude the element or have no opinion (neither).

(*) elements with little/no consensus

<table>
<thead>
<tr>
<th>OTPF category</th>
<th># of responses</th>
<th>% of agreement*</th>
<th>Include/exclude/neither</th>
</tr>
</thead>
<tbody>
<tr>
<td>Motor skills: posture</td>
<td>13</td>
<td>72.2%*</td>
<td></td>
</tr>
<tr>
<td>Motor skills: coordination</td>
<td>10</td>
<td>55.6%*</td>
<td></td>
</tr>
<tr>
<td>Process skills: overall</td>
<td>12</td>
<td>66.7%*</td>
<td></td>
</tr>
<tr>
<td>Process skills: Energy</td>
<td>12</td>
<td>66.7%*</td>
<td></td>
</tr>
<tr>
<td>Process skills: Knowledge</td>
<td>5</td>
<td>27.8%</td>
<td></td>
</tr>
<tr>
<td>Process skills: Temporal</td>
<td>6</td>
<td>33.3%</td>
<td></td>
</tr>
<tr>
<td>Process skills: Organization</td>
<td>12</td>
<td>66.7%*</td>
<td></td>
</tr>
<tr>
<td>Communication/Interaction</td>
<td>7</td>
<td>38.9%*</td>
<td></td>
</tr>
<tr>
<td>Communication/Interaction</td>
<td>4</td>
<td>22.2%</td>
<td></td>
</tr>
<tr>
<td>Communication/Interaction:</td>
<td>8</td>
<td>44.4%*</td>
<td></td>
</tr>
<tr>
<td>skills: Relations</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
For the sake of saving space, Habits (Performance Patterns) and Context are combined.

Based on the consensus compiled from Round Two data, more than 75% of our panel of expert occupational therapists agree that the following elements should be addressed for the client:

<table>
<thead>
<tr>
<th>OTPF Category</th>
<th># of responses</th>
<th>% of agreement for inclusion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Habits: Routines</td>
<td>15</td>
<td>83.3%</td>
</tr>
<tr>
<td>Habits: Roles</td>
<td>15</td>
<td>83.3%</td>
</tr>
<tr>
<td>Context: Physical</td>
<td>14</td>
<td>77.8%</td>
</tr>
<tr>
<td>Context: Social</td>
<td>18</td>
<td>100%</td>
</tr>
<tr>
<td>Context: Personal</td>
<td>15</td>
<td>83.3%</td>
</tr>
<tr>
<td>Context: Temporal</td>
<td>14</td>
<td>77.8%</td>
</tr>
<tr>
<td>Context: Virtual</td>
<td>14</td>
<td>77.8%</td>
</tr>
</tbody>
</table>

No elements were excluded in this section.

Please review the following elements where consensus is weak or absent, and indicate in the right hand column whether you would include the element, exclude the element or have no opinion (neither).

(* elements with little/no consensus)

<table>
<thead>
<tr>
<th>OTPF Category</th>
<th># of responses</th>
<th>% of agreement</th>
<th>Include/Exclude/Neither</th>
</tr>
</thead>
<tbody>
<tr>
<td>Habits: overall</td>
<td>13</td>
<td>72.2%</td>
<td></td>
</tr>
<tr>
<td>Habits: Useful</td>
<td>7</td>
<td>58.9%*</td>
<td></td>
</tr>
<tr>
<td>Habits: Inappropriated</td>
<td>5</td>
<td>27.3%</td>
<td></td>
</tr>
<tr>
<td>Context: overall</td>
<td>12</td>
<td>66.7%*</td>
<td></td>
</tr>
<tr>
<td>Context: Cultural</td>
<td>12</td>
<td>66.7%*</td>
<td></td>
</tr>
<tr>
<td>Context: Spiritual</td>
<td>11</td>
<td>61.5%*</td>
<td></td>
</tr>
</tbody>
</table>
In the area of Activity Demands:

Based on the consensus compiled from Round Two data, more than 75% of our panel of expert occupational therapists agree that the following elements should be addressed for this client:

<table>
<thead>
<tr>
<th>OTPF category</th>
<th># of responses</th>
<th>% of agreement for inclusion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Activity Demands: Space demands</td>
<td>14</td>
<td>77.8%</td>
</tr>
</tbody>
</table>

No elements were excluded in this section.

Please review the following elements where consensus is weak or absent, and indicate in the right hand column whether you would include the element, exclude the element or have no opinion (neither).

(* elements with little/no consensus)

<table>
<thead>
<tr>
<th>OTPF category</th>
<th># of responses</th>
<th>% of agreement</th>
<th>Include/exclude/neither</th>
</tr>
</thead>
<tbody>
<tr>
<td>Activity Demands overall</td>
<td>11</td>
<td>61.1%*</td>
<td></td>
</tr>
<tr>
<td>Activity Demands: Objects and their properties</td>
<td>13</td>
<td>72.2%</td>
<td></td>
</tr>
<tr>
<td>Activity Demands: Social demands</td>
<td>12</td>
<td>66.7%*</td>
<td></td>
</tr>
<tr>
<td>Activity Demands: Sequence and timing</td>
<td>11</td>
<td>61.1%*</td>
<td></td>
</tr>
<tr>
<td>Activity Demands: Required actions</td>
<td>11</td>
<td>61.1%*</td>
<td></td>
</tr>
<tr>
<td>Activity Demands: Required body functions</td>
<td>13</td>
<td>72.2%</td>
<td></td>
</tr>
<tr>
<td>Activity Demands: Required body structures</td>
<td>11</td>
<td>67.1%*</td>
<td></td>
</tr>
</tbody>
</table>
**In the area of Client Factors:**

Based on the consensus compiled from Round Two data, more than 75% of our panel of expert occupational therapists agree that the following elements should be addressed for this client:

<table>
<thead>
<tr>
<th>OTPF categories</th>
<th># of responses</th>
<th>% of agreement for inclusion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Client Factors: Sensory functions and pain</td>
<td>15</td>
<td>83.3%</td>
</tr>
<tr>
<td>Client Factors: Neuromusculoskeletal and movement functions</td>
<td>14</td>
<td>77.8%</td>
</tr>
</tbody>
</table>

Only one element was found to have 0-1 response and thus was excluded from this section.

| Client Factors: Voice and speech functions             | 0              | 0                            |

Please review the following elements where consensus is weak or absent, and indicate in the right hand column whether you would include the element, exclude the element, or have no opinion (neither).

