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Establishing an Occupational Therapy Practice in a Rural Community

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ESTABLISHING AN OCCUPATIONAL THERAPY PRACTICE IN A RURAL
COMMUNITY

by

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A Scholarly Project

Submitted to the Occupational Therapy Department

of the

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This Scholarly Project Paper, submitted by Jessica Reep in partial fulfillment of the requirement for the Degree of Master's of Occupational Therapy from the University of North Dakota, has been read by the Faculty Advisor under whom the work has been done and is hereby approved.

Faculty Advisor

Date

PERMISSION

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Department Occupational Therapy
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Table 1

Challenges and Rewards of Rural Practice

Challenges	Rewards
Lack of professional support	Gain experience in a variety of settings
Lack of continuing education opportunities	Feel valued by rural community members
Traveling long distances	Closely experience client's community life
Lack of specialized training/orientation	Great need for OT in rural areas
Lack of financial support	Diversity of clinical practice
Lack of supportive management	Develop new areas of professional knowledge
Heavy caseloads	Deliver continuous and holistic care

Table 2

Challenges and Rewards of Rural Living

Challenges	Rewards
Limited social outlets	Less stressful environment
Loss of privacy	Friendly atmosphere
Lack of employment opportunities	Lower cost of living
Lack of cultural pursuits	Healthier lifestyle (no pollution)

Table 3

Possible Solutions

1. Establish lines of communication with medical specialists and equipment vendors in the nearest metropolitan areas.
2. Improve networking and communication with health care professionals.
3. Provide more opportunities for students to have rural clinical experiences.
4. Provide structured mentorship for new therapists.
5. Increased technology to increase communication with other therapists.
6. Regular meetings with a therapist in a nearby town, regional OT group meetings, and use of the Internet and teleconferencing to pool resources.
7. Establish satellite programs on a rural campus.
8. Provide appropriate liaison and clear communication with clients and support staff regarding therapy objectives and programs.
9. Careful prioritizing of workloads and analysis of timeframes to maintain equity.

CHAPTER I

INTRODUCTION

The Census Bureau (1993) defines "urban for the 1990 census as comprising all territory, population, and housing units in urbanized areas and in places of 2,500 or more persons outside urbanized areas." Rural areas are all "territory, population and housing units not classified as urban." Therefore, rural communities are considered those with a population of 2,500 or less. Rural Americans make up 20% of the nation's population and typically face decreased access to healthcare, decreased available technology, and decreased payment for medical services. Due to the lack of wealth, shortage of medical professionals, and increasing numbers of young people leaving rural areas, there is a great shortage of health care services available to rural communities (Ricketts, Johnson-Webb, & Randolph, 1999). Included in the shortage of services are occupational therapy services, which are often not accessible to rural residents due to the shortages of occupational therapists practicing in rural communities.

The problems that arise include people living in rural communities either have increasing health problems that are not treated, or are facing the inconvenience of having to travel long distances to receive the health care services they need. In some cases, occupational therapists working in larger metropolitan areas are contracting with smaller communities to provide services within their community, requiring them to drive long distances and work long hours to provide services to clients who live in distant rural

communities. The lack of access to occupational therapy services results in a decrease in the well-being and quality of life of many rural residents. Expanding occupational therapy practices to more rural communities will improve the quality of life of rural residents as well as open up more opportunities for occupational therapists to gain experience in a variety of practice settings and develop new areas of professional knowledge.

Access to health care in rural communities has been researched extensively, however research with special attention to occupational therapy has been lacking, especially in the United States. Australia and Canada have conducted more research on rural occupational therapy practice, however the information continues to be limited. Specific issues that have been investigated include the social interactions, employment and economic issues, and the uniqueness of rural culture. The challenges and rewards of rural practice and living have also been investigated to compare the differences between rural and urban practice. Specific issues related to occupational therapy that have been investigated include the challenges and rewards of rural OT practice, issues related to new graduates, perceptions and experiences of rural occupational therapists, student fieldwork experiences in rural practice, and recruitment and retention issues.

The following chapters profile the aspects of rural culture and practice that are pertinent to establishing an OT practice in a rural community. Chapter two involves the review of the literature on the issues relating to rural culture and allied health services with a concentration on occupational therapy. Chapter three describes the methods involved in the process involved in the review of the literature and the process of developing a rural OT practice manual. Chapter four presents a detailed manual for

establishing an OT practice in a rural community to be utilized by potential therapists interested in rural practice. Finally, chapter five summarizes the project and includes some of the limitations and recommendations for future development and/or modifications of the manual.

CHAPTER II

LITERATURE REVIEW

Rural residents compose approximately one-fourth of the nation's population, however continue to face shortages of health care services, which has begun to plague rural communities (Geller, 1997). Due to the lack of wealth, shortage of medical professionals, and the increase of younger generations leaving rural areas there is a great shortage of health care services available to rural communities. The problems that arise include people living in rural communities either have increasing health problems that are not treated, or are facing the inconvenience of having to travel long distances to receive the health care services they need. Occupational Therapy is a practice that is not common to most rural communities and for those communities that do have an OT practice it is difficult to recruit and retain therapists. According to an epidemiological survey of the health needs of disabled people in a rural community conducted by Kent & Barnes (2000), amongst rehabilitation professionals the most frequently recorded need was for occupational therapy.

There is a wide range of explanations for the shortage of Occupational Therapy services and the inability to recruit and retain therapists in rural areas. To explore these issues, current research has explored the experiences of rural therapists in various positions. They have investigated the experience of new graduates working in rural practice as well as the experience of therapists working in rural schools. The literature

has explored the influence of fieldwork placement on future practice areas, and the attitudes of students attending a rural fieldwork unit. Other issues that were explored include recruitment and retention of therapists, and the challenges and rewards of rural practice. Most of the research studies that have been conducted on rural health issues are qualitative, looking at the experience and perceptions of rural therapists to fully understand why the problems are occurring, as well as possible solutions. However, in one study a Clinical Experience Program was developed at the Royal Children's Hospital in Queensland Australia to correlate the data that has been collected from other qualitative studies. (Parkin, McMahon, Upfield, Copley, and Hollands 2001). The aim of this program was to improve continuity of care of clients from rural and remote areas. The majority of rural allied health professionals reported that the program was beneficial and should continue to be offered. The literature has established that there is a great need for rural therapists and they have stressed the importance of recruitment and retention of therapists to rural communities.

The reason for reviewing the literature is to determine what the current issues are facing rural health care, to facilitate the exploration of possible solutions. Before one can consider working in a rural practice it is important to recognize common trends in rural health as well as to appreciate the experiences that rural practitioners are facing. It is also important to explore not only the aspects of rural practice but also the aspects of rural culture and lifestyle as both can have an impact on a therapist's decision to work in a rural community. Also, in a rural community there is a greater likelihood of a therapist taking on a generalist role with a variety of responsibilities; therefore it is important to explore the features of rural practice in a variety of settings, such as schools, hospitals, nursing

homes, etc. This review will look at the aspects of rural life and rural health, recruitment and retention issues, and finally challenges for the future. It will conclude with a stated problem as well as a proposed solution.

Culture of Rural Life

The Census Bureau (1993) defines "urban for the 1990 census as comprising all territory, population, and housing units in urbanized areas and in places of 2,500 or more persons outside urbanized areas." Rural areas are all "territory, population and housing units not classified as urban." Therefore, rural communities are considered those with a population of 2,500 or less. Another term that is often associated with rural regions is "frontier." Frontier county status is based on population densities within counties.

Although there is no universally agreed-upon threshold, counties with fewer than seven persons per square mile are most often classified as "frontier" (Ricketts, Johnson-Webb, & Randolph, 1999). Rural lifestyle has a unique culture of its own when compared to that of urban lifestyle. Rural people believe they share communities that provide an incomparable way of life that provide them with control over their lives (Geller, 1997). The aspects of rural social interaction, employment, and health care are factors that can help provide rural citizens with this control. Each of these factors can help define rural lifestyle and encourage better understanding of the values and beliefs of rural residents.

