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Current Knowledge of Occupational Therapists in Wyoming Regarding the Affordable Care Act: A Quantitative Pilot Study

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CURRENT KNOWLEDGE OF OCCUPATIONAL THERAPISTS IN WYOMING REGARDING THE AFFORDABLE CARE ACT: A QUANTITATIVE PILOT STUDY

by

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An Independent Study

Submitted to the Occupational Therapy Department

of the

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In partial fulfillment of the requirements

for the degree of

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This Independent Study, submitted by Christopher J.M. Greenman and Lauren C. Harvey in partial fulfillment of the requirement for the Degree of Master 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.

Brian C. Lambert

Signature of Faculty Advisor

April 20, 2015

Date

PERMISSION

Title Current Knowledge of Occupational Therapists in Wyoming: A Quantitative Pilot Study

Department Occupational Therapy

Degree Master of Occupational Therapy

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Christopher J.M. Greeman
4/20/2015

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TABLE OF CONTENTS

LIST OF FIGURES

LIST OF TABLES

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ABSTRACT

There is little information and research addressing occupational therapists' knowledge level and ability to implement the Affordable Care Act (ACA). This leads to the following problem statements: occupational therapists' knowledge level of and ability to implement changes to practice is unknown; furthermore, it is unknown if there is a difference in knowledge level based on professional membership, years of practice, and area of practice; and it is also unknown which aspects or areas of the ACA occupational therapists would like to know more about, and if there is a difference based upon professional membership, years of practice or area of practice.

The researchers created a quantitative, mail-based survey to gain insight to the problem statements. The researchers obtained approval from University of North Dakota's Institutional Review Board (IRB) to administer this survey to occupational therapists licensed in Wyoming, and mailed the survey. The researchers utilized SPSS® version 22 to test correlational statistics and data. Independent samples t-tests and ANOVA were utilized to test significance and analyze possible correlations.

The survey was sent to 281 Wyoming occupational therapists, with a total of 139 (49.47%) occupational therapists returning the survey. More of the occupational therapists (63 of 139 or 45.32%) rated their general knowledge of the ACA as a two on a scale of one to five than in any other area. When asked about specific areas of the ACA

and its relationship to occupational therapy most occupational therapists (37%-46% or 52-64 of 139) rated themselves as having no knowledge or as a one out of five on each area. Additionally, most occupational therapists (approximately 49% or 67 of 139) rated their research habits at a one, indicating that they do not research current changes in legislation regarding the ACA. Furthermore, with the correlational statistics completed, relationships between variables were detected. Relationships were found with knowledge level of the ACA and occupational therapists working in orthopedics and geriatrics. Furthermore, pediatric practitioners reported a lower need for knowledge about the ACA than those in any other area ($p<.001$); however, occupational therapists practicing in SNFs (33 of 130) reported a greater need for knowledge than those in other areas ($p=.0465$).

CHAPTER I

INTRODUCTION

Rationale

The ACA has made significant changes to the healthcare environment and policy (www.healthcare.gov; www.hhs.gov). It is necessary for occupational therapists to be aware of the current healthcare environment, including political and economic changes, such as those found in the ACA (Jacobs & McCormack, 2011, Brown, 2013; Fisher & Friesema, 2013; Hildenbrand & Lamb, 2013; Morley & Rennison, 2011). The purpose of this study was to pilot a survey designed to gather general information about the knowledge of occupational therapists regarding the ACA and areas of desired knowledge, and to compare responses in those areas to determine any correlations between both areas and position on the ACA, membership in professional organizations, years of practice, and practice areas. In piloting this survey, researchers were provided the ability to test the survey, as well as gain information regarding ACA knowledge of Wyoming occupational therapists.

Theoretical Framework

Since occupational therapists need to be prepared to make alterations to their practice due to these healthcare changes, the Transtheoretical Model or the Stages of Change Model is the most appropriate. In this model there are six stages of change:

precontemplation, contemplation, preparation, action, maintenance, and termination (Bastable, 2011). People in the precontemplation stage do not have an intention to change, they are often uninformed or under-informed of the consequences of not changing (Bastable, 2011; Prochaska, 2008). People in this stage would be expected to not be prepared to change and to avoid steps needed to be taken to implement these new changes due to fear, lack of knowledge, or lack of motivation (Bastable, 2011; Prochaska, 2008). Occupational therapists in this stage of implementation of the ACA may be fearful of the changes it may make in their practice, unaware of the changes associated with the ACA and its implementation date, or think it will be repealed or reformed.

As a person transitions to the contemplation stage he or she accepts the need to address the change (Bastable, 2011; Prochaska, 2008). However, when people in this stage are unsure of the changes or the results the changes may have, they tend to not act (Prochaska, 2008). Occupational therapists in this stage will be most likely to understand that there is a change and desire to implement these changes, but have not yet begun to formulate a plan or prepare to change. These therapists may be unsure of the changes the ACA could make to their practice area or may be unsure if there will be changes to the ACA. As people in this stage transition to the next, they often experience an increase in desire or a press for change.

People in the preparation stage have experienced an increase in desire or press for change, and are beginning to make plans for when the change occurs or for how to change (Bastable, 2011; Prochaska, 2008). Occupational therapists in this stage would be most likely to begin considering their current knowledge level and abilities to assist

clients under the changes. Action oriented plans or groups tend to work best for people in this stage (Prochaska, 2008), so occupational therapists in this stage may benefit the most by joining discussion groups or journal clubs to share information learned with other therapists. This will allow them to have a firm support base for the next stage.

The next stage is the action stage; people in this stage change their behaviors in relation to the new environment (Bastable, 2011; Prochaska, 2008). An occupational therapist in this stage may write policy changes, create educational pamphlets for clients, or modify their current practice. He or she may experience excitement in the new skills and knowledge or in his or her ability to share information with others. He or she recognizes the importance of the change and becomes aware of the need to maintain the changes implemented.

The next stage is maintenance; those in this stage often either consider how the action plan is being implemented or may demonstrate overconfidence (Bastable, 2011; Prochaska, 2008). Occupational therapists in this stage would analyze any changes made and modify them as needed, but may make mistakes as they do so. Occupational therapists in this stage would generally recognize their mistakes and modify their program as needed. As they transition to the next stage, the occupational therapist recognizes the need to terminate the change or to make aspects of maintenance permanent.

The final stage of change is termination. People experiencing this stage are familiar with the previous changes, but may be less vigilant with maintenance (Bastable, 2011). People in this stage are like to have made permanent changes to their behavior

(Prochaska, 2008). Occupational therapists in this stage would most likely continually research the ACA, but may not feel the need to make more changes to their practice.

The ACA is a new piece of legislation that implements changes to the healthcare environment. Occupational therapists will go through the stages of change when implementing the changes associated with the ACA. Typically people in positions of power, with more experience in a field, have a supportive environment, or have a strong sense of academic transition through the stages of change faster, with fewer experiences of fear and doubt (Clark, 2013; Prochaska, 2007). Additionally, people who are able to discuss change implementation and conceptualize specific changes with people from other disciplines may experience a broader understanding and more success (Clark, 2013).

Statement of the Problem

Occupational therapists' knowledge level of and ability to implement changes to practice is unknown; furthermore, it is unknown if there is a difference in knowledge level based on professional membership, years of practice, and area of practice. It is also unknown which aspects or areas of the ACA occupational therapists would like to know more about, and if there is a difference based upon professional membership, years of practice or area of practice.

Assumption

Occupational therapists want to provide the best care possible for their patients. They want to comply with all legal and ethical expectations placed upon them. As a result, occupational therapists will have an opinion on and be knowledgeable of the ACA

and the various effects the implementation of the ACA has on patients and practice, or a strong desire to learn more.

Scope and Delimitation

The survey investigated the occupational therapists' perceived levels of knowledge regarding the ACA, habits related to ACA changes, areas of interest for possible continuing education, national and state organization affiliation, area of practice, and the amount of time a therapist has been practicing. The study occurred from January 2014 to December 2014. The surveys were mailed to and completed by occupational therapists who are licensed in the state of Wyoming. All data analysis took place in Casper, Wyoming.

Importance of the Study

The study investigates occupational therapists' perception of their knowledge regarding the ACA. There is no research regarding occupational therapists knowledge level of the ACA or areas in which they would like to know more. This study establishes a pilot for a tool designed to gather data regarding occupational therapists' knowledge level, stances on the ACA, areas in which occupational therapists want to become more knowledgeable, and years and areas of practice.

CHAPTER II

Literature Review

The ACA was signed into law on March 23, 2010, thus beginning the current healthcare reform, and placing comprehensive health insurance reforms into effect nationwide. With this new law going into effect, there have been dramatic changes to healthcare in the United States. There are more protections for healthcare consumers, as insurance companies are required to provide coverage for certain types of care including pre-existing health conditions, preventative care, and other services which were previously not requirements for coverage (www.healthcare.gov; www.hhs.gov). Citizens are required to at least carry catastrophic coverage or Medicare, but continue to have the option of private insurance plans, employer-paid insurance, or more comprehensive plans (www.healthcare.gov; www.hhs.gov). Although the reforms of the ACA have taken effect, the general public and medical professionals are not knowledgeable regarding the law and are unable to identify the effects the law has on them as individuals and professionals (Gross et al., n.d.; Zamosky, 2013; Brodie, Dean, & Cho, 2013; Keckley, Coughlin, & Stanley, 2013). There is little research regarding occupational therapists' knowledge of the ACA or the implications it may have on various practice settings. It is imperative that occupational therapists are not only informed regarding the law, but are

also able to take advantage of current changes for the betterment of the profession and their client base (Brown, 2013; Fisher & Friesema, 2013; Hildenbrand & Lamb, 2013; Morley & Rennison, 2011).