* Elements with little/no consensus

<table>
<thead>
<tr>
<th>OTPF categories</th>
<th># of responses</th>
<th>% of agreement</th>
<th>Include/exclude/neither</th>
</tr>
</thead>
<tbody>
<tr>
<td>Client Factors: overall</td>
<td>12</td>
<td>66.7%*</td>
<td></td>
</tr>
<tr>
<td>Client Factors: Mental functions</td>
<td>13</td>
<td>72.2%</td>
<td></td>
</tr>
<tr>
<td>Client Factors: Cardiovascular, hematologic, immunological and respiratory functions</td>
<td>9</td>
<td>59%*</td>
<td></td>
</tr>
<tr>
<td>Client Factors: Digestive, metabolic &amp; endocrine functions</td>
<td>8</td>
<td>44.4%*</td>
<td></td>
</tr>
<tr>
<td>Client Factors: Genitourinary &amp; reproductive functions</td>
<td>11</td>
<td>61.1%*</td>
<td></td>
</tr>
<tr>
<td>Client Factors: Skin and related structures functions</td>
<td>12</td>
<td>66.7%*</td>
<td></td>
</tr>
</tbody>
</table>
Thank you for all your patience, time and support! I will be glad to send any of you details of the findings – either indicate it on the returned form or email me.
Case Two: Mary Price

**Area of Occupation**

Based on the consensus compiled from Round Two data, more than 75% of our panel of expert occupational therapists agree that the following elements should be addressed for this client:

<table>
<thead>
<tr>
<th>OTPF category</th>
<th># of responses</th>
<th>% of agreement for inclusion</th>
</tr>
</thead>
<tbody>
<tr>
<td>ADL: overall</td>
<td>15</td>
<td>83.3%</td>
</tr>
<tr>
<td>ADL: Bathing</td>
<td>15</td>
<td>83.3%</td>
</tr>
<tr>
<td>ADL: Functional mobility</td>
<td>18</td>
<td>100%</td>
</tr>
<tr>
<td>IADL: overall</td>
<td>16</td>
<td>88.9%</td>
</tr>
<tr>
<td>IADL: Community mobility</td>
<td>18</td>
<td>100%</td>
</tr>
<tr>
<td>IADL: Meal preparation &amp; cleaning</td>
<td>16</td>
<td>88.9%</td>
</tr>
<tr>
<td>IADL: Safety procedures &amp; emergencies</td>
<td>14</td>
<td>77.8%</td>
</tr>
<tr>
<td>IADL: Shopping</td>
<td>17</td>
<td>94.4%</td>
</tr>
<tr>
<td>Work: Job performance</td>
<td>18</td>
<td>100%</td>
</tr>
<tr>
<td>Leisure: overall</td>
<td>14</td>
<td>77.8%</td>
</tr>
<tr>
<td>Leisure: Participation</td>
<td>15</td>
<td>83.3%</td>
</tr>
<tr>
<td>Social Participation: overall</td>
<td>15</td>
<td>83.3%</td>
</tr>
</tbody>
</table>

Exclusion of the following elements is based on selection of the element by less than 3 respondents (less than 12%)

<table>
<thead>
<tr>
<th>OTPF category</th>
<th># of responses</th>
<th>% of agreement (exclusion)</th>
</tr>
</thead>
<tbody>
<tr>
<td>ADL: Bowel/bladder</td>
<td>2</td>
<td>11.1%</td>
</tr>
<tr>
<td>ADL: Eating</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>ADL: Feeding</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>ADL: Personal Device care</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>IADL: Care of others</td>
<td>1</td>
<td>5.6%</td>
</tr>
<tr>
<td>1-ADL: Care of pets</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>IADL: Child rearing</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>IADL: Communication device use</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>IADL: Financial Management</td>
<td>2</td>
<td>11.1%</td>
</tr>
</tbody>
</table>

Work: employment seeking & acquisition

| Work: employment seeking & acquisition | 2 | 11.1% |
Please review the following elements where consensus is weak or absent and indicate in the right-hand column whether you would include the element, exclude the element or have no opinion (neither).

(* elements with little/no consensus)

<table>
<thead>
<tr>
<th>OTF/ category</th>
<th># of responses</th>
<th>% of agreement</th>
<th>Include/exclude/neither</th>
</tr>
</thead>
<tbody>
<tr>
<td>ADL: Showering</td>
<td>7</td>
<td>38.9%*</td>
<td></td>
</tr>
<tr>
<td>ADL: Dressing</td>
<td>10</td>
<td>55.6%*</td>
<td></td>
</tr>
<tr>
<td>ADL: Personal hygiene and grooming</td>
<td>5</td>
<td>27.8%</td>
<td></td>
</tr>
<tr>
<td>ADL: Sexual activity</td>
<td>10</td>
<td>55.6%*</td>
<td></td>
</tr>
<tr>
<td>ADL: Sleeprest</td>
<td>3</td>
<td>16.7%</td>
<td></td>
</tr>
<tr>
<td>ADL: Toilet hygiene</td>
<td>13</td>
<td>72.2%*</td>
<td></td>
</tr>
<tr>
<td>IADL: Health management &amp; maintenance</td>
<td>3</td>
<td>16.7%</td>
<td></td>
</tr>
<tr>
<td>IADL: Home establishment &amp; maintenance</td>
<td>8</td>
<td>44.4%*</td>
<td></td>
</tr>
<tr>
<td>Work: Employment interests &amp; pursuits</td>
<td>4</td>
<td>22.2%</td>
<td></td>
</tr>
<tr>
<td>Work: Retirement preparation &amp; adjustment</td>
<td>4</td>
<td>22.2%</td>
<td></td>
</tr>
<tr>
<td>Work: Volunteer exploration</td>
<td>3</td>
<td>16.7%*</td>
<td></td>
</tr>
<tr>
<td>Work: Volunteer participation</td>
<td>5</td>
<td>16.7%</td>
<td></td>
</tr>
<tr>
<td>PLAY</td>
<td>3</td>
<td>16.7%</td>
<td></td>
</tr>
<tr>
<td>Leisure: Exploration</td>
<td>10</td>
<td>55.6%*</td>
<td></td>
</tr>
<tr>
<td>Social Participation: community</td>
<td>11</td>
<td>61.1%*</td>
<td></td>
</tr>
<tr>
<td>Social Participation: Family</td>
<td>11</td>
<td>61.1%*</td>
<td></td>
</tr>
<tr>
<td>Social Participation: Pet/Friend</td>
<td>11</td>
<td>61.1%*</td>
<td></td>
</tr>
</tbody>
</table>
In the area of Performance Skills:

Based on the consensus compiled from Round Two data, more than 75% of our panel of expert occupational therapists agree that the following elements should be addressed for this client:

<table>
<thead>
<tr>
<th>OTPF category</th>
<th># of responses</th>
<th>% of agreement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Motor Skills: Mobility</td>
<td>18</td>
<td>100%</td>
</tr>
<tr>
<td>Motor skills: Strength and effort</td>
<td>15</td>
<td>83.3%</td>
</tr>
<tr>
<td>Motor skills: Energy</td>
<td>16</td>
<td>89.9%</td>
</tr>
<tr>
<td>Process skills: Adaptation</td>
<td>15</td>
<td>83.3%</td>
</tr>
</tbody>
</table>

Exclusion of the following elements is based on selection of the element by less than 3 respondents (less than 12%)

<table>
<thead>
<tr>
<th>OTPF category</th>
<th># of responses</th>
<th>% of agreement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Communication/Interaction Skills: Physicality</td>
<td>1</td>
<td>5.6%</td>
</tr>
</tbody>
</table>

Please review the following elements where consensus is weak or absent, and indicate in the right hand column whether you would include the element, exclude the element, or have no opinion (Neither).

(* elements with little/no consensus)

<table>
<thead>
<tr>
<th>OTPF category</th>
<th># of responses</th>
<th>% of agreement</th>
<th>Include/exclude/Neither</th>
</tr>
</thead>
<tbody>
<tr>
<td>Motor skills overall</td>
<td>11</td>
<td>61.1%*</td>
<td></td>
</tr>
<tr>
<td>Motor skills: posture</td>
<td>10</td>
<td>55.5%*</td>
<td></td>
</tr>
<tr>
<td>Motor skills: coordination</td>
<td>4</td>
<td>22.2%</td>
<td></td>
</tr>
<tr>
<td>Process skills: energy</td>
<td>11</td>
<td>61.1%*</td>
<td></td>
</tr>
<tr>
<td>Process skills: knowledge</td>
<td>7</td>
<td>38.9%*</td>
<td></td>
</tr>
<tr>
<td>Process skills: temporal organization</td>
<td>3</td>
<td>27.8%</td>
<td></td>
</tr>
<tr>
<td>Process skills: organization of space and objects</td>
<td>13</td>
<td>72.2%</td>
<td></td>
</tr>
<tr>
<td>Communication/Interaction skills overall</td>
<td>6</td>
<td>33.3%</td>
<td></td>
</tr>
<tr>
<td>Communication/Interaction skills: Information exchange</td>
<td>3</td>
<td>16.7%</td>
<td></td>
</tr>
<tr>
<td>Communication/Interaction skills: relation</td>
<td>8</td>
<td>44.4%*</td>
<td></td>
</tr>
</tbody>
</table>
For the sake of saving space, Habits (Performance Patterns) and Context are combined.

Based on the consensus compiled from Round Two data, more than 75% of our panel of expert occupational therapists agree that the following elements should be addressed for this client:

<table>
<thead>
<tr>
<th>OTPF categories</th>
<th># of responses</th>
<th>% of agreement for inclusion</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Habits</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Routines</td>
<td>16</td>
<td>88.9%</td>
</tr>
<tr>
<td>Roles</td>
<td>16</td>
<td>98.9%</td>
</tr>
<tr>
<td><strong>Context</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Social</td>
<td>18</td>
<td>100%</td>
</tr>
<tr>
<td>Personal</td>
<td>15</td>
<td>23.3%</td>
</tr>
<tr>
<td>Temporal</td>
<td>15</td>
<td>83.3%</td>
</tr>
</tbody>
</table>

Only one element was found to have less than 3 responses (less than 12%) and thus was excluded in this section:

| **Habits** Dominating | 2 | 11.1% |

Please review the following elements where consensus was weak or absent and indicate in the right-hand column whether you would include the element, exclude the element or have no opinion (neither).

(* elements with little/no consensus)

<table>
<thead>
<tr>
<th>OTPF category</th>
<th># of responses</th>
<th>% of agreement</th>
<th>Include/exclude/neither</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Habits</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Overall</td>
<td>12</td>
<td>66.7%*</td>
<td></td>
</tr>
<tr>
<td>Useful</td>
<td>6</td>
<td>33.3%</td>
<td></td>
</tr>
<tr>
<td>impoverished</td>
<td>3</td>
<td>16.6%</td>
<td></td>
</tr>
<tr>
<td><strong>Context</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Overall</td>
<td>12</td>
<td>66.7%*</td>
<td></td>
</tr>
<tr>
<td>Cultural</td>
<td>12</td>
<td>66.7%*</td>
<td></td>
</tr>
<tr>
<td>Physical</td>
<td>12</td>
<td>66.7%*</td>
<td></td>
</tr>
<tr>
<td>Spiritual</td>
<td>11</td>
<td>61.1%*</td>
<td></td>
</tr>
<tr>
<td>Virtual</td>
<td>10</td>
<td>55.5%</td>
<td></td>
</tr>
</tbody>
</table>
In the area of Activity Demands:

Based on the consensus compiled from Round Two data, more than 75% of our panel of expert occupational therapists agree that the following elements should be addressed for this client:

<table>
<thead>
<tr>
<th>OTPF category</th>
<th># of responses</th>
<th>% of agreement for inclusion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Activity Demands: Space demands</td>
<td>14</td>
<td>75.8%</td>
</tr>
</tbody>
</table>

No elements were excluded in this section.

