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# Doing It Right: OT Meeting Population Needs with COVID-19

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## Erratum
Typo corrected in Table 1

## Credentials Display
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In 2010, the U.S. Department of Health and Human Services (HHS) identified strategic goals for health promotion and disease prevention in *Healthy People 2020*. Some of the overarching goals were to "achieve health equity, eliminate disparities, and improve the health of all groups" in order to address inequities tied to race and ethnicity, gender, socioeconomic status, geography, and disability (p. 3). The plan also targeted health disparities by recognizing social determinants of health and creating "social and physical environments that promote good health," including the development of policy and programs (HHS, 2010, p. 3). Health disparities are population specific and quantify "differences in disease rates, health outcomes, and access to health care services" (American Occupational Therapy Association [AOTA], 2013, p. S48). In times of crisis, vulnerable populations may be particularly susceptible to disease, illness, and mortality because of health disparities related to social and environmental barriers and determinants of health. AOTA's official stand on nondiscrimination and inclusion is that every individual be treated fairly and equitably (AOTA, 2014b); that an individual's culture, race, ethnicity, age, and capacities be respected; and that all occupational therapy personnel avoid prejudice and bias (AOTA, 2015). As a profession, occupational therapy promotes access and inclusion and limits health disparities in daily practice. Advocacy is a critical role and value of the profession for promoting resilience for populations based on health equity and occupational justice.

## Crisis in Health Care

On March 11, 2020, the World Health Organization (WHO) declared the COVID-19 novel coronavirus a pandemic. The global community experienced the rapid spread of the respiratory disease and an accompanying scarcity of resources, such as personal protective equipment (PPE) for frontline health care providers; ventilators to combat acute respiratory distress syndrome (ARDS); and hospital beds for people in acute, life-threatening distress. Shortly after the pandemic was declared, the Centers for Disease Control and Prevention (CDC) issued guidelines to slow the spread of the novel coronavirus and reduce stress on the U.S. health care systems to accommodate the affected population. The guidelines included three components: social distancing, quarantine, and isolation (CDC, 2020). As a consequence, hospital and health systems shut down or limited access to routine ambulatory services, including services provided by specialty clinics, occupational therapy, physical therapy, and speech therapy. This reduction of in-person services left health care providers scrambling to untangle Medicare and other reimbursement regulatory loopholes to rapidly employ telehealth technologies to reach the most vulnerable clients and patients in society. Each of these changes to health care are problematic for vulnerable populations across the country, populations who are already marginalized by social determinants of health that affect participation and quality of life. National leadership responses guide state reactions, which typically focus on general population health and leave the disabled population vulnerable.

## Society and Disability in a Pandemic

It can be argued that during a social crisis, whether it is a pandemic or a natural disaster, all of society becomes "disabled" as social and economic disruption of daily life routines lead to occupational deprivation and isolation that impact the health and well-being of all (AOTA, 2011). However, gaps in population health disparities have been exaggerated during the COVID-19 pandemic. Social and occupational injustices reveal barriers to equitable care and health in three ways: the individual (micro), community (meso), and societal (macro) levels of environmental factors and human functioning (Bailliard et al., 2020; Hammel et al., 2015). The COVID-19 pandemic reinforces the concept that environmental factors of health and participation exist at each of the three levels, have transactive properties, and include systems and institutions that intersect and influence patient and client outcomes (Bailliard et al., 2020;

Cutchin & Dickie, 2013; Hammel et al., 2015). Individuals with disabilities are more likely to be impacted by a disruption in services in the event of a pandemic such as COVID-19, particularly in home and community supports, and a lack of access to critical services to sustain health and well-being in daily living activities (Klimkina, 2020). Consideration of each of the levels is critical in sustaining occupational performance.

According to the World Federation of Occupational Therapists' (WFOT) position on occupational therapy and human rights, and in the vision of *Healthy People 2020*, all people have the right "to participate in a range of occupations that support survival, health and well-being so that populations, communities, families and individuals can flourish and realize their potential" (WFOT, 2019, p. 1). For individuals, disparities exist in the degree of isolation, deprivation, and disruption experienced during social distancing and quarantine; in their skill level and self-efficacy to achieve adequate crisis-preparedness; and in their ability to maintain health and safety (Adams et al., 2019; Campbell et al., 2009). Inequities exist geographically and in varying levels of community emergency preparedness and resilience, and in communities' ability to bridge and bond support networks and organizations to care for their members in times of crisis (Adams et al., 2019). Populations marginalized by race and ethnicity, socioeconomic status, age, and disability have been specifically identified by the HHS Office for Civil Rights in Action as particularly vulnerable and have been the focus of several disability rights groups alleging that some state crisis triage protocols, in fact, discriminated against these vulnerable groups in the decision-making process for rationing and allocating life-saving care and equipment during the pandemic (HHS, 2020; Kaiser Family Foundation, 2020; Persad et al., 2020). Discriminatory language emerged in crisis triage protocols that led disability advocates to file complaints with the HHS. Advocacy groups and organizations cited complaints alleging states such as Alabama and Pennsylvania were in violation of Human Rights laws and legislation that protected people with disabilities from discriminatory practices, such as deprioritizing the disabled when making decisions about who receives critical care and ventilators (HHS, 2020).