Despite the healthcare reform becoming law, the opinions and levels of knowledge still greatly vary. There have been studies published regarding the efficacy of specific types of healthcare. However, the results may not be meaningful as they often do not consider either a single or multiple aspects related to healthcare including: ethics, politics, finances, or technicalities, so these areas may be left out of existing research (Rockers et al. 2013). Many citizens are uninformed regarding the law, but most have opinions in regard to the law (Gross et al., n.d.; Zamosky, 2013). In 2012, over two-thirds of the general public had opinions in regard to the law: approximately one-third were in favor and over two-thirds opposed (Gross et al., n.d.; Brodie, Dean, & Cho, 2013). This trend is extended to the healthcare field: 32% of physicians oppose the law (Zamosky, 2013). Despite the fact that approximately two-thirds of the population has an opinion regarding the ACA, most of the population is not knowledgeable with regard to the law (Gross et al., n.d.; Zamosky, 2013; Brodie, Dean, & Cho, 2013). Nine out of ten medical doctors believe the public is uneducated regarding the ACA and how healthcare plans will function (Zamosky, 2013; Keckley, Coughlin, & Stanley, 2013). Furthermore, approximately 20% of the general public are unaware that the ACA is law (Henry J. Kaiser Foundation, 2013). Survey data regarding knowledge of the ACA showed that fewer than half of the respondents answered with the equivalent of a C (70%) or more of the questions correctly (Gross et al., n.d.). Additionally, most of these

respondents were not certain of their answer; only 3% of the respondents who answered most questions correctly were certain of their answers. Furthermore, over 20% of respondents who were certain of their answers did not answer any questions correctly (Gross et al., n.d.). This indicates that the people who claim to know the most about the ACA may actually know the least. Within the medical field, 57% of physicians are not familiar enough with the law to be able to say if and how it could affect their practice (Zamosky, 2013). Overall, people with greater knowledge of the law are more likely to favor it (Gross et al.).

Although the ACA has now been considered law since March 23, 2010, findings by Barcellos et al. (2014) indicate that prior to the implementation of the ACA, the general population had a low knowledge pertaining to the ACA. The survey included objective knowledge of the current health care reform, overall health insurance literacy, participant's subjective knowledge of the ACA, and the expected changes in healthcare as a result of the implementation of the ACA. Research and data is lacking related to the knowledge level of occupational therapists and the new healthcare law. The research within the general population regarding opinions and knowledge of the ACA indicates an overall lack of knowledge, but participants did report having favorable or unfavorable opinions regarding the ACA. This disinterest in health law, but decided favor or disfavor among individuals with regard to the changes, may stem from a variety of reasons. One of these reasons may be related to the Balance Budget Act (BBA) of 1996. Research indicates that many people experienced changes to their healthcare plans and ability to obtain services after implementation of the BBA (Caro, Porell, Sullivan, Safran-Norton,

& Miltiades, 2002; Younis, & Cissell, 2006). The experiences of the general public and healthcare professionals during BBA changes may invoke negative reactions regarding current healthcare reform. Current research indicates that over half of the general population would like to see improvements to the ACA, and approximately one-third would like to see the ACA repealed or replaced (Brodie, Hamel, Di Julio, & Firth, 2014). Trends and survey data regarding knowledge levels and attitude toward the ACA exist; however, research regarding occupational therapy practitioners' knowledge or opinion regarding the ACA is nonexistent.

The ACA is a new piece of legislation that implements changes to the healthcare environment. As this law is implemented, medical professionals will go through the stages of change when implementing the changes associated with the ACA. Typically people in positions of power, with more experience in a field, who have a supportive environment, or have a strong sense of academic trust transition through the stages of change faster, with fewer experiences of fear and doubt (Clark, 2013; Prochaska, 2007). Additionally, people who are able to discuss change implementation and conceptualize specific changes with people from other disciplines may experience a broader understanding and more success in transitioning (Clark, 2013). Therefore, occupational therapists who have these factors may be more comfortable as they transition to a new healthcare policy.

Access to research, supportive environment, and a strong sense of academic trust may increase when associated with a professional organization. For example, one of the benefits of becoming a member to a professional organization, such as the American

Occupational Therapy Association (AOTA) is access to continuing education, professional resources, and advocacy (AOTA, n.d.; Steinhauer, Schweiker, Henry, Zarinkelki, & Tona, 2008). Although these benefits could prove to be valuable in knowledge of and access to resources on the ACA, quantitative or qualitative research regarding members' and nonmembers' knowledge and access to the ACA is nonexistent.

The ACA's expansion of who qualifies for healthcare benefits means a higher percentage of the population will now require or be eligible for services that previously were not (Metzler, Tomlinson, Nanof, & Hitchon, 2012; Chang, T. & Davis, M. (2013). For example, Stoffel (2013) reported community mental health centers, community health centers, and behavioral health centers may be expanding health services available as a result of the ACA's design of benefits packages. Although a low percentage of occupational therapists work in these three settings, opportunities are available for occupational therapists to make a positive impact on the needs of these clients by increasing job opportunities in these settings. In 2010, AOTA conducted a workforce study that shed some light on where occupational therapists are currently working. Most occupational therapy practitioners work one of three settings: hospitals (26.2%), schools (21.6%), and long-term care/skilled nursing facilities (19.9%). Approximately one-third of occupational therapy practitioners also reported working in a setting in conjunction with their primary setting. The majority of these occupational therapists (30.6%) work at long-term care or skilled nursing facilities for secondary work (American Occupational Therapy Association, 2013).

Not only does the ACA increase access to healthcare, but there is also strong evidence to support the fact that the ACA will also reduce costs of healthcare expenses. Chang & Davis (2013) predict that the increase in young, healthy Medicaid beneficiaries due to income levels will help drive the cost of care within the Medicaid pool down. It was also predicted that, although the overall cost of coverage for these individuals will decrease, there will be an influx of risk factors that lead to preventable conditions within this pool (Chang & Davis, 2013). Fortunately, the ACA increases access to preventative care. This is further projected by those professionals in charge of healthcare reform and implementation to lower the costs of services. As previously mentioned, these outcomes are largely attributed to an increased emphasis on preventative measures (www.hhs.gov, n.d.). To further support a reduction in healthcare costs the tenets of the ACA support coordinated care efforts between healthcare disciplines. Cason (2012) reported that two of the models supported by the ACA encourage pathways of coordinated care, improving the quality of health care services, and ultimately reducing costs through encouraging these positive changes in the healthcare field.

One of the main premises behind the ACA is to increase access to health care. Metzler, Hartmann, and Lowenthal (2012) describe how the Obama Administration feels it is imperative to strengthen and expand the primary care workforce. One way of accomplishing this is to increase accessibility to primary care physicians and nurses. The reasoning behind this notion is that these healthcare professionals help to prevent disease

and illness for Americans across the country (www.hhs.gov; Cason, 2012). Occupational therapy is well equipped and in a prime position to provide preventative care.

Not only is the ACA projected to reduce costs of healthcare, but the ACA is also projected to expand benefits once unavailable to insured persons. One in four citizens has, at one point or another, had health coverage denied or premiums increased as a result of a preexisting condition (Zamosky, 2013). Coverage availability is being enhanced through increased access to Medicaid as well as subsidized, private insurance (Abraham, 2014; Chang & Davis, 2013). The latter is, in large part, due to the exchanges of health insurance plans following the ACA becoming law and access to insurance through healthcare.gov (Abraham, 2014). Changes initiated when the ACA was signed into law should help to significantly decrease these numbers while concurrently improving the quality of consumers' health care services (Cason, 2012). Although there is an expected increase in overall health coverage, rural residents or states that have not expanded Medicaid coverage are likely to see an increased coverage gap (Newkirk & Damico, 2014; Kaiser Commission on Medicaid and the Uninsured, 2013). Wyoming falls under both these categories. Therefore, this may be one may reason that many people in Wyoming may not see the benefits of the ACA.

The changes made by the ACA could be beneficial to occupational therapy and its practitioners. The healthcare reform gives professionals within the occupational therapy profession the opportunity to advocate through: evidence-based treatment; measurable, functional outcomes, and cost reduction (Rifkin, 2013). Hildenbrand and Lamb (2013)

discuss the excellent opportunity the field of occupational therapy has in this age of change within healthcare.