Please review the following elements where consensus was weak or absent and indicate in the right hand column whether you would include the element, exclude the element or have no opinion (neither). (* elements with little/no consensus)

<table>
<thead>
<tr>
<th>OTPF category</th>
<th># of responses</th>
<th>% of agreement</th>
<th>include/exclude/neither</th>
</tr>
</thead>
<tbody>
<tr>
<td>Activity Demands overall</td>
<td>17</td>
<td>61.1%*</td>
<td></td>
</tr>
<tr>
<td>Activity Demands: Objects and their properties</td>
<td>13</td>
<td>72.2%</td>
<td></td>
</tr>
<tr>
<td>Activity Demands: Social demands</td>
<td>12</td>
<td>56.7%*</td>
<td></td>
</tr>
<tr>
<td>Activity Demands: Sequence and timing</td>
<td>9</td>
<td>50%*</td>
<td></td>
</tr>
<tr>
<td>Activity Demands: Required actions</td>
<td>10</td>
<td>55.5%*</td>
<td></td>
</tr>
<tr>
<td>Activity Demands: Required body functions</td>
<td>13</td>
<td>72.2%</td>
<td></td>
</tr>
<tr>
<td>Activity Demands: Required body structures</td>
<td>11</td>
<td>61.1%*</td>
<td></td>
</tr>
</tbody>
</table>
Client Factors
Based on the consensus compiled from Round Two data, more than 75% of our panel of expert occupational therapists agree that the following elements should be addressed for this client:

<table>
<thead>
<tr>
<th>OTPF category</th>
<th># of responses</th>
<th>% of agreement for inclusion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Client Factors: Neurovascular and movement functions</td>
<td>14</td>
<td>77.8%</td>
</tr>
</tbody>
</table>

Exclusion of the following elements is based on selection of the element by less than 3 respondents (less than 12%)

<table>
<thead>
<tr>
<th>OTPF category</th>
<th># of responses</th>
<th>% of agreement (exclusion)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Client Factors: Cardiovascular, hematologic, immunological &amp; respiratory functions</td>
<td>2</td>
<td>11.1%</td>
</tr>
<tr>
<td>Client Factors: Voice and speech functions</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Client Factors: Digestive, metabolic and endocrine functions</td>
<td>1</td>
<td>5.6%</td>
</tr>
<tr>
<td>Client Factors: Genitourinary &amp; reproductive functions</td>
<td>0</td>
<td>9</td>
</tr>
<tr>
<td>Client Factors: Skin and related structures function</td>
<td>2</td>
<td>11.1%</td>
</tr>
</tbody>
</table>

Please review the following elements where consensus was weak or absent and indicate in the right-hand column whether you would include the element, exclude the element or have no opinion (neither). (* elements with little/no consensus)

<table>
<thead>
<tr>
<th>OTPF category</th>
<th># of responses</th>
<th>% of agreement</th>
<th>include/exclude/neither</th>
</tr>
</thead>
<tbody>
<tr>
<td>Client Factors overall</td>
<td>12</td>
<td>66.7%*</td>
<td></td>
</tr>
<tr>
<td>Client factors: Mental functions</td>
<td>8</td>
<td>44.4%*</td>
<td></td>
</tr>
<tr>
<td>Client factors: Sensory functions &amp; pain</td>
<td>13</td>
<td>72.2%</td>
<td></td>
</tr>
<tr>
<td>Client factors: Client structures - body structures</td>
<td>11</td>
<td>61.1%*</td>
<td></td>
</tr>
</tbody>
</table>
On-Line Version of Round 3.

Again, screen shots of the Web version are included here. Some shots were cropped to avoid duplication of content; some shots were edited to form composite figures to display whole Web pages (which required scrolling).

Figure E20. Demographic information request for respondents accompanying Round 3.
Figure 6.21. Screen shot for Round 3 questionnaire. Case one information. Data from Round 2 again presented in tabular format preceding response grid.
Figure E2: Edited partial screen shot of tables containing remaining Areas of Occupation data from Round 2 responses for Case One (Joe Remora).
Figure E23. Screen shot of response section of Round 3 for Case One.

Figure E24. Edited partial screen shot of Performance Skills section data from Round 2.
Figure E25. Edited partial screen shot displays the response items for the Performance Skills questions to be filled out by respondents.
Figure E26. Screen shot of both tables reflecting responses from Round 2 Case One for the sections Performance Patterns and Contexts of the Practice Framework. Note that this page requires the respondent to complete all responses and submit them by hitting the "next" button.
Figure E27. Edited screen shot of table reflecting Round 2 responses for the section of the Practice Framework Activity Demands for Case One.
Figure E28. Screen shot of table reflecting data from Round 2 regarding the section of the Practice Framework Client Factors, and the items which required responses. This page had a “Next” below this screen, which took respondents to the next case study.
Figure E29. Screen shot of next screen. Visual cue for respondents to switch to the second case presented, as well as the table of responses for Round 2, Case two Areas of Occupation categories.
Figure E30: Edited screen shot with remaining tables of data from Round 2 Care Two, and Areas of Occupation categories requiring responses for Round 3.
Figure E31. Edited screen shots displaying the data tables from Round 2, Case Two as well as the categories that required answers in Round 3.
Figure E32. Screen shot with data tables for Performance Patterns and Contexts for Round 2, Case Two and the requested responses for Round 3.
Figure E33. Screen shot of the top of the final response page of the Round 3 on the Web. This screen shows the data table for Activity Demands, and the response grid for Activity Demands.
Figure E34. Bottom of final response page for Round 3 on the Web site survey, presenting the data table for the section of the Practice Framework Client Factors and the response grid for Case two.
Figure E35. Closing screen shot after completion of the Round 3 survey.
Appendix F