Social interaction among rural people is core to the rural lifestyle. It is important to understand the values and beliefs of rural citizens to be accepted into a rural community. Rural people have rich social lives and their lives revolve around daily social interactions. Rural America includes a diversity of cultures characterized by

communities that provide supportive and friendly lifestyles. When driving down a rural road, it is common to see drivers wave or touch their cap to acknowledge a meeting, unlike the rather anonymous interactions of urban America. Rural life revolves around a core of social institutions: family, community, school, and church (Geller, 1997). These institutes provide a location for rural community members to congregate and socialize. Rural cultures have been romanticized as having a slower pace and more respect for one's neighbors, as great places to raise kids and having more respect for older people. In rural communities people know each other well and place more meaning on casual social interaction (Cummins, 2001). Wilkinson (1991) states that people in rural areas are likely to encounter one another in many different roles, such as parent-teacher, merchant-customer, official-consultant, etc. Rural life encourages integration among contacts that will be repeated and intimate, and that they will likely have strong ties to one another.

When examining rural culture, it is important to look at employment and economic issues. While employment growth has been strong generally, there continues to exist a disproportionate larger percentage of new jobs being created within metropolitan areas, while those in rural areas lag behind (Cason, 2001). Compensation for these jobs also differs significantly, with rural residents receiving considerably less in both wages and benefits (Stewart, Gavazzi, McHenry, & Sheidegger, 2001). The decrease in employment and competition with metropolitan areas has affected the rural economy. Rural citizens are no longer loyal to their hometown stores and are traveling long distances to receive goods in urban areas because of cheaper prices and more selection. The decrease in spending money in rural areas has created economic problems including

poverty, welfare, and homelessness. Buss (2001) states that poverty remains in rural communities because they still lack substantial competitive advantages over other places even after heavy public investment. The increase in poverty has also caused the numbers of people on welfare to increase. Some rural counties currently have a ratio as high as two adult welfare recipients to every available job (Feyen, 2001). The decrease in the communities' economy and increase in poverty has a negative impact on the rural health care system.

It is important to be aware of the unique problems of rural health care when considering working in a rural practice. There is little question that the hospital is the hub of the health care delivery system in rural communities, however a factor affecting rural hospitals is population loss and a declining rural economy (Geller, 1997). Population loss has affected rural health care due to hospitals losing patients that provide them with funds to maintain their health care system, which decreases some of the services available to rural citizens. This has caused a significant decrease in access to health care for rural citizens. Also, barriers to accessing the limited services and resources, such as the lack of public transportation, negative attitudes toward public social services, and the geographic dispersion of services prevent many rural people from receiving needed services (Cummins, 2001). The decrease in access to health care can have detrimental effects on the well being of rural citizens. Compared with their urban counterparts, rural Americans are more likely to contract chronic health conditions, to experience injuries, and to be in poor health (Levine, Lishner, Richardson, & Porter, 2001). Rural patients are likely to see doctors less often and usually late in the course of an illness. Rural areas report higher rates of chronic disease and infant mortality.

Injuries related to use of farm machinery and rural occupational hazards associated with mining, forestry, and fishing are unique problems for rural health care systems. Trauma mortality, especially for motor vehicle crashes and gun related reasons, is disproportionately higher in rural areas (Ricketts, 1999). Another issue is that health care is available in rural communities is generally less specialized than in urban areas, despite the fact that rural residents on average pay a greater percentage of their incomes for health services due to the elevated population of elderly residents (Levine et al., 2001). According to Moore (2001) Medicare reimbursement to rural hospitals is 40% less than to urban hospitals, due to the fact that many rural people are without a political voice unlike their urban counterparts. The decrease in access to health care has negatively impacted the health and well being of rural residents.

Living in a rural community can have many benefits. Rural communities can offer a less stressful environment, a social atmosphere, safety, and lower cost of living (Boonyawiroj, Haven, Freeman, Parker, Mullenberg, Temme, Benschoter, and Benson, 1996). Rural communities often place more of an emphasis on spending time with friends and family rather than on having a successful career or making money. According to Mitchell (1995), the top four reasons for entering rural practice pertained to social factors such as a relaxed lifestyle, healthier lifestyle, no pollution, and a less stressful lifestyle. Rural people have rich social lives and they make their own entertainment. Friday night after the football game teenagers often gather to “cruise Main Street” or have a bonfire in the middle of a field. Adults will often gather at the local bar or have social gatherings with their friends once a week to play cards (Geller, 1997). The close connection of the community as well as the friendliness and laid back

personalities of rural citizens creates a welcoming environment which facilitates socialization. These are a few of the benefits of rural communities that attract people to establish their homes and careers there.

Although there are some definite benefits to living in rural communities there are some challenges as well. The challenges that face people living in rural communities are hard to ignore for they may often be the reason why the communities are so sparsely populated. They may also be the reasons why people who were raised in rural communities do not return home after leaving. Some of the challenges include limited social outlets and convenient amenities (Wills & Case-Smith, 1996). Although rural communities may value social relationships, there are limited places of entertainment and shopping that other urban areas are able to provide especially for younger adults. Some of these may include nightclubs, restaurants, movie theaters, concerts, sporting events, museums, shopping malls, and fast food chains. Also, in rural communities where everyone knows everyone else, it is difficult to keep ones personal life private. Wills & Case-Smith (1996) suggest that privacy and a sense of anonymity may be lost. It may be difficult to keep professional and personal boundaries with clients who are often seen outside of the clinical setting. Another challenge of rural living is the decreased employment opportunities for significant others. According to Bent (1999), it is the lack of accommodation and employment for other family members that make it difficult to establish a life and family in a rural community. The opportunity for a professional career in a rural community is difficult; therefore locating two separate careers for a married couple in the same rural community is limited. These challenges have made rural living as well as attracting people to rural communities arduous.

Rural Health Practice

Rural areas generally have few rehabilitation services available locally and people with disabilities often face a lack of physical, occupational, and speech therapists. Rural Americans, in general, receive fewer specialized services, travel farther to obtain these services, and have fewer choices than do non-rural residents (Levine et al., 2001). There are many different arenas that occupational therapists would be of value to in rural communities including, schools, hospitals, nursing homes, clinics, etc. Occupational Therapy can provide rural residents with rehabilitation services such as adaptive equipment, home evaluations, wheelchair positioning, sensory integration, compensatory strategies, and job analysis to name a few of the services. Not only can occupational therapists provide services but also can become advocates for clients to help create the programs and service delivery systems they use.

Rural practitioners are typically required to take on a generalist role due to the lack of professional support, and therefore there is a wide range of professional skills that are required to be a successful therapist in a rural community. One of the themes that emerged from Wills & Case-Smith's (1996) ethnographic study of therapist working in rural schools is that they are considered a jack-of-all-trades which describes how therapists are required to have a broad knowledge base to be successful. Due to the professional isolation often encountered in rural practice, therapists are required to know all aspects of OT, as well as aspects of other professions. Often rural therapists will require knowledge of various practice settings such as pediatrics, rehabilitation, hand therapy, school-based therapy, home health, etc. Kohler & Mayberry (1993) surveyed rural occupational therapists to investigate factors that affected occupational therapy

practice in rural regions of the Rocky Mountains. Data was compared with a similar study conducted with the Northwest region of Alaska, Idaho, Montana, and Washington. Both studies confirmed that there is a need for more occupational therapists in these regions, however the Rocky Mountain study by Kanny & Greenberg (1988) expanded on the previous study by determining five skills that were considered most important for occupational therapists in rural settings. These skills include, problem-solving, education of client and family, consultation, giving standardized evaluations, and program development (Kohler & Mayberry, 1993). Similarly, Milstead (2001) identified well-developed communication skills, being resourceful, creativity, lateral thinking, and a working knowledge of management principles as important to rural practice (Milstead, 2001). Finally, Elliot-Schmidt & Strong's (1995) survey showed that observation of behavioral/cultural differences, good listening skills, ability to maintain confidentiality, ability to enjoy new experiences, ability to manage hostility, and ability to be motivated and committed as valuable skills for rural practice.