The ACA requires that specific services be covered, but does not define what those services entail. This means there are many opportunities for occupational therapy practitioners and occupational therapy organizations to advocate for the betterment of the profession (Brown, 2013; Rifkin, 2013). For example the ACA requires coverage of habilitative and rehabilitative services, but state organizations and ad hoc reform committees make recommendations and decisions about what is covered, thus leading to variance between states (Brown, 2013). When state organizations team up with practitioners and AOTA, information designed to empower and encourage participation and advocacy of occupational therapy's inclusion in habilitative services is enhanced (Brown, 2013; Rifkin, 2013). For example, in Arkansas, habilitative services must include maintenance of function and be covered as extensively as rehabilitative services (Brown, 2013). Unfortunately, when local, state, and national organizations do not collaborate, the implementation of the law can be too ambiguous or only include specific populations (Brown, 2013).

The ACA can also benefit from the involvement of occupational therapy practitioners and occupational therapy organizations. Through collaboration with AOTA, the ACA now includes more benefits for consumers: access to more services; care provided by qualified, licensed professionals; claims reviewed by peers; and improved appeals process (Rifkin, 2013; Zamosky, 2013; Cason, 2012; Fisher & Friesma, 2013). With occupational therapy's comprehensive approach, including occupational

therapists in this coordinated team process is very fitting (Cason, 2012). In client-centered comprehensive treatment, the functional outcomes and client satisfaction are often higher (Fisher & Friesma, 2013). With occupational therapy's core values being centered on the client, inclusion of occupational therapists as members and case managers within treatment teams will enhance outcomes for clients (Cason, 2012; Kanny, 1993). Additionally, interdisciplinary care or primary care with supplemental health-related services are two of the most effective forms of healthcare when working with specific populations such as the elderly (Boult et al., 2009). Since occupational therapy is part of these care approaches, evidence suggest that the involvement of occupational therapy will assist in the goals of the ACA in providing successful healthcare. Occupational therapy practitioners have a large knowledge base and receive much training in the interactions of the person and his or her abilities in relation to the environment and task, activity, or occupation at hand, making them the perfect solution to decrease risks both during treatment and after discharge (Fisher & Friesema, 2013). Additionally, occupational therapy can utilize evidence to design best-care practices for specific facilities and facility types; thus, resulting in more streamlined care with an increase in positive outcomes (Fisher & Friesma, 2013). The holistic approach occupational therapy practitioners have toward their patients should be especially welcome in this time of healthcare reform. The field of occupational therapy has historically focused on areas including wellness, health promotion, and illness and injury prevention. With these same areas being spotlighted in healthcare reform, occupational therapy practitioners can definitely help with the current needs in healthcare (AOTA,

n.d.). Furthermore, occupational therapy's keen and unique ability to analyze performance skills, contexts, environments, and more merits further research pertaining to the how the changes that have accompanied the ACA will impact occupational therapy practitioners.

Ultimately, there are a myriad of changes that have accompanied implementation and enforcement of the ACA, and many more are bound to follow. Increased access to health care services is crucial for virtually every citizen as nearly everyone uses healthcare services at some point in their life. Reducing the cost of healthcare services would be a universally welcomed change and a change expected to come to fruition. The expansion of benefits afforded to the population as a whole would similarly be appreciated. As the field of occupational therapy becomes more knowledgeable and aware of the impending changes in health care, occupational therapy practitioners will be better able to see positive outcomes for their clients as well as the profession as a whole (Braveman & Metzler, 2012; Brown, 2013; Rifkin, 2013; Fisher & Friesema, 2013; Hildenbrand & Lamb, 2013).

CHAPTER III

Research Methodology

Research Design, Locale, Data Sources, and Population

This study was conducted through an anonymous, quantitative mail-based survey. The study was based out of the University of North Dakota at the additional location in Casper, Wyoming. This locale was chosen based on convenience as it was a central location for all of the researchers, and is the location where surveys and data will be stored. The survey was mail-based, so respondents were able to complete the survey when they found it to be convenient.

The population of the study included occupational therapists who have a Wyoming license/registration. The researchers used a state generated list of registered occupational therapists in Wyoming. The researchers then excluded any occupational therapist whose license expired before July 30, 2014. When the exclusion criteria was applied, there were a total of 328 occupational therapists identified as potential participants. The researchers were unable to find valid addresses for 47 of these occupational therapists, leaving a potential of 281 of the occupational therapists to be surveyed. Of the occupational therapists who were mailed the survey, 139 (49.47%) responded.

Instrumentation and Data Collection

SPSS® version 22, was used to measure whether there were any correlations between knowledge level of experienced and less experienced occupational therapists with regard to the ACA, knowledge level of occupational therapists who practice in different settings with regard to the ACA, opinion of the ACA and practice settings, and a myriad of other plausible correlations. The survey was mailed to all registered occupational therapists with valid mailing addresses. Participation in the survey was stated to be completely voluntary. Reliability was encouraged through anonymous participation in the survey research rather than linking answers to each participant. Validity was promoted by quantifying answers and using statistics software to run correlational analyses. Conclusive statements were only used where strong statistical correlations existed.

Tools for Data Collection

To collect data regarding occupational therapists' knowledge level of and ability to implement ACA changes to practice, a spreadsheet and graphing programs, as well as SPSS® were utilized. To calculate all descriptive statistics, Microsoft Excel® and LibreOffice® were utilized. These programs were both utilized to total the number of responses for each question and area, find percentages of each, and create graphs and charts showing descriptive statistics. Three different statistical measures were chosen to analyze the data collected within the surveys. These measures included Chi square tests, independent samples t-tests, and ANOVA tests. Chi square tests were utilized to analyze significant levels when comparing categorical variables with binary variables. T-tests

were utilized when examining binary variables with continuous variables. ANOVA tests were utilized when testing categorical variables with continuous variables. Categorical variables included position on the ACA and years of practice of the participant. Binary variables included the area of practice of the participant, membership in either AOTA or WYOTA, and the individual questions making up the composite "desire to know more" variable. Continuous variables included composite knowledge score, composite score of desire to know more about the ACA, and the individual questions that made up the composite knowledge score.

CHAPTER IV

PRESENTATION, ANALYSIS & INTERPRETATION OF DATA

After data collection was completed, raw data was compiled and organized. In an attempt to obtain more significant results, the researchers developed a series of questions to gain greater insight as to the knowledge level of occupational therapists with respect to different aspects of the ACA.

Overall, occupational therapists' knowledge level of and ability to implement changes to practice is unknown with regard to the ACA. The first seven questions in the survey (see Survey in Appendix A and B) measured occupational therapists' self-reported knowledge of the ACA in various areas. These seven areas included self-report of: knowledge of the ACA, understanding of how the ACA affects clients, ability to explain the ACA to clients, ability to help clients find resources regarding the ACA, knowledge of how the ACA affects their practice, how much reported research the therapist engages in with regard to the effects the ACA has on their practice and on their clients (Figure 1). When considered together, the scores can be added to gain a composite knowledge score. The composite knowledge scores ranged from a low reported knowledge score of two with a high reported knowledge score of 35, and two respondents declined to answer all knowledge questions (table 1).

Figure 1: Knowledge by Area

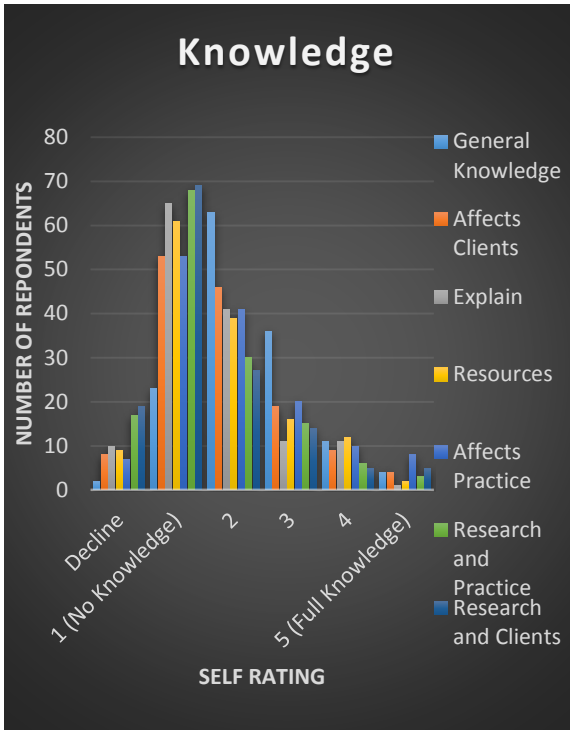


Table 1: Composite Knowledge

Composite Knowledge Score					
		Freq-uency	Perc-ent	Valid Percent	Cumulative Percent
Valid	2	1	0.7	0.7	0.7
	3	1	0.7	0.7	1.5
	5	1	0.7	0.7	2.2
	6	2	1.4	1.5	3.6
	7	21	15.1	15.3	19
	8	13	9.4	9.5	28.5
	9	12	8.6	8.8	37.2
	10	13	9.4	9.5	46.7
	11	6	4.3	4.4	51.1
	12	11	7.9	8	59.1
	13	5	3.6	3.6	62.8
	14	7	5	5.1	67.9
	15	6	4.3	4.4	72.3
	16	8	5.8	5.8	78.1
	17	5	3.6	3.6	81.8
	18	4	2.9	2.9	84.7
	19	5	3.6	3.6	88.3
	20	3	2.2	2.2	90.5
	21	1	0.7	0.7	91.2
	22	1	0.7	0.7	92
	23	1	0.7	0.7	92.7
	24	2	1.4	1.5	94.2
	25	1	0.7	0.7	94.9
	28	3	2.2	2.2	97.1
	29	1	0.7	0.7	97.8
	30	1	0.7	0.7	98.5
	31	1	0.7	0.7	99.3
	35	1	0.7	0.7	100
	Total	137	98.6	100	
Missing	System	2	1.4		
Total		139	100		