**Ethics and Decision-Making**

Utilitarian approaches to decision-making emerged during the pandemic that argued that decisions be based on the premise of "most lives" saved and "most life-years" saved (Emanuel et al., 2020, p. 2051). These echo the rehabilitation-derived concept of "disability-adjusted life years" and the idea that disability contributes negatively in society as an undue burden (Kielhofner, 2005). Decisions by health care providers illustrate the transactional web of occupation and how macro, meso, and micro levels of functioning and environments intersect and influence individual participation, as well as the occupational rights of a targeted population to receive access to equitable health care (AOTA, 2014b; Hammel et al., 2015). For example, Section 1557 of the Affordable Care Act, Section 540 of the Rehabilitation Act, the Age Discrimination Act of 1975, and Title II of the Americans with Disabilities Act (HHS, 2020) are all macro-level facilitators (Hammel et al., 2015) that ensure persons with disabilities "not be denied medical care based on the basis of stereotypes, assessments of quality of life, or judgments about a person's relative 'worth' based on the presence or absence of disabilities or age" (HHS, 2020, para 3). States using discriminatory language and exclusion criteria on the basis of disability or age in their crisis triage protocols (meso level of influence) are failing to comply with ADA regulations (macro level facilitator) (Hammel et al., 2015) and exposing individuals with disabilities as targets of implicit biases from their health care providers; biases that include judgments on quality of life and relative life "worth" and that infringe on the human right and belief that each individual has equal worth in their own right. These biases

and infringements are all examples of micro-level injustices and micro-aggressions (Bailliard et al., 2020; Kaiser Family Foundation, 2020)

**Occupational Therapy and Disability Models**

By recognizing the impact COVID-19 has on the disabled at the individual, community, and societal levels, occupational therapists should be challenged to adopt a population health approach to client-centered occupational therapy practice. Viewing disability in the context of an individual or as a population creates opposing views as to where disability is actually situated (Cutchin & Dickie, 2013; McCormack & Collins, 2010). The medical model of disability perceives it as a restriction or lack of ability as a result of impairment in the range that is considered normal for a human being (Cutchin & Dickie, 2013), and it is situated with the individual as a deficit (McCormack & Collins, 2010). In 1976, the social model of disability was adopted by the disability advocacy community, which asserted that disability is not situated with the individual, impairments, and services; rather, disability is a neutral characteristic and not a medical problem that needs a cure (Dunn & Andrews, 2015). Disability is situated in the environment, a perspective that empowers disability advocates and members of the disability community to break down external barriers in the built environment, societal attitudes, prejudice, and/or discrimination (Dunn & Andrews, 2015). When occupational therapists work with individuals, the emphasis is typically on developing prevention, treatment, and remediation programs, which situate the disability with the individual and only addresses individual issues and deficits (McCormack & Collins, 2010). Viewing disability from the vantage point of the social model of disability allows occupational therapists to transfer disability to the social, cultural, and political paradigm (McCormack & Collins, 2010) and, thus, create interventions for groups, communities, and populations; support enablement; remove barriers; and promote inclusion, particularly in times of disasters. According to the *Occupational Therapy Practice Framework* (OTPF3),

> Interventions provided to groups and populations are directed to all the members collectively rather than specific to people within the group. Practitioners direct their interventions toward current or potential disabling conditions with the goal of enhancing the health, well-being, and participation of all group members collectively. (AOTA, 2014a, p. S15)

In recognition of the capabilities approach, there is a distinct connection between human rights and occupational rights, including the right to well-being (Hammel, 2015). *The Participatory Occupational Justice Framework* provides guidance to bridge individual, group, and population-based interventions, since true occupational justice requires "doing justice" in all three environments (Bailliard et al., 2020; Whiteford et al., 2018) and recognizes the transactional web between the micro, meso, and macro levels of society that impact participation, inclusion, and health equity. With social distancing, individuals with disabilities may experience even more occupational deprivation, given the challenge of support workers reticence to perform in-home care, which reinforces social isolation for the disabled population. Creating a population-based, client-centered practice using an occupational justice framework and a social model of disability lens creates a truly holistic practice addressing occupational and social injustice and the potential to create true change. AOTA's *Societal Statement on Health Disparities* enforces "occupational therapist practitioners have the responsibility to intervene with individuals and communities to limit the effects of inequities that result in health disparities" (Braveman et al., 2013, p. S7). We have established occupation and participation as pluralistic, transactional, and influenced by all