Rural practitioners are often faced with many challenges. Wills & Case-Smith (1996) conducted an ethnographic study to identify the unique experiences of occupational therapists who practice in rural schools. All participants in this study expressed a sense of isolation related to being the only pediatric occupational therapist in their region. This is a common theme that was found in the literature. Elliot-Schmidt & Strong (1995) found that the isolation might be explained partly by the lack of professional support or supervision available, compounded by the wide variety offered by a large caseload. Wills & Case-Smith found that rural practitioners valued continuing education, but found it difficult to attend continuing education courses because of the

long distance required to travel and workloads made it difficult to schedule time off. Without the opportunity to attend continuing education courses, the therapist find it difficult to keep up with the latest trends and changes in practice. Millsted (2001) reports a common challenge of rural practice is the lack of orientation to their position and the community. The lack of orientation meant that initially the job was often stressful with the therapists having to work out what the position entailed, and time spent puzzling over such things as policy and procedures, referral agencies, and relevant contacts in the town. Seven out of ten rural therapists in Millsted's (2001) study reported that they believed they were performing senior responsibilities without the commensurate pay and conditions. This can be a hindrance to working in a rural position because a therapist may be able to make more money working in an urban area without the extra work. Fifty-three percent of the respondents (physiotherapists, occupational therapists, and speech pathologists) in an interview conducted by Bent (1999) felt that management and organizational problems were a major concern to them. Issues identified included: a lack of understanding by management and agencies of allied health services, skills, knowledge, and roles, inadequate or absence of orientation processes, barriers to service delivery, inadequate resourcing and inappropriate infrastructure, unrealistic workloads, and little or no support for professional development (Bent, 1999). To summarize, the common challenges of rural practice that have been found throughout the literature include professional isolation, heavy caseloads, lack of continuing education opportunities, lack of initial orientation, possibility of performing senior responsibilities without commensurate pay, and lack of supportive management systems.

There are various rewards for working within a rural health practice. Rural professionals often find their practice more generalized and have the opportunity to experience work in a variety of different areas, such as school systems, hospitals, nursing homes, etc. (Russell, Clark, and Barney, 1996). Bent (1999) conducted direct interviews with rural health workers and found that 59% of respondents felt that diversity of clinical practice and the opportunity to develop new areas of their professional knowledge as aspects of their work that they particularly valued. Millsted (2001) conducted ethnographic interviews with ten occupational therapists to explore their experience working in rural practice, and found the therapists felt they were valued by the rural community members and had the opportunity to develop autonomy and independence. Rural community members often appreciate the medical professionals because it limits them from having to travel to receive services and it allows them to better establish a relationship with their therapists. Another positive aspect of rural practice is the therapist has the opportunity to observe their clients within the community, therefore they may have a better understanding of what the clients needs are and they may be better able to adapt their treatment to match the person's lifestyle (Elliott-Schmidt & Strong, 1995). To summarize, the common rewards found throughout the literature include, the opportunity to gain a wide variety of experiences, diversity of clinical practice, the opportunity to develop new areas of professional knowledge, feeling valued by community, opportunity to develop independence, and the opportunity to experience client's community lifestyle.

Recruitment and Retention Issues

Many of the challenges of rural practice have made it difficult to recruit and retain rural therapists. It is important to look at the factors affecting recruitment and

retention to determine if there are changes that can be made to decrease this setback to rural health. Millsteed (2001) reports that failure to retain health professionals in rural areas contribute to the poor health status of these communities through an inability to deliver reliable and consistent services. Twenty-five percent of the respondents in a survey conducted by Elliot-Schmidt & Strong (1995) indicated that their reason for undertaking rural practice was because they had originally come from a rural upbringing. Boonyawiroj et al., (1996) conducted a study to identify attitudes of faculty members in a school of allied health toward rural living and practice. Results identified that spouse relocation was identified as an important factor for rural Physical Therapy recruitment, and the subjects felt that visible role models supporting rural health would help to recruit as well as retain rural therapists. Results from research studies concerning recruitment and retention issues can be used to promote possible solutions. Possible recruitment and retention solutions include, recruiting medical professionals with a rural upbringing, assisting with relocation as well as career options for significant others, and providing opportunities to express the positive aspects of rural health, Raising the profile of remote area practice is another option to increase recruitment and retention. This can be achieved by developing an understanding of the realities and rewards of remote area practice through literature, undergraduate allied health professional courses, placement of students in remote settings, and promoting and understanding of rural allied health services at executive levels within employing agencies (Bent, 1999).

Bent (1999) found that most allied health professional positions were not appropriate for new graduates, due to the depth and breadth of knowledge required for

successful management of caseloads. On the contrary the majority of the literature has revealed that there is an array of rewards for new graduates working in rural positions. New graduates are of great importance to the recruitment of rural therapists because they are often the ones searching for jobs. New graduates who first started out working in rural practice reported that they felt an initial period of feeling overwhelmed and uncertain of what is expected (Millstead, 2001). This is important information when looking at recruiting new graduates to a rural practice. Recruitment of new graduates may increase if there is a more structured orientation and training program available to illustrate expectations and decrease feeling overwhelmed.

Challenges for the Future

There are many possible solutions to resolve the conflict of shortages of rural health care workers and the challenges of recruitment and retention. According to a survey conducted by Elliot-Schmidt & Strong (1995) many of the participants indicated that areas of improvement in rural practice include, more resources, equipment, library facilities, more time/staff, better administration, and improved professional development opportunities. One of the major challenges of rural practice is professional isolation as well as lack of medical equipment. To fill this void, participants believed it would be beneficial to establish lines of communication with medical specialists and equipment vendors in the nearest metropolitan areas (Wills & Case-Smith, 1996). Kohler & Mayberry (1993) suggest that educational videotapes and other educational materials be made available through a regional resource library. Also, computer networks can allow intercommunication, support, and fast transfer of ideas.

Another challenge for rural health is recruitment and retention of health care workers. Some strategies to manage this problem have been illustrated within the literature. Kohler & Mayberry (1993) suggests that more opportunities for students to have rural clinical experiences will help to increase recruitment. The fieldwork component of occupational therapy training has been identified as the most important influence on choice of clinical practice area (Christie, Joyce, & Moeller, 1985). Kohler & Mayberry also suggest that structured mentorship for new therapists is another method of increasing recruitment and retention. Appropriate liaison and clear communication with clients and support staff regarding therapy objectives and programs is vital to the success of therapy interventions. In addition, careful prioritizing of workloads and analysis of timeframes is necessary to maintain equity of service to all clients (Bent, 1999).

Conclusion

When working in a rural environment it is important to first understand the culture of the clients being treated, because the treatment goals of someone living in a rural community may differ from those of someone living in an urban community depending upon the context with which they live. It is also important to gain an understanding of the culture to build a relationship with the community residents to allow them to develop an accepting and trusting relationship with the healthcare provider. It is also valuable to explore the challenges and rewards of rural living as well as rural practice to add an overall understanding of what the rural experience is like (The challenges and rewards of rural living and rural practice are presented in Tables 1 & 2).

Another important aspect to explore is the professional skills required of a rural therapist. The literature reveals an overall trend of rural communities facing shortages of and difficulty with recruitment and retention of health care workers. Overcoming the challenges of rural practice is crucial to increase recruitment and retention of rural health care workers (Possible solutions to increase rural recruitment and retention are presented in Table 3). Although the majority of the literature on rural occupational therapy has been found in Australia many of the concepts appear to be applicable to practice in rural America, as well. It is evident that there is a great need for medical professionals in rural communities, however there continues to be a shortage. The proposed solution to this problem is to educate potential occupational therapists on the rewards of rural health as well as to generate changes to overcome some of the challenges faced by rural health care workers. It is also essential that rural occupational therapists have a guide to follow demonstrating the proper procedure to establish a rural practice to support potential therapists who may otherwise not consider a rural position because they fear the process is not straightforward and too complicated. An occupational therapy rural practice handbook has been produced as a tool for therapists who are considering establishing a rural practice to utilize to make the transition into rural health less complicated.