Similarly, occupational therapists' desire for additional knowledge with regard to the ACA is unknown. Questions nine through 14 within the survey measured occupational therapists' self-reported desire to learn more about the ACA. These six areas included occupational therapists' desire to know more about: helping clients access benefits from the ACA, resources regarding the ACA, how the field of occupational therapy will be affected by the ACA, what can be done to ensure their practice continues to prosper under the ACA, what opportunities the field of occupational therapy might have under the ACA, and how each respondent can advocate for occupational therapy under the ACA (figure 2). The scores for each of these categories can be added together to form a composite need for knowledge score, which ranged from a low reported desire for additional knowledge score of one with a high reported desire for additional knowledge score of six, and nine therapists declining to answer (table 2).

Figure 2: Desired Learning by Area

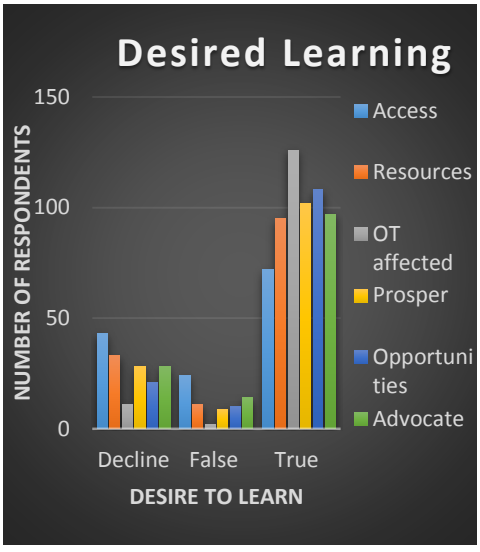


Table 2: Composite Need

Desire to Know More Composite Score (Composite Need)					
		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1	7	5	5.4	5.4
	2	14	10.1	10.8	16.2
	3	12	8.6	9.2	25.4
	4	19	13.7	14.6	40
	5	15	10.8	11.5	51.5
	6	63	45.3	48.5	100
	Total	130	93.5	100	
Missing	System	9	6.5		
Total		139	100		

It is also unknown whether factors including participation in professional membership organizations like AOTA and WYOTA, how many years practiced, and area of practice influence level of knowledge with regard to the ACA. Questions 15, 16, 17, and 18 within the survey measured these factors. Areas of practiced included: orthopedics, pediatrics, home health, mental or behavioral health, geriatrics, SNF, community education, developmental disabilities, professor, other, and choose not to answer (table 3). Practitioners were also asked to indicate their years of experience by circling one of five options: 0 to 5 years, 6 to 10 years, 11 to 15 years, 16 to 20 years, or greater than 20 years of experience (table 4). Membership in AOTA or WYOTA was measured in a yes, no, or decline response (tables 5 and 6 respectively).

Table 3: Area of Practice

Area of Practice		
Area	Frequency	Valid Percent
Orthopedic	44	31.7
Pediatrics	64	46
Home Health	22	15.8
Mental or Behavioral Health	5	3.6
Geriatrics	29	20.9
SNF	34	24.5
Community Education	8	5.8
Developmental Disabilities	21	15.1
Professor	9	6.5
Other	16	11.5
No Answer	4	2.9
Total	256	184.3

Note: Many respondents indicated multiple practice areas, causing the total frequency to be greater than the number of respondents and the total percent to be greater than 100.

Table 4: Years Practiced

Years Practiced					
	Number of Years Practiced	Frequency	Percent	Valid Percent	Cumulative Percent
Valid	0-5	22	15.8	16.2	16.2
	6-10	20	14.4	14.7	30.9
	11-15	29	20.9	21.3	52.2
	16-20	25	18	18.4	70.6
	20 +	40	28.8	29.4	100
	Total	136	97.8	100	
Missing	System	3	2.2		
Total		139	100		

Table 5: AOTA Membership

Are You An AOTA Member					
		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	No	68	48.9	51.9	51.9
	Yes	63	45.3	48.1	100
	Total	131	94.2	100	
Missing	System	8	5.8		
Total		139	100		

Table 6: WYOTA Membership

Are You A WYOTA Member					
		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	No	58	41.7	44.3	44.3
	Yes	73	52.5	55.7	100
	Total	131	94.2	100	
Missing	System	8	5.8		
Total		139	100		

More participants (63 of 139 or 45.32%) rated their general knowledge of the ACA as a two on a scale of one to five than in any other area. When asked about specific areas of the ACA and its relationship to occupational therapy, most participants (37%-46% 51- 64 of 139) based on practice area) rated themselves as having no knowledge, or as a one out of five on each area. This is consistent with ACA knowledge amongst the

general population and medical professionals (Gross et al., n.d.; Zamosky, 2013; Brodie, Dean, & Cho, 2013; Keckley, Coughlin, & Stanley, 2013). This general lack of knowledge would increase difficulty in implementation of any changes. There was not a significant difference in knowledge levels based on years or area of practice for most areas; however, occupational therapists in orthopedics (44 of 137) [tables 7 and 8] and geriatrics (29 of 137) [tables 9 and 10] did report more knowledge about the ACA than therapists practicing in other area (p=.0295 and p=.03 respectively).

Table 7: Orthopedic Composite Knowledge

Orthopedic Composite Knowledge				
Area of Practice	N	Mean	Std. Deviation	Std. Error Mean
Not Orthopedic	93	12.1	6.168	0.064
Orthopedic	44	14.2	5.781	0.872

Table 8: Orthopedic Independent Samples Test for Composite Knowledge

Orthopedic Independent Samples Test for Composite Knowledge									
	Levene's Test for Equality of Variances		t-Test for Equality of Means						
	F	Sig	T	Df	Sig (2-tailed)	Mean Difference	Std. Error Difference	95% Confidence Interval of the Difference	
								Lower	Upper
Equal Variances Assumed	0.033	0.857	-1.905	135	0.059	-2.108	1.107	-4.296	0.081
Equal Variances Not Assumed			-1.95	89.636	0.054	-2.108	1.081	-4.256	0.04

Table 9: Geriatric Composite Knowledge

Geriatrics Composite Knowledge				
Area of Practice	N	Mean	Std. Deviation	Std. Error Mean
Not Geriatrics	108	12.28	6.074	0.584
Geriatrics	29	14.62	5.967	1.108

Table 10: Geriatric Independent Samples Test for Composite Knowledge

Geriatrics Independent Samples Test for Composite Knowledge									
	Levene's Test for Equality of Variances		t-Test for Equality of Means						
	F	Sig	t	Df	Sig (2-tailed)	Mean Difference	Std. Error Difference	95% Confidence Interval of the Difference	
								Lower	Upper
Equal Variances Assumed	0.074	0.786	-1.851	135	0.066	-2.343	1.266	-4.846	0.16
Equal Variances Not Assumed			-1.87	44.843	0.068	-2.343	1.253	-4.866	0.18

There is also an overall desire to know more about the ACA and its implications on occupational therapy (51.8%-90.6% or 72-126 of 139 based on practice area). There is little difference among areas of practice in their desire to learn more about the ACA. Occupational therapists who practice in pediatrics (63 of 130) reported the need for knowledge about the ACA to be less than those in any other area ($p<.001$) [tables 11 and 12]. Conversely, occupational therapists practicing in SNFs (33 of 130) reported a greater need for knowledge than those in other areas ($p=.0465$) [tables 13 and 14]. There is not a significant difference in desired knowledge among therapists with different numbers of years of experience.