Data Tables from Deiphi Rounds
Data tables for Case One

Case One (Joe Pemoro) Data - ADL Categories

<table>
<thead>
<tr>
<th>Table F1 Case One</th>
<th>Include</th>
<th>Neither</th>
</tr>
</thead>
<tbody>
<tr>
<td>Subcategories (Areas of Occupation)</td>
<td>Round 1</td>
<td></td>
</tr>
<tr>
<td>Activities of Daily Living (overall)</td>
<td>15</td>
<td></td>
</tr>
<tr>
<td>Bathing/showering</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>Bowel/bladder management</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Dressing</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Eating</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Feeding</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Functional Mobility</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>Personal Device Care</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Personal Hygiene &amp; Grooming</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>Sexual Activity</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Sleep/Rest</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Toilet Hygiene</td>
<td>3</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Table F2 Case One</th>
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<th>Neither</th>
</tr>
</thead>
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<tr>
<td>Subcategories (Areas of Occupation)</td>
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<td></td>
</tr>
<tr>
<td>Activities of Daily Living (overall)</td>
<td>15</td>
<td>0</td>
</tr>
<tr>
<td>Bathing/showering</td>
<td>15</td>
<td>0</td>
</tr>
<tr>
<td>Bowel/bladder management</td>
<td>12</td>
<td>2</td>
</tr>
<tr>
<td>Dressing</td>
<td>12</td>
<td>2</td>
</tr>
<tr>
<td>Eating</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Feeding</td>
<td>1</td>
<td>9</td>
</tr>
<tr>
<td>Functional Mobility</td>
<td>18</td>
<td>0</td>
</tr>
<tr>
<td>Personal Device Care</td>
<td>2</td>
<td>9</td>
</tr>
<tr>
<td>Personal Hygiene &amp; Grooming</td>
<td>13</td>
<td>0</td>
</tr>
<tr>
<td>Sexual Activity</td>
<td>14</td>
<td>1</td>
</tr>
<tr>
<td>Sleep/Rest</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>Toilet Hygiene</td>
<td>18</td>
<td>0</td>
</tr>
</tbody>
</table>
Case One ADL Tables (continued)

<table>
<thead>
<tr>
<th>Subcategories (Areas of Occupation)</th>
<th>Include</th>
<th>Exclude</th>
<th>Neither</th>
</tr>
</thead>
<tbody>
<tr>
<td>Activities of Daily Living (overall)</td>
<td>15</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td>Bathing/showering</td>
<td>15</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Bowel/bladder management</td>
<td>16</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>Dressing</td>
<td>15</td>
<td>3</td>
<td>0</td>
</tr>
<tr>
<td>Eating</td>
<td>0</td>
<td>18</td>
<td>0</td>
</tr>
<tr>
<td>Feeding</td>
<td>1</td>
<td>17</td>
<td>0</td>
</tr>
<tr>
<td>Functional Mobility</td>
<td>18</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Personal Device Care</td>
<td>2</td>
<td>16</td>
<td>0</td>
</tr>
<tr>
<td>Personal Hygiene &amp; Grooming</td>
<td>15</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Sexual Activity</td>
<td>14</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Sleep/Rest</td>
<td>5</td>
<td>10</td>
<td>3</td>
</tr>
<tr>
<td>Toilet Hygiene</td>
<td>18</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Percentage of Agreement</th>
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<th>Exclude</th>
<th>Neither</th>
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<tbody>
<tr>
<td>Activities of Daily Living (overall)</td>
<td>83.3%</td>
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<td>16.7%</td>
</tr>
<tr>
<td>Bathing/showering</td>
<td>83.3%</td>
<td>11.1%</td>
<td>5.6%</td>
</tr>
<tr>
<td>Bowel/bladder management</td>
<td>88.9%</td>
<td>11.1%</td>
<td>0.0%</td>
</tr>
<tr>
<td>Dressing</td>
<td>83.3%</td>
<td>16.7%</td>
<td>0.0%</td>
</tr>
<tr>
<td>Eating</td>
<td>0.0%</td>
<td>100.0%</td>
<td>0.0%</td>
</tr>
<tr>
<td>Feeding</td>
<td>5.6%</td>
<td>94.4%</td>
<td>0.0%</td>
</tr>
<tr>
<td>Functional Mobility</td>
<td>100.0%</td>
<td>0.0%</td>
<td>0.0%</td>
</tr>
<tr>
<td>Personal Device Care</td>
<td>11.1%</td>
<td>88.9%</td>
<td>0.0%</td>
</tr>
<tr>
<td>Personal Hygiene &amp; Grooming</td>
<td>83.3%</td>
<td>11.1%</td>
<td>5.6%</td>
</tr>
<tr>
<td>Sexual Activity</td>
<td>77.8%</td>
<td>0.0%</td>
<td>0.0%</td>
</tr>
<tr>
<td>Sleep/Rest</td>
<td>27.8%</td>
<td>55.6%</td>
<td>16.7%</td>
</tr>
<tr>
<td>Toilet Hygiene</td>
<td>100.0%</td>
<td>0.0%</td>
<td>0.0%</td>
</tr>
</tbody>
</table>
Case One (Joe Remora) IADL Categories