CHAPTER III

ACTIVITIES/METHODOLOGY

The process of developing a manual for establishing an OT practice in a rural community began with an extensive review of current literature on rural allied healthcare with a concentration on occupational therapy. Topics of importance to this project included recruitment and retention issues, challenges and rewards of rural practice, issues facing new graduates in rural practice, and the specific skills necessary for an occupational therapist practicing in a rural community. Along with researching issues facing rural allied health, the exploration of rural culture was also considered a necessary component to rural practice. The process of developing the literature review involved search engines such as PubMed and CINAHL focusing on allied health issues in rural communities. OT search was also utilized to explore research on issues facing occupational therapy in rural communities. Library resources, as well as information from the Rural Assistance Center were used to explore aspects of rural culture. After reviewing the literature it is felt that a manual for establishing an OT practice in a rural community will help attract increased numbers of occupational therapists to rural communities thereby improving the health care of rural residents.

The process of developing this manual began with a proposed outline of the product. It was decided that the manual should be separated into three consecutive phases. Taking into account pertinent information found within the literature. The information found from reviewing the literature on rural culture was utilized to develop

the first phase, which consists of getting to know the community. The literature revealed that rural communities have a unique culture of their own and it is important to develop a relationship with the stakeholders of the community before considering employment. A rural North Dakota community (Stanley, ND) was chosen to use in the manual as an example to serve as template for therapists to use when considering establishing a rural OT practice. The Internet, local phone book, and residents within the community were used to develop a detailed list of the names and phone numbers of the allied health professional and stakeholders of the community. Information regarding understanding rural culture was developed utilizing library and Internet resources used in the literature review.

Phase II was developed to help the therapist market OT services to potential employers and the members of the community. The American Occupational Therapy Association website was utilized to obtain information such as practice setting fact sheets, potential funding sources, definition of occupational therapy, and information regarding potential referral bases. Occupational therapy textbooks were also utilized to develop fact sheets on the various types of practice settings.

Phase III involves the processes involved with implementation of rural practice after employment has been established. Internet resources were used to develop a definition and explanation of occupational therapy services in layman terms to use in the letter of introduction to the community. A general contract template was utilized to develop a contract between the hospital and school system as well as the mentorship contract. The Department of Labor bureau of labor statistics median wage for occupational therapists in North Dakota was utilized to determine the appropriate wage

for the occupational therapist to be included in the contract. Literature on mentorship relationships were also utilized to develop the responsibilities of the mentor included in the mentorship contract. Information regarding technology and how it can be used to decrease isolation and continuing education opportunities was taken from a rural health care delivery handbook regarding the use of technology developed by the California Health Care Foundation. Recruitment and retention issues were included in the manual due to the significant attention the literature placed on this topic and its importance to rural practice. The information was taken from resources used in the literature review as well as added information found using Internet searches.

Establishing an OT Practice in a Rural Community



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Introduction

There is a great need for occupational therapy services in rural communities, however due to decreased knowledge of occupational therapy, funding, and recruitment issues, therapy services have been lacking. As a result, many rural people with disabilities need to drive long distances to receive OT services. Establishing an occupational therapy practice in a rural community can be challenging, however this manual has been designed to simplify this process. There are three main phases to follow when establishing an OT practice in a rural community. Examples have been taken from a rural North Dakota community, Stanley, to provide a better understanding of what each phase entails.

The first phase (Phase I), which is titled “Getting to Know the Community” should be completed before accepting employment in a rural community. The purpose of this phase is to gain an understanding of the community and its culture. The information will help guide the process of establishing an OT practice by understanding the needs of the community members. It will also show that the therapist is willing to invest in and show an interest in the rural community. This process will help lead into the next phase, which involves marketing of the therapist to help secure the OT position desired.

The second phase (Phase II) is titled “Marketing of the Occupational Therapy Services,” which should be carried out prior to employment. The purpose of this phase is to market occupational therapy services and its benefits to potential employers. This process will also promote a positive relationship with the allied health care providers of the community. The final phase (Phase III) is titled “Implementation of OT Practice,” which should be carried out after employment has been secured. The purpose of this

phase is to assist with the procedures involved with establishing an OT practice. It is hoped that this manual will simplify the process of establishing an OT practice in a rural community. There are many other resources that can be utilized to assist with this process, some possible resources available will be located in this manual for further reference.

Phase I

Getting to Know the Community



Phase I – Getting to Know the Community

A rural community consists of the people who live directly in the community, surrounding communities, and those living on farms but still consider the community their hometown. This phase involves getting to know the health care facilities, school systems, and human services available to the community as well as the administration, city council members, and county commissioners. The most important aspect of Phase I involves understanding rural culture to gain an understanding of the needs of the rural residents. Resources on getting to know a rural community will be provided at the end of Phase I as a quick reference.

Before establishing an occupational therapy practice in a rural community, it is important to explore the healthcare facilities and services available to the community. Examples of some of the healthcare facilities that may exist in a rural community include a hospital, clinic, nursing home, home health services, dentist, chiropractor, pharmacy, county nurse's office, alcoholics anonymous, county social services, and public school systems. It is important to keep in mind that due to decreased services available to rural healthcare facilities, services are often contracted with other medical facilities in a nearby metropolitan area. However, this may be inconvenient for rural residents as it causes them to possibly drive long distances to receive services.

Along with exploring healthcare facilities, it is also important to build a relationship with the administrators of these facilities as well as the stakeholders of the community. These are the people who will provide important resources for establishing a practice as well as the people who occupational therapy services will be marketed towards. A detailed list of the healthcare facilities and administrators will need to be

completed as a resource to guide to assist with the process of establishing an OT practice.

Following is an example of what the detailed list would look like in Stanley, North

Dakota.

Mountrail County Medical Center:

Address: 615 6th Street SE

Stanley, ND 58784-4323

Mountrail County Hospital.....**phone #** (701) 628-2424

Total staffed beds – 11

General adult medical and surgical care

Administrator – Mitch Leupp.....**phone #** (701) 628-3191

Physicians – Dr. S. Mungee.....**phone #** (701) 628-2505

Dr. S. Dahr.....**phone #** (701) 628-2505

Dr. Monica Mayor (on call).....**phone #** (701) 628-2424

Director of Nursing – Connie Schmit, RN.....**phone #** (701) 628-2424

Mountrail County Clinic.....**phone #** (701) 628-2505

Administrator – Mitch Leupp.....**phone #** (701) 628-3191

Physical Therapist – Melanie Skaar, PTR.....**phone #** (701) 628-2505

Physical Therapy Assistant – Jessica Pappa, PTA.....**phone #** (701)-628-1234

Mountrail County Bethel Home (Nursing Home).....**phone #** (701) 628-2442

Administrator - Mitch Loupe.....**phone #** (701) 628-3191

Director of Nursing – Sandy Anderson, RN.....**phone #** (701) 775-3285

Social Worker - Joann Reep, SW.....**phone #** (701) 628-2696

Mountrail County Social Services:

Alcoholics Anonymous (AA)

Administrator – Faye Borud.....**phone #** (701) 628-2952

Domestic Violence Program:

Provides resources on how to receive help for women and men who experience domestic violence.

Administrator – Colleen Reese.....**phone # (701) 628-3233**

Golden Age Club:

An establishment for senior citizens to congregate for games and socialization.

Administrator – Lorraine Krieger.....**phone # (701) 628-2101**

Tri City:

A developmental home for residents who have a developmental disability.