Table 11: Pediatric Composite Need

Pediatric Composite Need				
Area of Practice	N	Mean	Std. Deviation	Std. Error Mean
Not Pediatric	67	5.07	1.352	0.165
Pediatric	63	4.13	1.791	0.226

Table 12: Pediatric Independent Samples Test for Composite Need

Pediatric Independent Samples Test for Composite Need									
	Levene's Test for Equality of Variances		t-Test for Equality of Means						
	F	Sig	t	Df	Sig (2-tailed)	Mean Difference	Std. Error Difference	95% Confidence Interval of the Difference	
								Lower	Upper
Equal Variances Assumed	8.537	0.004	3.417	128	0.001	0.948	0.277	0.399	1.496
Equal Variances Not Assumed			3.388	115.158	0.001	0.948	0.28	0.394	1.502

Table 13: SNF Composite Need

SNF Composite Need				
Area of Practice	N	Mean	Std. Deviation	Std. Error Mean
Not SNF	97	4.47	1.721	0.175
SNF	33	5.03	1.334	0.232

Table 14: SNF Independent Samples Test for Composite Need

SNF Independent Samples Test for Composite Knowledge									
	Levene's Test for Equality of Variances		t-Test for Equality of Means						
	F	Sig	t	Df	Sig (2-tailed)	Mean Difference	Std. Error Difference	95% Confidence Interval of the Difference	
								Lower	Upper
Equal Variances Assumed	5.84	0.017	-1.69	128	0.093	-0.556	0.329	-1.207	0.095
Equal Variances Not Assumed			-1.913	70.883	0.06	-0.556	0.291	-1.136	0.023

There is not a statistically significant difference between knowledge, desired learning, and position on the ACA among AOTA members, WYOTA members, and nonmembers. Despite this, respondents who were not members of WYOTA were more likely to think that the ACA needed to be reformed than WYOTA members (37.04% of 20 of 54 of nonmembers and 27.54% 19 of 69 of members). Respondents who stated they were members of WYOTA were more likely to either oppose (27.54% or 19 of 69) or be in favor (23.19%16 of 69) of the ACA than respondents who were not members (24.07% or 13 of 54 oppose and 20.37% or 11 of 54 in favor). This trend is consistent with respondents who were AOTA members and those who were not. Members of AOTA were more likely to either oppose or favor (30.51% or 18 of 59 and 22.03% 13 of 59 respectively) than nonmembers (21.88% or 14 of 64 and 21.88% or 14 of 64 respectively). Respondents not associated with AOTA (34.38% or 22 of 64) were more likely to think that the ACA needs to be reformed than AOTA members (28.81% 17 of 59).

Another noticeable trend occurred between position on the ACA and both composite knowledge and composite need for knowledge scores. When asked what their position on the ACA was, respondents who declined to answer had a lower composite knowledge (12.0) score of the ACA than those who favored, opposed, or would like to reform the ACA (13.13-13.15) [figure 2.1]. Additionally, respondents who opposed the ACA had a lower composite desire for learning (4.14), and those who favor the ACA had a higher composite desire for learning (5.13) [figure 2.2]. Respondents who did not state

their position on the ACA had a composite score of 4.79 for desired learning, and those who were in favor of reforming the ACA scored a 4.59 in composite desired learning.

Figure 2.1

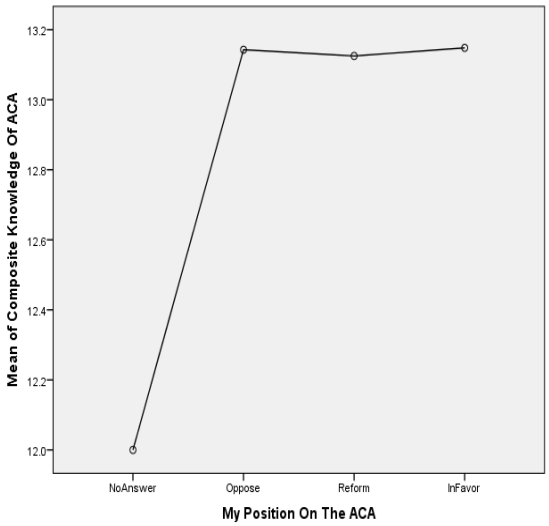
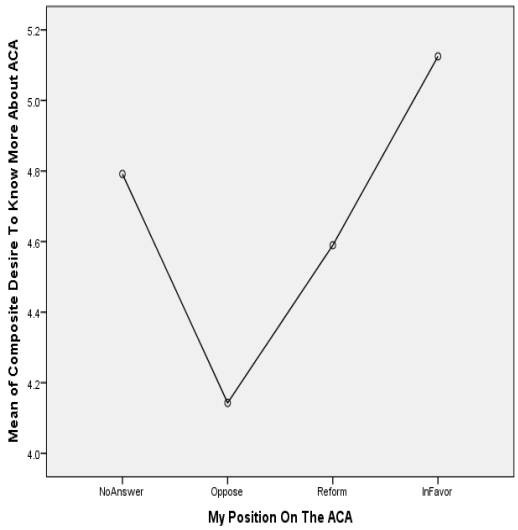


Figure 2.2



CHAPTER V

SUMMARY, CONCLUSIONS & RECOMMENDATIONS

Summary of Findings and Conclusions

Occupational therapists' knowledge level of and ability to implement changes to practice were previously unknown. Overall, there was a strong trend indicating Wyoming occupational therapists rate their knowledge of the ACA as low. This is shown by most occupational therapists, rating their knowledge level at a level two in general knowledge (45.32% or 63 of 139) of the ACA and as a level one in each sub area (38.13%-46.76% or 53-65 of 139). Additionally, most occupational therapists (48.92% or 68 of 139) selected one on a scale of one to five indicating they do not research the ACA; however, most respondents indicated (51.80% -90.65% or 72-126 of 139) that they would like more knowledge in all areas surveyed regarding ACA. Furthermore, Wyoming has not expanded Medicare coverages, meaning that there are more insurance gaps in the general population. This could make it more difficult to find information regarding implementation of the ACA in Wyoming.

It was unknown if there is a difference in knowledge level based on professional membership, years of practice, and area of practice. Occupational therapists in orthopedics and geriatrics did report more knowledge about the ACA than therapists

practicing in other areas (p=.0295 and p=.03 respectively). This could be due to the billing practices in these areas. Services in orthopedics and geriatrics were more likely to be covered by private insurance, Medicaid, and Medicare prior to the ACA than services in other areas. This could mean that occupational therapists in these areas are more likely to see changes in the way they bill or changes in what individuals pay for out of pocket.

It was also unknown which aspects or areas of the ACA occupational therapists would like to know more about, and if there is a difference based upon professional membership, years of practice or area of practice. Occupational therapists who practice in pediatrics reported the need for knowledge about the ACA to be less than those in any other area ($p<.001$). This could be due to where pediatric occupational therapists practice. Many respondents in this area selected pediatrics as an area of practice, but wrote in that they were in a school-based setting. Those practicing in a school-based setting may see their area of practice as being covered under educational laws such as No Child Left Behind (NCLB) and the Individuals with Disabilities Education Act (IDEA). These initiatives may promote a belief that the ACA won't impact their practice or clients directly through their services. Conversely, occupational therapists practicing in SNFs reported a greater need for knowledge than those in other areas (p=.0465). This may be due to the manner in which SNFs are reimbursed. Many residents in SNFs are covered by Medicaid and Medicare. This means that the regulations on occupational therapy services in this area may have seen changes more immediately than in other areas of practice.

Although there is no statistically significant difference between respondents who were members of a professional organization and those who were not in opinion on the ACA, there was a noticeable trend. Members of both AOTA and WYOTA were more likely to either favor or oppose the ACA than nonmembers, who were more likely to think it needs to be reformed. This could be due to the involvement and personalities of people involved in professional organizations. People involved in professional organizations may be more likely to be active in the development of legislation. This could mean that they are more likely to have a strong opinion regarding implementation of laws or bills.

When comparing respondents' position on the ACA with both composite knowledge and composite need for knowledge scores a noticeable, but not significant trend emerged. Respondents who declined to answer had a lower composite knowledge (12.0) score of the ACA than those who favored, opposed, or would like to reform the ACA (13.13-13.15). This phenomena could occur if the respondents who declined to give their position on the ACA did so due to an awareness of their lack of knowledge. Additionally, respondents who opposed the ACA had a lower composite desire for learning (4.14), and those who favor the ACA had a higher composite desire for learning (5.13). This result could be due to a lack of interest or a desire to repeal the ACA in those who opposed. This trend could further be explained by an interest in and a perception of demand for knowledge in those who favor the ACA. Respondents who did not state their position on the ACA had a composite score of 4.79 for desired learning, which falls after those who favor the ACA and those who are in favor of reforming the

ACA. This could be due to an awareness of their lack of knowledge and desire to learn. Respondents who were in favor of reforming the ACA scored a 4.59 in composite desired learning, this could indicate that some of these respondents are transitioning to the contemplation stage.

Finally, this study served as a way to pilot a survey tool created by the researchers. This study yielded results that are consistent with similar studies of medical professionals and the general public. This shows that the survey tool is capable of producing valid results when used to gather information in this area. Additionally, significant findings can be realized with regard to occupational therapists' knowledge level with current legislative efforts on a statewide basis.

Recommendations

Recommendations for Survey Changes

One of the purposes of the study was to pilot this survey; based on the results, the researchers have recommendations for changes to the survey. First, rather than having a decline to answer section for each of the questions, it is recommended that decline to answer is assumed if the respondent does not answer the question; leaving a question blank is declining to answer. Additionally, it would be helpful to respondents to have a Likert scale to rate knowledge levels and research habits rather than a numerical scale. In having the numeric scale, perceptions of what each number represents may vary from respondent to respondent. On the true/false questions, asking therapists to select the areas they would like more knowledge, many of the therapists marked true, but left others blank rather than marking decline or false.