<table>
<thead>
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<th>Table F5 Case One</th>
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<th>Include</th>
<th></th>
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</tr>
</thead>
<tbody>
<tr>
<td>Round 1</td>
<td></td>
<td>Subcategores (Areas of Occupation)</td>
<td></td>
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</tr>
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<td>IADL (overall)</td>
<td>13</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Care of others</td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Care of pets</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Child rearing</td>
<td>0</td>
<td></td>
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</tr>
<tr>
<td>Communication Device Use</td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Community Mobility</td>
<td>6</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Financial Management</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Health Management &amp; Main.</td>
<td>2</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Home Establish. &amp; Main.</td>
<td>2</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Meal Preparation &amp; Cleanup</td>
<td>2</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Safety Procedures &amp; Emergency resp.</td>
<td>3</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Shopping</td>
<td>2</td>
<td></td>
<td></td>
<td></td>
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</table>

<table>
<thead>
<tr>
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</tr>
</thead>
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<td></td>
<td>Subcategores (Areas of Occupation)</td>
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<td>IADL (overall)</td>
<td>15</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Care of others</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Care of pets</td>
<td>4</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Child rearing</td>
<td>2</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Communication Device Use</td>
<td>6</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Community Mobility</td>
<td>18</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Financial Management</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Health Management &amp; Main.</td>
<td>4</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Home Establish. &amp; Main.</td>
<td>3</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Meal Preparation &amp; Cleanup</td>
<td>5</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Safety Procedures &amp; Emergency resp.</td>
<td>15</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Shopping</td>
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<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Table F7 Case One

<table>
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<tr>
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<th>Include</th>
<th>Exclude</th>
<th>Neither</th>
</tr>
</thead>
<tbody>
<tr>
<td>IADL (overall)</td>
<td>15</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td>Care of others</td>
<td>1</td>
<td>15</td>
<td>2</td>
</tr>
<tr>
<td>Care of pets</td>
<td>4</td>
<td>12</td>
<td>2</td>
</tr>
<tr>
<td>Child rearing</td>
<td>2</td>
<td>16</td>
<td>0</td>
</tr>
<tr>
<td>Communication Device Use</td>
<td>4</td>
<td>13</td>
<td>1</td>
</tr>
<tr>
<td>Community Mobility</td>
<td>18</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Financial Management</td>
<td>0</td>
<td>2</td>
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<tr>
<td>Routines</td>
<td></td>
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<tr>
<td>Roles</td>
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#### Table F19. Case One

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<td>8</td>
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<td>Impoverished</td>
<td>6</td>
<td>8</td>
<td>4</td>
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<tr>
<td>Dominating</td>
<td>0</td>
<td>18</td>
<td>0</td>
</tr>
<tr>
<td>Routines</td>
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<td>0</td>
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<td>Roles</td>
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Case One Performance Patterns Tables (Continued)

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<td>0.0%</td>
</tr>
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Case One (Joe Remora) Context categories

| Contexts (overall)  | Include |  |
|---------------------|---------|
| Cultural            | 7       |
| Physical            | 14      |
| Social              | 13      |
| Personal            | 11      |
| Spiritual           | 4       |
| Temporal            | 7       |
| Virtual             | 5       |

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<th>Neither</th>
</tr>
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<tr>
<td>Physical</td>
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<td>2</td>
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<tr>
<td>Social</td>
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</tr>
<tr>
<td>Personal</td>
<td>15</td>
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<td>Spiritual</td>
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Table T23, Case One

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<tr>
<td>Physical</td>
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<td>0</td>
</tr>
<tr>
<td>Social</td>
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<td>Personal</td>
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<td>0</td>
<td>0</td>
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<tr>
<td>Spiritual</td>
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<td>2</td>
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<td>Temporal</td>
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Case One Context Tables (Continued)

Table T24, Case One

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<td>0.0%</td>
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<td>Physical</td>
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<tr>
<td>Social</td>
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<td>0.0%</td>
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<tr>
<td>Personal</td>
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<td>0.0%</td>
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<tr>
<td>Spiritual</td>
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<td>11.1%</td>
<td>11.1%</td>
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Case One (Joe Remora): Activity Demands Categories

Table T25, Case One

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<td>Overall</td>
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<tr>
<td>Objects and their properties</td>
<td>13</td>
</tr>
<tr>
<td>Space demands</td>
<td>11</td>
</tr>
<tr>
<td>Social demands</td>
<td>9</td>
</tr>
<tr>
<td>Sequence &amp; timing</td>
<td>7</td>
</tr>
<tr>
<td>Required actions</td>
<td>12</td>
</tr>
<tr>
<td>Required body functions</td>
<td>11</td>
</tr>
<tr>
<td>Required body structures</td>
<td>10</td>
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### Table F26. Case One

<table>
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<td>0</td>
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<tr>
<td>objects and their properties</td>
<td>13</td>
<td>0</td>
</tr>
<tr>
<td>space demands</td>
<td>14</td>
<td>0</td>
</tr>
<tr>
<td>Social demands</td>
<td>12</td>
<td>0</td>
</tr>
<tr>
<td>Sequence &amp; timing</td>
<td>11</td>
<td>0</td>
</tr>
<tr>
<td>Required actions</td>
<td>11</td>
<td>0</td>
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<tr>
<td>Required body functions</td>
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<td>0</td>
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<tr>
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### Table F27. Case One

<table>
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</thead>
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<td>Activity Demands (overall)</td>
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<td>0</td>
<td>3</td>
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<tr>
<td>objects and their properties</td>
<td>16</td>
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<td>2</td>
</tr>
<tr>
<td>space demands</td>
<td>14</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Social demands</td>
<td>16</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Sequence &amp; timing</td>
<td>17</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Required actions</td>
<td>17</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Required body functions</td>
<td>16</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td>Required body structures</td>
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Case One Activity Demands Tables (Continued)

### Table F28. Case One

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<td>Activity Demands (overall)</td>
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<tr>
<td>objects and their properties</td>
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<td>11.1%</td>
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<tr>
<td>space demands</td>
<td>77.8%</td>
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<td>0.0%</td>
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<td>Social demands</td>
<td>88.9%</td>
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<td>5.6%</td>
</tr>
<tr>
<td>Sequence &amp; timing</td>
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<td>5.6%</td>
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<td>Required actions</td>
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<td>0.0%</td>
<td>5.6%</td>
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<td>Required body functions</td>
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<td>16.7%</td>
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<td>Required body structure</td>
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Case One (Joe Remora) Client Factors Categories