Administrator – Darly Williams.....**phone # (701) 628-2990**

County Commissioners:

Dave Hynek.....**phone # (701) 755-3372**

Stan Wright.....**phone # (701) 628-2628**

Greg Boschee.....**phone # (701) 862-3670**

Public School System:

Address: Stanley Community Schools
PO Box 10
Stanley, ND 58784

Elementary School – 836 students

Superintendent - Wayne Stanley.....**phone # (701) 628-3811**

Principal - Mark Morgan.....**phone # (701) 628-2422**

High School – 512 students

Principal - Scott Ulland.....**phone # (701) 628-2342**

Special Education – Nancy Meiers.....**phone # (701) 755-3344**

School Board:

Ray Schepp.....**phone # (701) 628-1539**
Scott Meiers.....**phone # (701) 755-3344**
Ron Aadnes.....**phone # (701) 628-3417**
Cherlyn Biwer.....**phone # (701) 628-2594**
Kevin Harstad.....**phone # (701) 628-2381**

Other:

Dentist Office – Dr. Dale Brewster.....**phone # (701) 628-2138**
Chiropractor – Dr. Greg Mortensen.....**phone # (701) 628-7246**
Dakota Drug Pharmacy - Brent Rodenhizer.....**phone # (701) 628-2255**
County Nurses Office - Debbie Lund, RN.....**phone # (701) 628-2951**
Local Newspaper – The Promotor.....**phone # (701) 628-2333**

City Council:

Kelly Wilhelmi – President.....**phone # (701) 628-1230**
Tim Holte – Mayor.....**phone # (701) 628-1427**
Dale Kilen – municipal judge**phone # (701) 628-3451**
Neil Faber.....**phone # (701) 628-1117**
Myron Tande.....**phone # (701) 628-2936**
Rand Olson.....**phone # (701) 628-2263**
Robert Nohr.....**phone # (701) 628-3280**
Scott Ulland.....**phone # (701) 628-1434**

Understanding Rural Culture

One of the most important aspects of getting to know a rural community is the process of understanding rural culture. For people who have not experience rural life first hand may experience “culture shock” when relocating to a rural community. Although, rural communities have a unique culture of their own it is important to remember that not all rural communities are the same and some of the aspects of rural culture can not be generalized to all rural communities. To build a better relationship with the members of a rural community it is important to first explore the aspects of rural culture and then take a look at the unique cultural aspects of the rural community of interest.

The well-being of America's rural people and places depends upon many things the availability of good-paying jobs; access to critical services such as education, health care, and communication; strong communities; and a healthy natural environment to name a few. And while urban America is equally dependent upon these things, the challenges to well-being look very different in rural areas than in urban. Rural people and communities today are engaged in and depend upon a wide range of economic activities from manufacturing to mining, from recreational services to agriculture and everything in between. Yet, rural residents are likely to have many of their needs such as shopping, medical care, and banking at least partially met by providers in urban areas.

<http://www.nal.usda.gov/ric/ricpubs/understd.htm>. Rural communities similar to urban counterparts have their strengths and weaknesses. Some of the strengths of rural communities include a strong informal support network that is often seen among community members who support each other during times of tragedy such as a

community member with a terminal illness or a natural disaster. This is also seen with the successfulness of community fundraising efforts as entire communities are willing to give their time and money to assist with a good cause. Social relationships are often cohesive and meaningful. Rural people typically have a group of friends that they associate with and participate in many activities together such as sporting events, school programs, birthday parties, and vacations. People in rural communities are often considered friendly and it is common to have conversations with other people while grocery shopping, filling the car with gas, and running errands. Although there are many strengths to rural communities there are some weaknesses as well. This includes skewed population demographics which are often seen in rural communities where the majority of the community members are of the same race and ethnicity. This can often create communities that are less educated about other ethnicities and can increase the potential for people to be less open-minded about cultural issues. Another weakness includes a fluctuating economy which can create problems such as decreased access to health care, decrease transportation opportunities, and decreased amenities such as clothing stores, restaurants, and hotels. Rural people are often considered resistant to change and it typically takes rural people longer to accept changes to their community. In order to propose a new idea or possible change to the community it is important to first establish trust with the community members and to greatly promote the benefits of change to their community. Once this has been done it is important to involve the community members with the planning process. After changes have been made and the benefits are clear residents of the community will be grateful and show their appreciation. Finally, rural

communities often are faced with limited resources. Therefore, it is important for a therapist to be resourceful and utilize resources found outside of the community.

Understanding rural culture can be accomplished through researching literature, however a rural communities culture can not be fully understood without experiencing the lifestyle first hand. Allow the community members to discover more information about you and occupational therapy services. Be prepared to explore the rewards and challenges of rural living and practice and compare them to your personality and values to determine if rural practice is a right fit for you. Finally, take pride in considering rural practice as there is a great need for occupational therapy services and the community members will greatly appreciate your presence in the community.

Phase II Marketing OT Services



Phase II – Marketing OT Services

Marketing OT services will be vital in securing employment in a rural community. Rural health care professionals are often uninformed of occupational therapy services due to the scarcity of OT practitioners in the surrounding areas. This phase involves writing a letter of introduction to the allied health professionals to promote occupational therapy and to establish a relationship with other allied health care workers. This will involve directly meeting with potential employers and other allied health professionals of the community to discuss the importance of OT services for this community. Occupational therapy fact sheets on the various types of practice settings such as the school system, skilled nursing facility, hospital, social services, and home health will be provided to define the diverse therapy services provided in each type of setting. Potential referral bases and funding resources such as reimbursement will also be provided to assist with the marketing process. The information provided may be given to allied health professionals and potential employers to use a resource to understand the services occupational therapy can provide and how they can be utilized within the health care system.

March 21, 2005

Allied Health Professionals
Mountrail County Medical Center
615 6th Street SE
Stanley, ND 58784-4323

To Whom It May Concern:

There are many rural residents that can benefit from occupational therapy services. Some rural residents may already receive OT services but are forced to drive long distances to attend treatment sessions. Others may not acquire needed services because of the lack of knowledge about the services that Occupational Therapists can provide. Occupational therapy can help the residents of this community to increase their quality of life by providing treatment and resources to promote participation in their daily activities despite their limitations.

The American Occupational Therapy Association defines occupational therapy as skilled treatment that helps individuals achieve independence in all facets of their lives. It gives people the “skills for the job of living” necessary for independent and satisfying lives. Occupational therapy embraces a holistic approach to treatment considering every aspect of a patient’s life taking into account the person’s skills/limitations, occupations, and their environment. A few services provided include treatment programs to improve one’s ability to perform daily activities, home adaptations, recommendations and training on the use of adaptive equipment, and consultation to family members and caregivers of someone with a physical or psychological disability.

A few examples of those who benefit from occupational therapy include:

- People with limitations following stroke, heart attack, spinal cord injury, or head injury
- People who suffer from arthritis and Multiple Sclerosis
- Children with learning problems or Development Disabilities
- People suffering from mental health or behavioral problems
- People with burns, amputations, and hip/knee replacements
- People with visual or cognitive impairments that affect driving ability

I hope that you have learned more about what occupational therapy services can provide and how they can benefit the residents of this community. I am interested in meeting with you and getting to know you better. I will be contacting you to set up an appointment. I can be reached at (701) 629-1887 or jreep@medicine.nodak.edu for further information. Thank you for your time.

Sincerely,

Jessica Reep, MOTS

Potential Referral Bases

School Systems:

Occupational therapy (OT) is a related service under Part B of the Individuals with Disabilities Education Act (IDEA). If a child has a disability, as defined by IDEA, and needs special education and related services to meet unique learning needs, then he/she might be eligible for OT services. Eligibility for special education does not mean automatic eligibility for related services, including OT. The final determination is made by the multidisciplinary team in concert with the occupational therapist.

Hospital, Outpatient, and Nursing home:

Typically, occupational therapy services are provided in these practice settings with referrals from physicians. Every state has different referral procedures, however North Dakota does not have any specific referral requirements. It is important to verify third party payer referral requirements in states that do not have specific requirements. More information pertaining to specific state requirements can be found on the American Occupational Therapy Association website. Not only can family practice physicians make referrals to OT but also, orthopedic surgeons, psychologists, pediatricians, cardiologists, neurologists, etc.

It will be important to promote and market occupational therapy services to the members of the IDEA team involved with the school systems as well as the local physicians and physicians from nearby communities. If the physicians are unaware of

occupational therapy services they will be less likely to refer clients for therapy. This is a vital step in ensuring that you will receive referrals in order for your practice to prosper.

Potential Funding Sources

The marketing of OT services process will include informing potential employers on potential funding sources of occupational therapy services. The following is a brief description of the various reimbursement procedures utilized across a range of OT practice settings.