To receive more accurate data, the researchers recommend changing the directions to ask respondents to only mark the areas they would like to receive more information on. When asked about position on the ACA, a few respondents selected multiple responses. Rather than have the three options for this question, a five point Likert scale is recommended. This scale will include: I am in favor of the ACA, I am in favor of the ACA but it needs to be reformed, I neither favor nor oppose the ACA, I oppose the ACA but it could be better if reformed, and I oppose the ACA. The changes to the survey would not change the type of information gathered from it, but would assist in the ease of understanding. Finally, adding a school-based option when declaring area of practice could be beneficial. This would allow researchers to see if the reported less need for knowledge is concentrated to school-based occupational therapists or across all areas of pediatrics.

Recommendations for Future Research

Based upon the survey results and the overall lack of knowledge in this area of practice, there needs to be additional research. First, this research only targeted occupational therapists who have a license in the state of Wyoming. Different states may have different trends; therefore, similar research for each state is recommended. Furthermore, Wyoming is a state that has not expanded Medicare coverage. There could be differences between states that have and have not expanded Medicare coverage. It is recommended that results from these states be compared. Another area of future research could be why therapists working in geriatrics and orthopedics rated their knowledge as higher than those in other practice

areas. Additional research is also needed to discover why pediatric practitioners rated their need for knowledge as lower and practitioners in the SNF setting rated their need for knowledge as higher than those in other areas of practice. In both examining the significant results in knowledge and need for knowledge, the researchers have hypothesized some possibilities as to why this occurred, but do not have concrete evidence. Additionally, there was a trend between professional membership and position on the ACA. Although this was not a significant, further research could be used to find the reasoning behind this trend. This could be beneficial for further research.

APPENDICES

Appendix A

First Mailing

Letter

Dear Occupational Therapist,

With the implementation of the Affordable Care Act (ACA), it appears that many occupational therapists are unsure regarding the implications of the ACA on current practice. We are conducting a survey regarding where occupational therapists feel they need more knowledge related to implementation of the ACA. It is our intention to use the data collected in this survey to guide our efforts in educating occupational therapists regarding this law. We respectfully request that you complete this survey in order to inform our efforts. To ensure that we receive an adequate number of responses, we will resend the survey, but request you only complete it once.

Once you have completed the survey, please place it in the secrecy envelope and seal. Then place the survey and secrecy envelope in the pre-stamped mailing envelope and mail as soon as conveniently possible. Following this procedure helps to ensure your confidentiality.

Thank you for your time.

Sincerely,

Christopher J.M. Greenman, OTS & Lauren C. Harvey, OTS

Disclaimer and Consent (Notice to Survey Respondents):

The originators of this survey are solely responsible for its contents. **Your response to the survey is voluntary**. You may choose to decline to answer any question or series of questions. Your responses are completely anonymous; therefore, your responses cannot be traced back to you. No personally identified information is to be obtained on your survey. Additionally, your responses are combined with those of many others and summarized in a report to further protect your anonymity.

Your response will be processed and stored in the office at the University of North Dakota's Casper College site; if you do not wish your response and the information it contains to be processed or stored in the office at the University of North Dakota's Casper College site, please do not respond to the survey.

Do not forward this survey without the permission of the originators, and please contribute to its effectiveness by responding only once.

The researchers reserve the right to terminate or withdraw a survey, and your opportunity to participate in a survey, at any time and for any reason. The researchers alone have the right to view and use the survey results and may choose not to disclose the survey results to you.

The possibility of adverse reactions occurring due to your participation in the survey are minimal. Should an adverse reaction occur, it is the responsibility of the respondent to contact the researchers via email (acasurveywyot@gmail.com). The researchers will provide a list of resources. Since the possibility of adverse reactions are minimal, it is the respondent's responsibility to obtain and finance any adverse effect. If the respondent does not contact the researchers within two (2) years regarding adverse reactions, the researchers will not provide a list of resources.

The purpose of this study is for educational and research purposes. The results may or may not be published. With submission of the survey, you are consenting to the terms and conditions stated above.

Survey

1. Please rate your knowledge of the Affordable Care Act.

Decline	I have no knowledge				I have full knowledge
0	1	2	3	4	5

2. I know and understand how the ACA affects most of my clients.

Decline	I have no knowledge				I have full knowledge
0	1	2	3	4	5

3. I am able to explain the ACA to my clients.

Decline	I have no knowledge				I have full knowledge
0	1	2	3	4	5

4. I am able to help my clients find resources regarding the ACA.

Decline	I have no knowledge				I have full knowledge
0	1	2	3	4	5

5. I know how the ACA affects my practice.

Decline	I have no knowledge				I have full knowledge
0	1	2	3	4	5

6. I research the ACA and its effects on my practice.

Decline	I have no knowledge				I have full knowledge
0	1	2	3	4	5

7. I research the ACA and its effects on my clients.

Decline	I have no knowledge				I have full knowledge
0	1	2	3	4	5

8. Please circle the one that most describes your position on the ACA.

   I am in favor of the ACA

   The ACA needs to be reformed

   I oppose the ACA

   I choose not to answer

Please mark the following as true (T), false (F), or Decline (D):

I would like to know more about:

_____ Helping my clients access the ACA

_____ Resources regarding the ACA

_____ How occupational therapy will be affected by the ACA

_____ What I can do to ensure my practice continues to prosper under the ACA

_____ Opportunities for occupational therapy under the ACA

_____ How I can advocate for occupational therapy under the ACA.

In which field(s) of occupational therapy do you practice? (please circle all that apply)

Orthopedics	Pediatrics	Home Health
Mental or behavioral health	Geriatrics (not otherwise listed)	SNF
Community Education	Developmental Disabilities	Professor
Other	Choose Not to Answer	

Are you an AOTA member?
Yes No Decline
Are you a WYOTA member?
Yes No Decline
How long have you been a practitioner?
0-5 years 6-10 years 11-15 years 16-20 20+

Appendix B

Second Mailing

Letter

Dear Occupational Therapist,

This is the second mailing of this survey, **please disregard if you have already completed and submitted this survey**.

With the implementation of the Affordable Care Act (ACA), it appears that many occupational therapists are unsure regarding the implications of the ACA on current practice. We are conducting a survey regarding where occupational therapists feel they need more knowledge related to implementation of the ACA. It is our intention to use the data collected in this survey to guide our efforts in educating occupational therapists regarding this law. We respectfully request that you complete this survey in order to inform our efforts.

Once you have completed the survey, please place it in the secrecy envelope and seal. Then place the survey and secrecy envelope in the pre-stamped mailing envelope and mail as soon as conveniently possible. Following this procedure helps to ensure your confidentiality.

Thank you for your time.

Sincerely,

Christopher J.M. Greenman, OTS & Lauren C. Harvey, OTS

Disclaimer and Consent (Notice to Survey Respondents):

The originators of this survey are solely responsible for its contents. **Your response to the survey is voluntary**. You may choose to decline to answer any question or series of questions. Your responses are completely anonymous; therefore, your responses cannot be traced back to you. No personally identified information is to be obtained on your survey. Additionally, your responses are combined with those of many others and summarized in a report to further protect your anonymity.

Your response will be processed and stored in the office at the University of North Dakota's Casper College site; if you do not wish your response and the information it contains to be processed or stored in the office at the University of North Dakota's Casper College site, please do not respond to the survey.

Do not forward this survey without the permission of the originators, and please contribute to its effectiveness by responding only once.

The researchers reserve the right to terminate or withdraw a survey, and your opportunity to participate in a survey, at any time and for any reason. The researchers alone have the right to view and use the survey results and may choose not to disclose the survey results to you.

The possibility of adverse reactions occurring due to your participation in the survey are minimal. Should an adverse reaction occur, it is the responsibility of the respondent to contact the researchers via email (acasurveywyot@gmail.com). The researchers will provide a list of resources. Since the possibility of adverse reactions are minimal, it is the respondent's responsibility to obtain and finance any adverse effect. If the respondent does not contact the researchers within two (2) years regarding adverse reactions, the researchers will not provide a list of resources.

The purpose of this study is for educational and research purposes. The results may or may not be published. With submission of the survey, you are consenting to the terms and conditions stated above.