three (micro, meso, and macro) levels of human functioning. Occupational therapy interventions achieve the greatest outcomes and provide the most benefit to those we serve when holistic, client-centered, population-based practices are used in place of the individual, rehabilitation/medical models of disability intervention. Table 1 summarizes intervention suggestions at each of the levels, along with blending in concepts of disaster preparedness, response, and recovery considerations for occupational therapy actions. This table incorporates socio-political considerations in occupational therapy roles to support health and well-being in the three levels. This table integrates and adapts work from multiple sources along with the authors' ideas.

**Table 1**
*Micro, Meso, and Macro Interventions*

| Intervention Level | Type of Response | Intervention Examples |
|---|---|---|
| **Micro (Individual)** | Disaster-Preparedness | Assess efficacy skills in developing a disaster readiness plan using national and community household readiness plans to assist with identifying gaps and developing interventions. |
| | | Assist clients in developing local personal support networks to provide care in circumstances when usual caregivers or direct support professionals are not available for typical duties. Use of telehealth and video conferencing for occupational engagement options. |
| | | Develop comprehensive plans to access and communicate with support team and community agencies to attain staples such as food, water, and medical supplies. Explore telehealth options. |
| | | Determine efficacy and skill level of client's ability to direct untrained caregivers step-by-step in how to meet their needs and care routines. Telehealth options should be explored. |
| | | Identify barriers in current environment that may impact access to up-to-date information and instructions related to the current emergency situation (literacy, blind, deaf, assistive technology needs, AAC). |
| | Disaster-Response | Assess client's mental health, anxiety, depression. Recognize impacts of occupational disruption, occupational isolations, and occupational deprivation. |
| | | Assess client's need for assistance in structuring/restructuring daily routines and occupational engagement. |
| | | Provide strategies for stress-management and coping. |
| | | Assist with providing interventions to support children's education, play, and mental health needs to support occupational engagement. |
| | | Use telehealth technologies to access isolated clients requiring services. |
| | | Facilitate advocacy and efficacy skills to empower individuals and families to locate and use community resources. Provide access to community disability resources. |
| | | Provide clients and families access to local disability rights organizations and assess situations where discrimination, bias, or civil violations affected equitable care. |
| | Disaster-Recovery | Locate and communicate with clients and assess the impact occupational deprivation, isolation, and disruption may have had and provide interventions to support return to meaningful rituals and routines. |
| **Meso (Community) Level** | | Be involved in reviewing and developing community emergency preparedness and response plans building community resilience. |
| | | Advocate for disabled individuals to be involved in local community and state planning groups to inform policy makers of the needs of the disabled community. |
| | | Maintain involvement in your state occupational therapy association and licensing board to fight for access to telehealth services as an essential health care service delivery method. |

| Macro (Society) Level | Insist occupational therapists and disabled individuals gain a "seat at the table" when reviewing and revising state crisis triage protocols to ensure discriminatory language is omitted and care decisions are equitable to all populations. |
| --- | --- |
| | Inform community organizations and groups providing services to the disabled community about alternative access and information dissemination strategies to reach as many people as possible. |
| | File complaints with the HHS Office for Civil Rights of any violations community and state government policies or protocols may have involving effective communication practices, meaningful access to programs and materials, addressing needs of those with disabilities, and receiving equitable care and services. |
| | Work with AOTA to advocate for telehealth access and reimbursement by Center for Medicare Services and other health payor sources. |
| | Become a disability ally and stay connected with local, state, and national disability rights efforts through organizations such as the National Disability Rights Network. |

*Note*. Portions of the table were adapted from AOTA, 2011 materials.

## Conclusion

People in our global world are experiencing unprecedented challenges to our personal habits, routines, and lifestyles and, simultaneously, to our communal sense of inclusion and purpose. Leaders of economic systems, including health care systems, have been forced to institute decisions during the pandemic that they were unprepared to make. The public is aware for the first time of medical ethical dilemmas that exist from a shortage of resources, unequal power in decision-making, and a lack of adequate care for those who are institutionalized. Occupational therapists have continued to serve on the forefront in places like rehabilitation settings, skilled nursing facilities, schools, and inpatient units, including those with intensive care units and facilities designed for persons with behavioral health problems. The argument made in this paper is that we also have an important role to play in advocating for those with disabilities who may need services but will likely be unable to access and/or receive them given emerging crisis-response policies. We need not only to continue to serve clients individually but also to be actively involved with the disability culture and its right to equality in health care provision. Occupational therapists must actively consider roles at the individual, community, and societal levels to maintain a vital position in the U.S. health care system.

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