Hospital:

- Acute inpatient care services are reimbursed through a Perspective Payment System (PPS) per episode system based on Diagnostic Related Groups (DRGs). Each DRG has a payment weight assigned to it, based on the average resources used to treat Medicare patients in that DRG.

Nursing Home:

- Part A patients are billed by the minute on a perspective payment system based on the Resource Utilization Groups (RUG) category and Part B patients are billed by the unit.

Outpatient Rehabilitation:

- Outpatients are billed by the CPT code unit. The therapist does not get paid for any time they cannot bill for, so an indirect service log is built in for duties such as in-services, meetings, and looking for equipment, etc. A number of services can be billed free or included in the cost.

School Systems:

- Occupational therapy is a related service under Part B of the Individuals with Disabilities Education Act (IDEA), and is provided to help a student with a disability to benefit from special education. If a child has a

disability, as defined by IDEA, and needs special education and related services to meet unique learning needs, then he/she might be eligible for OT services. A child must be eligible for special education before being considered for OT services in the schools under IDEA. Schools can bill Medicaid for IDEA services.

Medicare Coverage for Occupational Therapy

Generally, occupational therapy is considered a covered service under Medicare if it meets the following criteria:

1. Services must be prescribed by a physician and furnished under a physician approved plan of care (developed by a physician or an occupational therapist).
2. Services must be performed by a qualified occupational therapist or occupational therapy assistant under the general supervision (or direct personal supervision in an occupational therapy private practice) of an occupational therapist, and
3. Services must be reasonable and necessary for the treatment of the individual's illness or injury.
 - a. Occupational therapy is considered reasonable and necessary when it is expected that the therapy will result in significant improvement in the patient's level of function within a reasonable amount of time.

For more detailed information about Medicare and Medicaid reimbursement procedures relating to occupational therapy go to <http://www.cms.hhs.gov/med>. and <http://www.aota.org>.

Phase III Implementing OT Services



Phase III – Implementation of OT Practice

This phase is carried out after employment has been secured and involves the important aspects of establishing an OT practice in a rural community. To announce the arrival of the OT position to the community a letter of introduction should be published in the local newspaper. This phase also involves obtaining a contract to work with the hospital, nursing home, clinic, and school systems to be able to provide occupational therapy services to all of these settings. A sample contract between the medical center (which includes the hospital, nursing home and clinic) and the public school systems in Stanley, ND is provided as an illustration of what this type of contract could resemble. One of the most common challenges of rural practice is professional isolation. A possible solution to this problem is to set up a mentoring contract with another occupational therapist in a nearby metropolitan area. A mentoring relationship is defined as one that may vary along a continuum from informal/short-term to formal/long-term in which faculty with useful experience, knowledge, skills, and/or wisdom offers advice, information, guidance, support, or opportunity to another faculty member or student for that individual's professional development (Berk, Berg, Mortimer, Walton-Moss, & Yeo, 2005).

The desirable characteristics of a mentor include:

- expertise
- professional integrity
- honesty
- accessibility
- approachability
- motivation
- respect by peers in field
- supportiveness and encouragement

A sample mentorship contract is provided to assist with this process. Also, methods of technology which can be utilized in the mentorship process are provided as well. Continuing education in a rural practice with a sole therapist can be challenging. Suggestions are provided to assist with taking part in continuing education opportunities without disrupting the responsibilities of the occupational therapist. With the large number of responsibilities of a sole therapist in a rural community it is recommended to hire another therapist to decrease the workload. Suggestions as well as some recruitment and retention issues for this process involved with rural practice are also provided.

Sample Letter of Introduction to the Community

Occupational Therapist Arrives to Town

Occupational therapists (OTs) help people improve their ability to perform tasks in their daily living and working environments. They work with individuals who have conditions that are mentally, physically, developmentally, or emotionally disabling. Their goal is to help clients have independent, productive, and satisfying lives. Jessica Reep is an occupational therapist who helps patients put together pieces of their lives disrupted by illness or injury. Jessica Reep received her master's degree in occupational therapy at UND in 2005 and did her internship at St. Lukes hospital in Cedar Rapids, Iowa and at Prairie Harvest Foundation in Grand Forks, ND. Jessica will be working with the physical therapist in the Mountrail County Medical clinic. Occupational therapy services will be provided to people of all ages including those in the hospital, nursing home, clinic, and children in the public school systems. Some of the services occupational therapy can provide include home adaptations, training on adaptive equipment, hand therapy, wheelchair positioning, rehabilitation after a stroke, and school modifications. The Mountrail County Medical clinic will offer occupational therapy services five days a week, Monday through Friday. Jessica will begin working on June 23 and can be reached at (701) 628-4245 for further information about occupational therapy services.

CONTRACTUAL SERVICES AGREEMENT

THIS AGREEMENT made and entered into by and between the Mountrail County Medical Center and the Stanley public school systems. Mountrail County Medical Center is hereafter contracted to allow the Occupational Therapist to provide services to students and faculty of the Stanley public school systems.

WHEREAS; the Stanley public school system requires services to:

- Implement initial assessment of client's needs, treatment planning, and intervention to increase client's level of independence in desired occupations.
- Obtain and train on the use of adaptive equipment and assistive technology to increase client's level of independence.
- Provide home assessments and adaptations of client's environment.
- Provide consultation to clients, family members, and caregivers.
- Implement documentation to medical reimburses.

NOW, THEREFORE, in consideration of the mutual agreement herein contained, the parties agree as follows:

1. The Stanley public school system hereby engages the Mountrail County Medical Center for services to include:
 - Observe a student engaging in an activity and provide strategies to facilitate the student's full participation.
 - Reduce barriers that limit student participation within the school environment.
 - Utilize assistive technology to support student success.
 - Support the needs of students with significant challenges such as by helping to determine methods for alternate assessment.
 - Help identify long-term goals for post-school outcomes
 - Help plan relevant instructional activities for ongoing implementation in the classroom.

2. Mountrail County Medical Center shall be compensated for all services performed and goods or services supplied according to the following considerations and terms:

Occupational therapy is a related service under Part B of the Individuals with Disabilities Education Act (IDEA), and is provided to help a student with a disability to benefit from special education. If a child has a

disability, as defined by IDEA, and needs special education and related services to meet unique learning needs, then he/she might be eligible for OT services. A child must be eligible for special education before being considered for OT services in the schools under IDEA. Schools can bill Medicaid for IDEA services. Eligibility for special education classes does not mean automatic eligibility for related services, including OT, the final determination is made by the multidisciplinary team in concert with the OT evaluation.

3. The Stanley public school system will not be responsible for insurance benefits, sick leave, or other employee benefits that will provided by the Mountrail County Medical Center. The occupational therapist will be available to the school systems ten hours a week to be determined by the therapist, special education coordinator, and superintendent of schools. The occupational therapist will be paid a minimum wage of \$22 per hour for services provided.
4. This agreement may be terminated by either party upon reasonable written notice (no less than 30 days) to the other party

Wayne Stanley
Superintendent of Stanley
public schools

Mitch Loupe
Administrator of Mountrail
County Medical Center

Date_____

Date_____

CONTRACTUAL SERVICES AGREEMENT

THIS AGREEMENT made and entered into by and between the Mountrail County Medical Center and the Trinity Hospital Occupational Therapy Department is hereafter contracted to provide mentorship to the Occupational Therapist employed with the Mountrail County Medical Center.

WHEREAS; the Mountrail County Occupational Therapy Department requires services to:

Provide guidance and training to a sole therapist in a rural community with limited resources and feedback from other occupational therapists. The mentorship relationship will aid the therapist in the rural community in providing evidence based practice and the best treatment for the client's within the rural community.

NOW, THEREFORE, in consideration of the mutual agreement herein contained, the parties agree as follow:

1. The Mountrail County Medical Center hereby engages the Trinity Hospital Occupational Therapy Department for services to include:

- The Trinity Hospital Occupational Therapy department will provide the Occupational Therapist employed with the Mountrail County Medical Center with a mentor.
- The mentor at the Trinity Hospital will be in contact with the mentee through the use of phone, email, and technology to aid in long-distance communication approximately ten hours a week.
- The mentor at the Trinity Hospital will have one face to face contract with the mentee once a month for two hours to evaluate the relationship and progress of the mentee.