Survey

1. Please rate your knowledge of the Affordable Care Act.

Decline	I have no knowledge				I have full knowledge
0	1	2	3	4	5

2. I know and understand how the ACA affects most of my clients.

Decline	I have no knowledge				I have full knowledge
0	1	2	3	4	5

3. I am able to explain the ACA to my clients.

Decline	I have no knowledge				I have full knowledge
0	1	2	3	4	5

4. I am able to help my clients find resources regarding the ACA.

Decline	I have no knowledge				I have full knowledge
0	1	2	3	4	5

5. I know how the ACA affects my practice.

Decline	I have no knowledge				I have full knowledge
0	1	2	3	4	5

6. I research the ACA and its effects on my practice.

Decline	I have no knowledge				I have full knowledge
0	1	2	3	4	5

7. I research the ACA and its effects on my clients.

Decline	I have no knowledge				I have full knowledge
0	1	2	3	4	5

1. Please circle the one that most describes your position on the ACA.

   I am in favor of the ACA

   The ACA needs to be reformed

   I oppose the ACA

   I choose not to answer

Please mark the following as true (T), false (F), or Decline (D):

I would like to know more about:

_____ Helping my clients access the ACA

_____ Resources regarding the ACA

_____ How occupational therapy will be affected by the ACA

_____ What I can do to ensure my practice continues to prosper under the ACA

_____ Opportunities for occupational therapy under the ACA

_____ How I can advocate for occupational therapy under the ACA.

In which field(s) of occupational therapy do you practice? (please circle all that apply)

Orthopedics	Pediatrics	Home Health
Mental or behavioral health	Geriatrics (not otherwise listed)	SNF
Community Education	Developmental Disabilities	Professor
Other	Choose Not to Answer	

Are you an AOTA member?
Yes No Decline
Are you a WYOTA member?
Yes No Decline
How long have you been a practitioner?
0-5 years 6-10 years 11-15 years 16-20 20+

Appendix C

IRB and Waiver or Alteration of Informed Consent

REPORT OF ACTION: EXEMPT/EXPEDITED REVIEW

University of North Dakota Institutional Review Board

Date: 7/2/2014 **Project Number:** IRB-201407-014

Principal Investigator: Greenman, Christopher; Harvey, Lauren

Department: Occupational Therapy

Project Title: Current Knowledge of Occupational Therapists in Wyoming Regarding the Affordable Care Act: A Quantitative Pilot Study

The above referenced project was reviewed by a designated member for the University's Institutional Review Board on JUL 8 2014 and the following action was taken:

☒ Project approved. **Expedited Review** Category No. 7
Next scheduled review must be before: JUL 7 2015

☐ **Copies of the attached consent form with the IRB approval stamp dated must be used in obtaining consent for this study.** Waiver of consent approved.

☐ Project approved. **Exempt Review** Category No. _____
This approval is valid until _____ as long as approved procedures are followed. No periodic review scheduled unless so stated in the Remarks Section.

☐ **Copies of the attached consent form with the IRB approval stamp dated must be used in obtaining consent for this study.**

☐ Minor modifications required. The required corrections/additions must be submitted to RDC for review and approval. **This study may NOT be started UNTIL final IRB approval has been received.**

☐ Project approval **deferred. This study may not be started until final IRB approval has been received.**
(See Remarks Section for further information.)

☐ Disapproved claim of exemption. This project requires Expedited or Full Board review. The Human Subjects Review Form must be filled out and submitted to the IRB for review.

☐ Proposed project is not human subjects research as defined under Federal regulations 45 CFR 46 or 21 CFR 50 and does not require IRB review.

☐ Not Research ☐ Not Human Subject

PLEASE NOTE: **Requested revisions for student proposals MUST include adviser's signature. All revisions MUST be highlighted and submitted to the IRB within 90 days of the above review date.**

☒ Education Requirements Completed. (Project cannot be started until IRB education requirements are met.)

cc: [redacted] Breann Lamborn

Signature of Designated IRB Member
UND's Institutional Review Board

7-8-14
Date

If the proposed project (clinical medical) is to be part of a research activity funded by a Federal Agency, a special assurance statement or a completed 310 Form may be required. Contact RDC to obtain the required documents.

(Revised 10/2006)

University of North Dakota Human Subjects Review Form
April 2014 Version

All research with human participants conducted by faculty, staff, and students associated with the University of North Dakota, must be reviewed and approved as prescribed by the University's policies and procedures governing the use of human subjects. It is the intent of the University of North Dakota (UND), through the Institutional Review Board (IRB) and Research Development and Compliance (RD&C), to assist investigators engaged in human subject research to conduct their research along ethical guidelines reflecting professional as well as community standards. The University has an obligation to ensure that all research involving human subjects meets regulations established by the United States Code of Federal Regulations (CFR). When completing the Human Subjects Review Form, use the "IRB Checklist" for additional guidance.

Please provide the information requested below. Handwritten forms are not accepted – responses must be typed on the form.

Principal Investigator: Christopher Greenman
Lauren Harvey

Telephone: (805)975-5061
(406)581-6677

E-mail Address: Christopher.Greenman@my.und.edu &
Lauren.Harvey@my.und.edu

Complete Mailing Address: 165 Columbine Dr. #4, Casper, WY 82604
4850 Squaw Creek, Casper, WY 82604

School/College: University of North Dakota Department: Occupational Therapy

Student Advisor (if applicable): Breann Lamborn

Telephone: E-mail Address: Breann.Lamborn@med.und.edu

Address or Box #:

School/College: University of North Dakota Department: Occupational Therapy

Project Title: Current Knowledge of Occupational Therapists in Wyoming Regarding the Affordable Care Act: A Quantitative Pilot Study

Proposed Project Dates: Beginning Date: 7/18/14 Completion Date: 1/30/15
(Including data analysis)

Funding agencies supporting this research: NA

Did the contract with the funding entity go through UND Grants and Contracts Administration? ☐ YES or ☒ NO
Attach a copy of the contract. Do not include any budgetary information. The IRB will not be able to review the study without a copy of the contract with the funding agency.

☐ YES or ☒ NO Does any researcher associated with this project have an economic interest in the research, or act as an officer or a director of any outside entity whose financial interests would reasonably appear to be affected by the research? If yes, submit on a separate piece of paper an additional explanation of the financial interest. The Principal Investigator and any researcher associated with this project should have a Financial Interests Disclosure Document on file with their department.

☒ YES or ☐ NO Will any research participants be obtained from another organization outside the University of North Dakota (e.g., hospitals, schools, public agencies, American Indian tribes/reservations)?

☐ YES or ☒ NO Will any data be collected at or obtained from another organization outside the University of North Dakota?

If yes to either of the previous two questions, list all organizations: Research participants will be gathered through Wyoming's database of practing occupational theranists, which is public information.

Letters from each organization must accompany this proposal. Each letter must illustrate that the organization understands its involvement and agrees to participate in the study. Letters must include the name and title of the individual signing the letter and should be printed on organizational letterhead.

Does any external site where the research will be conducted have its own IRB? ☐ YES ☐ NO ☒ N/A

If yes, does the external site plan to rely on UND's IRB for approval of this study? ☐ YES ☐ NO ☒ N/A
(If yes, contact the UND IRB at 701 777-4279 for additional requirements)

If your project has been or will be submitted to other IRBs, list those Boards below, along with the status of each proposal.

_____ Date submitted: _____ Status: ☐ Approved ☐ Pending

_____ Date submitted: _____ Status: ☐ Approved ☐ Pending

(include the name and address of the IRB, contact person at the IRB, and a phone number for that person)

Type of Project: Check "Yes" or "No" for each of the following.

☒ YES or ☐ NO New Project

☐ YES or ☒ NO Continuation/Renewal

☐ YES or ☒ NO Is this a Protocol Change for previously approved project? If yes, submit a signed Protocol Change Form, along with a signed copy of this form with the changes bolded or highlighted.

☐ YES or ☒ NO Does your project involve abstracting medical record information? If yes, complete the HIPAA Compliance Application and submit it with this form.

☐ YES or ☒ NO Does your project include Genetic Research?

☒ YES or ☐ NO Dissertation/Thesis/Independent Study

☒ YES or ☐ NO Student Research Project

Subject Classification: This study will involve subjects who are in the following special populations: Check all that apply.

- ☐ Children (< 18 years)
- ☐ Prisoners
- ☐ Cognitively impaired persons or persons unable to consent
- ☒ Other Registered Occupational Therapists
- ☐ UND Students
- ☐ Pregnant Women/Fetuses

Please use appropriate checklist when children, prisoners, pregnant women, or people who are unable to consent will be involved in the research.

This study will involve: Check all that apply.

- ☐ Deception (Attach Waiver or Alteration of Informed Consent Requirements)
- ☐ Radiation
- ☐ New Drugs (IND) IND # _____Attach Approval
- ☐ Investigational Device Exemption (IDE) # _____Attach Approval
- ☐ Non-approved Use of Drug(s)
- ☒ None of the above will be involved in this study
- ☐ Stem Cells
- ☐ Discarded Tissue
- ☐ Fetal Tissue
- ☐ Human Blood or Fluids
- ☐ Other _____

I. Project Overview

Please provide a brief explanation (limit to 200 words or less) of the rationale and purpose of the study, introduction of any sponsor(s) of the study, and justification for use of human subjects and/or special populations (e.g., vulnerable populations such as children, prisoners, pregnant women/fetuses).

Although the healthcare reforms of the Affordable Care Act (ACA) have taken effect, medical professionals are not knowledgeable regarding the law and are unable to identify the effect these reforms will have on practice. Due to the state of current implementation of the law, there is limited research addressing occupational therapists' level of knowledge regarding the impact the ACA may have on occupational

therapy practice. It is imperative that occupational therapists are not only informed regarding the clinical impact of the ACA, but are also able to take advantage of the reforms for the betterment of the profession. The new laws and regulations associated with the ACA have already created significant changes in the field of healthcare. The research regarding occupational therapists' knowledge and implementation of these laws and regulations appears to be very limited. The researchers will gain insight into the current knowledge level of practicing occupational therapists in Wyoming with regard to the changes being brought about by new laws and regulations associated with the ACA and correlations between knowledge, area of pratice, and number of years as a practitioners.