### Table F29. Case One

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<td>Round 1</td>
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<tr>
<td>Body function categories overall</td>
<td>3</td>
</tr>
<tr>
<td>Mental functions</td>
<td>9</td>
</tr>
<tr>
<td>sensory functions &amp; pain</td>
<td>9</td>
</tr>
<tr>
<td>Neuromusculoskeletal &amp; movement-related functions</td>
<td>12</td>
</tr>
<tr>
<td>Cardiovascular, hematological, immunological &amp;</td>
<td>3</td>
</tr>
<tr>
<td>respiratory systems functions</td>
<td></td>
</tr>
<tr>
<td>Voice &amp; speech functions</td>
<td>0</td>
</tr>
<tr>
<td>Digestive, metabolic &amp; endocrine system functions</td>
<td>3</td>
</tr>
<tr>
<td>Gastrointestinal &amp; reproductive functions</td>
<td>4</td>
</tr>
<tr>
<td>Skin &amp; related structures functions</td>
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<td>Body Structure Categories</td>
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### Table F30. Case One

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<td>Mental functions</td>
<td>13</td>
<td>2</td>
</tr>
<tr>
<td>sensory functions &amp; pain</td>
<td>15</td>
<td>0</td>
</tr>
<tr>
<td>Neuromusculoskeletal &amp; movement-related functions</td>
<td>14</td>
<td>1</td>
</tr>
<tr>
<td>Cardiovascular, hematological, immunological &amp;</td>
<td>9</td>
<td>2</td>
</tr>
<tr>
<td>respiratory systems functions</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Voice &amp; speech functions</td>
<td>0</td>
<td>9</td>
</tr>
<tr>
<td>Digestive, metabolic &amp; endocrine system functions</td>
<td>8</td>
<td>3</td>
</tr>
<tr>
<td>Gastrointestinal &amp; reproductive functions</td>
<td>11</td>
<td>1</td>
</tr>
<tr>
<td>Skin &amp; related structures functions</td>
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<td>1</td>
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<tr>
<td>Mental functions</td>
<td>15</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Sensory functions &amp; pain</td>
<td>15</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Neuromusculoskeletal &amp; movement-related functions</td>
<td>14</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Cardiovascular, hematological, immunological &amp; respiratory systems functions</td>
<td>9</td>
<td>7</td>
<td>2</td>
</tr>
<tr>
<td>Voice &amp; speech functions</td>
<td>0</td>
<td>18</td>
<td>0</td>
</tr>
<tr>
<td>Digestive, metabolic &amp; endocrine system functions</td>
<td>4</td>
<td>9</td>
<td>5</td>
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<tr>
<td>Genitourinary &amp; reproductive functions</td>
<td>13</td>
<td>4</td>
<td>1</td>
</tr>
<tr>
<td>Skin &amp; related structures functions</td>
<td>16</td>
<td>2</td>
<td>0</td>
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### Table F32. Case One

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</tr>
<tr>
<td>Mental functions</td>
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</tr>
<tr>
<td>Sensory functions &amp; pain</td>
<td>83.3%</td>
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<td>0.0%</td>
</tr>
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<td>Neuromusculoskeletal &amp; movement-related functions</td>
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<td>0.0%</td>
</tr>
<tr>
<td>Cardiovascular, hematological, immunological &amp; respiratory systems functions</td>
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<td>11.1%</td>
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<td>Voice &amp; speech functions</td>
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## Data tables for Case Two

### Table F33. Case Two - ADL Categories

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<tr>
<td>Activities of Daily living (overall)</td>
<td>16</td>
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</tr>
<tr>
<td>Bathing/showering</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Bowel/bladder management</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Dressing</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Eating</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Feeding</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Functional Mobility</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>Personal Device Care</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Personal Hygiene &amp; Grooming</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Sexual Activity</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>Sleep/Rest</td>
<td>1</td>
<td></td>
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<tr>
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### Table F34. Case Two

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</tr>
<tr>
<td>Bathing/showering</td>
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<td>Bowel/bladder management</td>
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<td>0</td>
<td>11</td>
</tr>
<tr>
<td>Feeding</td>
<td>0</td>
<td>9</td>
</tr>
<tr>
<td>Functional Mobility</td>
<td>18</td>
<td>0</td>
</tr>
<tr>
<td>Personal Device Care</td>
<td>1</td>
<td>9</td>
</tr>
<tr>
<td>Personal Hygiene &amp; Grooming</td>
<td>5</td>
<td>1</td>
</tr>
<tr>
<td>Sexual Activity</td>
<td>10</td>
<td>1</td>
</tr>
<tr>
<td>Sleep/Rest</td>
<td>3</td>
<td>6</td>
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## Table F35, Case Two

### Round 3

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<td>0</td>
</tr>
<tr>
<td>Bathing/showering</td>
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<td>4</td>
<td>1</td>
</tr>
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<td>Bowel/bladder management</td>
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</tr>
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<tr>
<td>Eating</td>
<td>0</td>
<td>18</td>
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<td>Feeding</td>
<td>0</td>
<td>18</td>
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</tr>
<tr>
<td>Functional Mobility</td>
<td>16</td>
<td>9</td>
<td>0</td>
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<tr>
<td>Personal Device Care</td>
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<td>17</td>
<td>0</td>
</tr>
<tr>
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<tr>
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<tr>
<td>Sleep/Rest</td>
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## Table F36, Case Two

### Percentage of Agreement

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<td>Bathing/showering</td>
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<td>Bowel/bladder management</td>
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<td>Dressing</td>
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<td>0.0%</td>
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<td>11.1%</td>
</tr>
<tr>
<td>Sleep/Rest</td>
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<td>16.7%</td>
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<td>Toilet Hygiene</td>
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### Case Two (Mary Price) Data - IADL Categories