2. Responsibilities of a mentor include:

- Commitment to mentoring a novice therapist approximately ten hours a week.
- Direct the mentee to appropriate resources and source materials in the field
- Offers guidance and direction regarding professional practice issues
- Provides constructive, clear, and useful feedback of the mentee's work in a timely manner
- Challenges the mentee to expand his or her abilities
- Respects mentee's uniqueness and acknowledges his or her contributions to OT practice through positive feedback

- Mentor will be available to the mentee approximately ten hours a week to be agreed upon between the mentor and mentee
3. Trinity Hospital shall be compensated by the Mountrail County Medical Center for services provided at a flat rate of \$20 per hour.
 5. This agreement may be terminated by either party upon reasonable written notice (no less than 30 days) to the other party.

Jessica Reep, OTR/L
Mountrail County Medical Center
Stanley, ND

Director of Trinity
Hospital Rehab Department
Minot, ND

Date_____

Date_____

Use of Technology

Using technology is one way to resolve some of the challenges provided by rural practice. These challenges include professional isolation, lack of structured mentorship, and lack of continuing education opportunities due to limited financial resources and inability to travel long distances to attend seminars.

Videoconferencing, also known as telemedicine is the process of conducting a [conference](#) between two or more participants at different sites by using [computer networks](#) to transmit audio and [video data](#). Each participant has a video camera, microphone, and speakers mounted on his or her computer. As the two participants speak to one another, their voices are carried over the network and delivered to the other's speakers, and whatever images appear in front of the [video camera](#) appear in a [window](#) on the other participant's [monitor](#). Multipoint videoconferencing allows three or more participants to sit in a [virtual](#) conference room and communicate as if they were sitting right next to each other. The use of technology such as videoconferencing can make it possible for a therapist to collaborate with other therapists and attend continuing education seminars via satellite systems. This type of technology helps create a collaborative environment between rural providers and their urban colleagues (Geller, 1997).

Although telemedicine and videoconferencing have been utilized with occupational therapy services the research on it is limited. The Canadian Association of Occupational Therapists (CAOT) recognizes that tele-occupational therapy will offer unlimited opportunities for effective, efficient and accessible occupational therapy services to all Canadians. Therefore, they are in the process of providing

information about practice advancement and research within the evolving tele-occupational therapy environment. Through this process the CAOT will:

Develop guidelines for use of information and telecommunications technologies that will enable members to deliver effective tele-occupational therapy services.

Collaborate with occupational therapy stakeholders to address the issues associated with remote consultations and supervision of support personnel.

Promote best tele-OT practice by encouraging partnerships among service and system provider's suppliers of technological innovation, and consumers.

Facilitate the dissemination of evidence-based knowledge through CAOT publications and continuing professional education activities to sustain successful tele-occupational therapy in Canada and globally.

Many videoconferencing capabilities are funded through government funded grants. The U.S. senate approved an appropriations bill in November 2001 that was signed by President Bush in December to provide over \$100 million dollars in loans to increase the penetration of broadband access to rural areas as well as \$22.5 million to be dispensed through an ongoing telemedicine and distance learning pilot program. More information regarding the technical aspects and setup of the technology equipment is provided in Appendix B.

Recruitment/Retention Issues

The heavy caseloads associated with being a sole therapist in a rural community can be challenging. To decrease levels of stress it is recommended to hire another occupational therapist or occupational therapy assistant. However, many of the challenges of rural practice have made it difficult to recruit and retain rural therapists. Some possible solutions have been found throughout occupational therapy literature. Twenty-five percent of the respondents in a survey conducted by Elliot-Schmidt & Strong (1995) indicated that their reason for undertaking rural practice was because they had originally come from a rural upbringing. This is important when searching for potential therapists to target OT students and professionals from rural communities who have experience with rural culture. A good method of recruiting potential therapist is by targeting occupational therapy students through university career fairs. Results identified that spouse relocation was identified as an important factor for rural therapy recruitment (Boonyawiroj et al., 1996). One of the biggest issues for occupational therapists interested in rural practice is the limited opportunities for significant others to find employment especially if they have a college degree. Some rural communities have already established a task force team that assists with recruiting medical professional to their community. These programs have been found to be beneficial and it is recommended to include people in this committee who are from the school systems, realtors, and young people who can help assist with relocation to the community. It has also been found that providing visible role models who help occupational therapists better understand the realities and rewards of rural practice through literature, undergraduate allied health professional courses, placement of students in remote settings, and promoting and understanding of rural allied health services at executive levels within

employing agencies will help increase recruitment efforts (Bent, 1999). Another program that has been established in a few rural communities is called a “grow your own” program. This program entails locating a high school student from a rural community who is interested in becoming an occupational therapist and provide incentives for them to come back to work for the community after graduation. Often a contract is signed between the medical facility and the student and the medical facility will often provide tuition reimbursement if the student agrees to work for the medical facility after graduation. These are only a few of the recruitment issues facing rural practice as well as possible solutions. Other recruitment methods can be found by searching the internet, medical literature, as well as rural health programs located on college campuses.

Recruitment issues facing rural communities are important, however retaining rural therapists is often overlooked. It is important after employing rural professionals to provide them with the type of environment that is encouraging and that allows them to want to stay long term. When recruiting new therapists it is important that they understand the rural culture and are aware of all of the challenges and rewards of rural living and practice before accepting employment. Some of the suggestions used to assist with recruiting therapists can also be used to increase retention such as hiring someone who is from a rural upbringing as they are more likely to remain in rural employment (Millstead, 2001). Some other suggestions include improving opportunities for professional development through the use of technology. Providing a structure orientation and initial training program can help increase the therapist’s level of comfort and confidence in a rural setting. Also, changing the structure of the organization to meet the needs of the therapist to increase confidence and decrease stress will help with

retention of therapist. Retention efforts may seem unrealistic, time consuming and expensive, however it is worth the investment because it will increase the likelihood of retaining therapists and decrease the costs that are associated with recruitment efforts.

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CHAPTER V

SUMMARY

Occupational therapists in rural practice find themselves working in a generalist position requiring a broad knowledge base. Also, professional isolation and decreased social opportunities in a rural community have added to the shortages of occupational therapists in rural practice. This has forced many rural residents requiring OT services to either drive long distances to receive treatment or they have not received needed services. Lacking occupational therapy services has aided in the decrease of quality of life as well as the decrease in the patient's ability to regain independence from a disability. For patients, the need to travel away from home results in a range of difficulties including time away from work, finding transportation, potential hazardous driving condition due to inclement weather, additional expenses, and missing or incomplete exchange of information between different health care providers.

Establishing an occupational therapy practice can be a comprehensive process especially in a rural community. The goal of this rural OT practice manual is to provide potential therapists interested in rural practice with resources to simplify the process of establishing an OT practice in a rural community. It is hoped that increased recruitment and retention efforts will attract therapists to rural practice to increase the quality of life and well being of rural residents who are facing increased health conditions due to the decrease in access to health care.

The challenges of rural practice have prevented therapists from establishing an OT practice in a rural community. To increase the recruitment and retention of rural therapists it is recommended to use the rewards of rural practice as well as find solutions to the challenges of rural practice to attract potential therapists. To summarize some of the challenges of rural practice include professional isolation, heavy caseloads, lack of continuing education opportunities, lack of specialized training, and limited financial support. Some of the rewards of rural practice including a variety of practice settings, opportunity to develop independence, closely experience clients within the community, and the great need for OT in rural communities should be utilized to promote recruitment of therapists. Before establishing employment in a rural community it is also recommended to explore the culture of the community and establish relationships with some of the community members. Once this is accomplished it is important to market OT services to prove the need and importance of having occupational therapy services available to the community, which will aid in the process of establishing employment. Finally, after employment has been secured there are many procedures to be followed with implementing the OT practice. The procedures are displayed within the manual to simplify the process of establishing an OT practice within a rural community.

The manual for rural practice contains three separate phases to be followed in consecutive order. Phase I is titled “Getting to know the Community” and its purpose is to develop an understanding of the community and to establish a relationship with the community members who will be impacted by the OT practice. Phase II is titled “Marketing OT Services” and its purpose is to prove that there is a need for occupational therapy services within the community and to promote occupational therapy to potential employers. Phase III is titled “Implementing an OT Practice” and its purpose is to take measures that are essential to establishing an OT practice in a rural community after employment has been established.

Samples within this manual have been taken from a rural community in North Dakota, which is not a representative of all rural communities in the United States. The goal of this

manual is to serve, as a general template that can be adapted to any rural community, however it is important to remember that all rural communities are different and the manual should be modified accordingly. Also, with this manual the therapist is employed through the medical center and is contracted to work with the school systems. Modifications will need to be made for the therapist who is considering establishing an independent occupational therapy practice. In this situation the therapist will need to establish separate contracts with the hospital, nursing home, and school systems. The therapist will also want to consider placement of the department, funding issues, and all other issues concerning starting a new business. It is recommended that future development of this manual be done to include a variety of rural communities as well as modifications to be conducive to the therapist interested in independent practice within a rural community.

APPENDIX A

Occupational Therapy In Inpatient and Outpatient Rehabilitation



Occupational therapists and occupational therapy assistants assist patients in a rehabilitation setting to regain independence with their daily

occupations.



Skills for the Job of Living

Life circumstances are taken into account during the treatment process. The person is what is important to the therapist. The person's wants, needs and desires for recovery are what the therapist will address and the goals they together, along with family and friends, as a team will reach for.

The profession of occupational therapy is concerned with a person's ability to participate in desired daily life activities or "occupations." Occupational therapy plays a vital role in a patient's recovery after a traumatic injury or illness. In an inpatient setting the patient is referred to occupational therapy per their physician after they are deemed medically stable to endure approximately three hours of therapy a day. In an outpatient setting the patient is referred to occupational therapy services by their physician and the patient voluntarily participates in therapy at a schedule set up by the therapist and the patient. Occupational therapy in a rehabilitation setting involves

- Assisting people who for one reason or another are unable to function independently.
- Increasing independence through function Occupational Therapy provides things like ADLs (activities of daily living-- eg. dressing, eating, cooking, bathing, and toileting).
- Enhancing Work, Play and Leisure Occupational Therapy helps others to help themselves
- Aiding individuals who for one reason or another are not functioning as independently as possible in the areas of daily living, work, play and leisure. Occupational Therapists treat the whole person!

Occupational therapists and occupational therapy assistants bring specific knowledge to the rehabilitation phase of a patient's recovery.

developmentally, living and work skills. Occupational therapists help clients not only to improve their basic motor functions and reasoning abilities, but also to compensate for permanent loss of function. Their goal is to help clients have independent, productive, and satisfying lives.

Occupational therapists assist clients in performing activities of all types, ranging from using a computer to caring for daily needs such as dressing, cooking, and eating. Physical exercises may be used to increase strength and dexterity, while other activities may be chosen to improve visual acuity and the ability to discern patterns. For example, a client with short-term memory loss might be encouraged to make lists to aid recall, and a person with coordination problems might be assigned exercises to improve hand-eye coordination. Occupational therapists also use computer programs to help clients improve decision making, abstract-reasoning, problem-solving, and perceptual skills, as well as memory, sequencing, and coordination—all of which are important for independent living.

Therapists instruct those with permanent disabilities, such as spinal cord injuries, cerebral palsy, or muscular dystrophy, in the use of adaptive equipment, including wheelchairs, splints, and aids for eating and dressing. They also design or make special equipment needed at home or at work. Therapists develop computer-aided adaptive equipment and teach clients with severe limitations how to use that equipment in order to communicate better and control various aspects of their environment.

Some occupational therapists treat individuals whose ability to function in a work environment has been impaired. These practitioners arrange employment, evaluate the work environment, plan work activities, and assess the client's progress. Therapists also may collaborate with the client and the employer to modify the work environment so that the work can be successfully completed.

Helping People of all Ages Develop the Skills for the Job of Living

Occupational Therapy Services in An Inpatient Rehabilitation Setting

Typical Diagnosis Include:

Brain injury, Stroke, Hip/knee replacement, Spinal Cord Injury, Multiple Sclerosis, Broken bones, Amputations, and General Weakness

Typical Treatments Include:

- Initial assessment of functioning
- ADL retraining
- Use of adaptive equipment
- Functional transfers (toilet, shower, etc.)
- Kitchen assessment
- Strengthening, range of motion, and endurance activities
- Fine motor activities (sewing, writing, etc.)
- Cognitive activities (checkbook, sequencing activities, etc.)



Occupational Therapy Services In an Outpatient Rehabilitation Setting

Typical Diagnosis Include:

Musculoskeletal disorders/injuries of the back, shoulder, arms, and hands, Cumulative trauma Repetitive injuries, Nerve related injuries, Work related injuries, and Burns.

Typical Treatments Include:

- Splinting
- Modalities
- Strengthening
- Industrial Rehab
- Body Mechanics
- Patient Education



Occupational Therapy in a Skilled Nursing Facility

Skills for the Job of Living
for your patients

Skills for achieving outcomes
for your nursing home



The role of occupational therapists and occupational therapy assistants in a nursing home is to help residents maintain quality of life, prevent falls, and increase independence with daily functioning

The profession of occupational therapy focuses on a person's ability to participate in desired daily life activities or "occupations." Occupational therapists and occupational therapy assistants provide valuable assessment, training and support to help older adults remain as independent as possible and injury-free. Staying active and safe are goals that older adults want for themselves: occupational therapists specialize in empowering older adults to do just that.

Occupational Therapy Treatments Include:

- Wheelchair positioning
- ADL training
- Decrease contractures (splinting)
- Preventing falls
- Preventing skin breakdown
- Increase independence with leisure activities
- Functional transfer training
- Cognitive activities
- Dysphasia treatments

Typical Diagnosis Include:

- Stroke
- Alzheimer's
- Multiple Sclerosis
- Amputations
- Brain injuries
- Dementia
- Hip fractures
- Parkinson's Disease
- Spinal cord injury

What is a Skilled Nursing Facility?

A skilled nursing facility, or "SNF," is a nursing home which provides skilled nursing and/or skilled rehabilitation services to patients who need skilled medical care that cannot be provided in a custodial level nursing home or in the patient's home.

How does Medicare cover skilled nursing home patients?

Medicare guidelines state that all therapy must be reasonable, necessary, specific, and effective treatment for the patient's condition. Policies developed by the Centers for Medicare and Medicaid Services the federal agency that administers the Medicare program require that therapy (1) is ordered by a physician or other qualified health care practitioner, (2) requires the skills of a qualified therapist rather than non-skilled nursing home staff, (3) is provided either by or under the direct supervision of a certified therapist and (4) is dictated by a written treatment plan. Medicare coverage also requires that the therapy meet the following conditions:

- the written treatment plan includes specific and measurable treatment goals related to the patient's condition along with a reasonable time estimate of when those goals will be achieved;
- the treatment plan describes the specific therapeutic interventions that will be used to restore the patient's levels of function that has been lost or reduced by illness or injury;
- the amount, frequency, and duration of therapy must be reasonable and necessary for the patient's condition;
- therapy must be provided with the expectation, based on the assessment made by the therapist, physician, or non-physician staff member (nurse practitioner, physician assistant, or clinical nurse specialist) of the patient's restoration potential, that the patient's condition will improve substantially in a reasonable and generally predictable period of time, or the therapy must be necessary for the establishment of a safe and effective maintenance program.
- Therapy only will be covered until the physician and/or therapist concludes that the patient is not going to improve; and the patient is seen by the physician or non-physician staff member at least every 30 days.

Occupational therapists use specified therapeutic approaches for self-care, energy conservation, homemaking and creative activities and assess for adaptive equipment to maximize the resident's level of function and quality of life.



Occupational Therapists provide services to individuals of all ages who need specialized assistance in learning skills to enable them to lead independent, productive, and satisfying lives through remedial therapeutic activities, environmental modifications, and/or adaptive living techniques.

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APPENDIX B

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