#### Table 137, Case Two

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<td>Communication Device Use</td>
<td></td>
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<tr>
<td>Community Mobility</td>
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<td></td>
</tr>
<tr>
<td>Financial Management</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Health Management &amp; Main.</td>
<td></td>
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<tr>
<td>Home Establish &amp; Main.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Meal Preparation &amp; Cleanup</td>
<td></td>
<td></td>
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<tr>
<td>Safety Procedures &amp; Emergency resp.</td>
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#### Table 138, Case Two

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<td>Care of pets</td>
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<td>Child rearing</td>
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<td>Communication Device Use</td>
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<td>Health Management &amp; Main.</td>
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<tr>
<td>Safety Procedures &amp; Emergency resp.</td>
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#### Subcategories (Areas of Occupation)

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</thead>
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<td>18</td>
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<td>Communication Device Use</td>
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<td>Safety Procedures &amp; Emergency resp.</td>
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### Table F.40, Case Two
#### Percentage of Agreement

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<td>Care of pets</td>
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<td>Communication Device Use</td>
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<td>Health Management &amp; Main</td>
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<td>16.7%</td>
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<td>Safety Procedures &amp; Emergency resp.</td>
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<tr>
<td>Play</td>
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<tr>
<td>Leisure participation</td>
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<tr>
<td>Social participation (overall)</td>
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### Table F42, Case Two

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<td>Job performance</td>
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<td>Retirement preparation &amp; adjustment</td>
<td>4</td>
<td>5</td>
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<tr>
<td>Volunteer exploration</td>
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<td>6</td>
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<tr>
<td>Volunteer participation</td>
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<td>5</td>
</tr>
<tr>
<td>Play</td>
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<td>8</td>
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</tr>
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<td>Job performance</td>
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<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Retirement preparation &amp; adjustment</td>
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<td>9</td>
<td>3</td>
</tr>
<tr>
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<td>3</td>
</tr>
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<td>Volunteer participation</td>
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<td>Pray</td>
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<td>8</td>
<td>4</td>
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<td>0</td>
</tr>
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<td>14</td>
<td>3</td>
<td>1</td>
</tr>
<tr>
<td>Leisure participation</td>
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<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Social participation (overall)</td>
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</tr>
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### Case Two Areas of Occupation Tables (Continued)

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<td>44.4%</td>
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<td>Employment seeking and acquisition</td>
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<td>88.9%</td>
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</tr>
<tr>
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</tr>
<tr>
<td>Play</td>
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<td>22.2%</td>
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Case Two (Mary Price) Data - Performance Skills Categories

**Table F45, Case Two**

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<td>Coordination</td>
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<tr>
<td>Strength &amp; effort</td>
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<td>Temporal Organization</td>
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<td>Organizing Space &amp; objects</td>
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**Table F46, Case Two**

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<td>Posture</td>
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<tr>
<td>Coordination</td>
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<td>Strength &amp; effort</td>
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<td>Energy</td>
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Case Two (Mary Price) Data – Performance Patterns Categories

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<tr>
<td>Routines</td>
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### Case Two (Mary Price) Data - Context Categories

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Case Two Context Tables (Continued)

Table F.55, Case Two

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Table F.56, Case Two

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Case Two (Mary Price) Data – Activity Demands Categories

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<td>Social demands (relates to social &amp; cultural contexts)</td>
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<td>Sequence &amp; timing</td>
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<td>Social demands (relates to social &amp; cultural contexts)</td>
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<tr>
<td>Sequence &amp; timing</td>
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<td>Social demands (relates to social &amp; cultural contexts)</td>
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<tr>
<td>Sequence &amp; timing</td>
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<td>Required actions</td>
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<td>objects and their properties</td>
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<td>11.1%</td>
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<td>Sequence &amp; timing</td>
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### Table F61, Case Two

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<td>sensory functions &amp; pain</td>
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<tr>
<td>Neuromusculoskeletal &amp; movement-related functions</td>
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</tr>
<tr>
<td>Cardiovascular, hematological, immunological &amp; respiratory systems functions</td>
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</tr>
<tr>
<td>Voice &amp; speech functions</td>
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<tr>
<td>Digestive, metabolic &amp; endocrine system functions</td>
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<td>Genitourinary &amp; reproductive functions</td>
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## Case Two Client Factors Tables (Continued)

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Case Two Client Factors: Tables (Continued)

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<td>Cardiovascular, hematological, immunological &amp; respiratory systems functions</td>
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<td>Body Structure Categories</td>
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APPENDIX G

Scoring Matrices
Figure G1. Case One Scoring Matrix

Level of response:
- 0 = not mentioned (absent)
- 1 = simple solution – one idea of mention; does not describe solution as part of integrated plan
- 2 = advanced solution: contains client input / personal narrative; part of the larger plan; offers more than one solution

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<tr>
<td>Health Management &amp; Maintenance</td>
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<td>Work (overall)</td>
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<td>Job performance</td>
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<td>Family</td>
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<td>Peers/Friends</td>
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<td>Organizing space &amp; objects</td>
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<td>Adaptation</td>
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Figure G1. Case One Scoring Matrix (continued)
Level of response:
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<td>Habits (overall)</td>
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<tr>
<td>Routines</td>
<td></td>
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<td>Roles</td>
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<table>
<thead>
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<th>Contexts (overall)</th>
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<td>Sequence &amp; timing</td>
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<td>Sensory functions &amp; Pain</td>
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<td>Neurouniversal &amp; movement-related functions</td>
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<td>Genitourinary &amp; reproductive functions</td>
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<td>Skin &amp; related structures functions</td>
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Figure G2. Case Two Scoring Matrix

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Performance Skills Categories

Motor skills (overall)

Posture |   |   |
Mobility |   |   |
Strength & effort |   |   |
Energy |   |   |

Process Skills (overall)

Energy |   |   |
Organizing space & objects |   |   |
Adaptation |   |   |
Figure G2. Case Two Scoring Matrix (continued)
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