II. Protocol Description

Please provide a thorough description of the procedures to be used by addressing the instructions under each of the following categories.

1. **Subject Selection.**

   a) Describe recruitment procedures (i.e., how subjects will be recruited, who will recruit them, where and when they will be recruited and for how long) and include copies of any advertisements, fliers, etc., that will be used to recruit subjects.
   The researchers will obtain addresses through a registry of registered occupational therapists in Wyoming. Subsequently, the survey regarding the therapists' knowledge will be sent to be filled out. Please see attached letter and survey.

   b) Describe your subject selection procedures and criteria, paying special attention to the rationale for including subjects from any of the categories listed in the "Subject Classification" section above.
   All registered occupational therapists practicing in Wyoming, this will provide a more accurate of occupational therapists' knowledge level. Pending the number of respondents, completed surveys will be randomly selected to further increase the validity of the study.

   c) Describe your exclusionary criteria and provide a rationale for excluding subject categories.
   Those participants who do not complete the full survey will be excluded from the research. This is necessary to ensure results void of bias as well as provide a full and accurate picture of this topic.

   d) Describe the estimated number of subjects that will participate and the rationale for using that number of subjects.
   It is expected that 200 of the 360 on the registry will return the survey.

   e) Specify the potential for valid results. If you have used a power analysis to determine the number of subjects, describe your method.
   This stuy has a potential for a high validity due to the quality of questionaire and methods of obtaining data. Additionally, data analysis will be completed via descriptive analysis techniques through SPSS. Data analysis will include a t-test, chi square test, and Pearson's parametric tests. If the number of responses is large, there is a possibility of randomizing the selection of participants. Furthermore, the researchers anticipate a return rate of no less than 50%.

2. **Description of Methodology.**

   a) Describe the procedures used to obtain informed consent.
   Informed consent will be obtained through inference; by completing and returning survey data, practitioners will be notified they are providing consent.

   b) Describe where the research will be conducted. Document the resources and facilities to be used to carry out the proposed research. Please note staffing, funding, and space available to conduct this research.
   The survey will be conducted via mail. The researchers will mail surveys and prestamped envelopes to prospective participants. Additional data analysis will occur at the University of North Dakota's Casper College sattelite program. All data will be stored in the faculty advisor's locked filing cabinent for three years.

   c) Indicate who will carry out the research procedures.

Christopher Greenman and Lauren Harvey will carry out the research procedures with aid provided by Professor Breann Lamborn and Dr. Anne Haskins.

d) Briefly describe the procedures and techniques to be used and the amount of time that is required by the subjects to complete them.
The subjects will be asked to complete a short survey, that is estimated to take no longer than 10 minutes.

e) Describe audio/visual procedures and proper disposal of tapes.
N/A

f) Describe the qualifications of the individuals conducting all procedures used in the study.
The students creating the survey are occupational therapy students at the University of North Dakota. They have each completed a bachelor's degree and have taken both quantitative and qualitative research courses. Additionally, the falcuty advisor has been an instructor at this program for eight (8) years, and is a coinstructor for a quantitative research methods class.

g) Describe compensation procedures (payment or class credit for the subjects, etc.).
N/A

Attachments Necessary: Copies of all instruments (such as survey/interview questions, data collection forms completed by subjects, etc.) must be attached to this proposal.

3. Risk Identification.

a) Clearly describe the anticipated risks to the subject/others including any physical, emotional, and financial risks that might result from this study.
Anticipated risks to participation in this study are minimal. It is possible that participants experience some anxiety while completing the survey.

b) Indicate whether there will be a way to link subject responses and/or data sheets to consent forms, and if so, what the justification is for having that link.
The responses will be kept anonymous through the procedures for returning the surveys. The privacy envelope and procedures ensure the researchers will not be able to link the survey results with addresses or the names of practitioners.

c) Provide a description of the data monitoring plan for all research that involves greater than minimal risk.
N/A

d) If the PI will be the lead-investigator for a multi-center study, or if the PI's organization will be the lead site in a multi-center study, include information about the management of information obtained in multi-site research that might be relevant to the protection of research participants, such as unanticipated problems involving risks to participants or others, interim results, or protocol modifications.
N/A

4. Subject Protection.

a) Describe precautions you will take to minimize potential risks to the subjects (e.g., sterile conditions, informing subjects that some individuals may have strong emotional reactions to the procedures, debriefing, etc.).
In order to minimize the potential risks, all survey responses will be anonymous. The prospective participants will be mailed a privacy envelop for enclosing their survey as well as a prestamped envelope. Participants will be asked to place the survey in the privacy envelop and the privacy envelop in the return envelop. Upon receiving the surveys, the researchers will destroy the return envelop. The subjects will be notified of the procedures via mail and will indicate they understand the procedures through the return of the survey. The respondents will be informed that emotional reactions may occur during the completion of the survey and procedures to take in this event. The respondents may email

the researchers for a list of resources within (2) years of survey completion. After receiving the list of resources, it is the responsibility of the respondent to locate and finance services.

b) Describe procedures you will implement to protect confidentiality and privacy of participants (such as coding subject data, removing identifying information, reporting data in aggregate form, not violating a participants space, not intruding where one is not welcome or trusted, not observing or recording what people expect not to be public, etc.). If participants who are likely to be vulnerable to coercion and undue influence are to be included in the research, define provisions to protect the privacy and interests of these participants and additional safeguards implemented to protect the rights and welfare of these participants.

In order to minimize the potential risks, all survey responses will be anonymous. The prospective participants will be mailed a privacy envelop for enclosing their survey as well as a prestamped envelope. Participants will be asked to place the survey in the privacy envelop and the privacy envelop in the return envelop. Upon receiving the surveys, the researchers will destroy the return envelop. In doing this, the researchers are able to ensure confidentiality of the survey.

c) Indicate that the subject will be provided with a copy of the consent form and how this will be done.

A copy of the consent form will be included with all surveys. The respondents will indicate their consent by returning the survey.

d) Describe the protocol regarding record retention. Please indicate that research data from this study and consent forms will both be retained in separate locked locations for a minimum of three years following the completion of the study. Describe: 1) the storage location of the research data (separate from consent forms and subject personal data)
2) who will have access to the data
3) how the data will be destroyed
4) the storage location of consent forms and personal data (separate from research data)
5) how the consent forms will be destroyed

1) All data will be stored in the faculty advisor's locked filing cabinet.
2) The two principle researchers and two advisors will have access to the data while completing research. At other times, information will be secured in the locked filing cabinet.
3) The data will be shredded after three (3) years of storage.
4) No personal data will be collected. Consent will be indicated by returning the survey. An unused copy of the survey and consent form will be stored in the filing cabinent with the responses.
5) The consent form will be shredded after three (3) years

e) Describe procedures to deal with adverse reactions (referrals to helping agencies, procedures for dealing with trauma, etc.).

Respondents may contact the researchers via email regarding any adverse response within two (2) years of compelting the survey. The researchers will provide a list of resources the respondent may use in the event of an adverse reaction; however, it is the responsibility of the respondent to obtain and finance any services needed.

f) Include an explanation of medical treatment available if injury or adverse reaction occurs and responsibility for costs involved.

The participant will be responsibe for costs and arrangement of services in the event of an adverse reaction. The researchers will provide a list of resources if requested.

III. Benefits of the Study

Clearly describe the benefits to the subject and to society resulting from this study (such as learning experiences, services received, etc.). **Please note:** extra credit and/or payment are not benefits and should be listed in the Protocol Description section under Methodology.

By participating in the study, participants will have an opportunity to help expand the knowledge of the relationship between the ACA and perceptions of current occupational therapists, as well as reflect upon theircurrent knowledge levels.

IV. Consent Form

Clearly describe the consent process below and be sure to include the following information in your description (Note: Simply

stating 'see attached consent form' is not sufficient. The items listed below must be addressed on this form.):

1) The person who will conduct the consent interview
2) The person who will provide consent or permission
3) Any waiting period between informing the prospective participant and obtaining consent
4) Steps taken to minimize the possibility of coercion or undue influence
5) The language to be used by those obtaining consent
6) The language understood by the prospective participant or the legally authorized representative
7) The information to be communicated to the prospective participant or the legally authorized representative

1) The consent will be indicated with the return of the survey.
2) In returning the survey, the respondent is consenting.
3) The respondent will have an opportunity to read the implied consent form and complete the survey at his or her leisure; however, a delayed response could result in the inability to participate.
4) In order to minimize coercion, all data obtained from the survey will be anonymous.
5) The implied consent consent will be written in English.
6) English is the language understood by prospective participants.
7) The information will be communicated in writing via mail and will be sent with the survey.

A copy of the consent form must be attached to this proposal. If no consent form is to be used, document the procedures to be used to protect human subjects, and complete the Application for Waiver or Alteration of Informed Consent Requirements. Refer to form IC 701-A, Informed Consent Checklist, and make sure that all the required elements are included. **Please note:** All records attained must be retained for a period of time sufficient to meet federal, state, and local regulations; sponsor requirements; and organizational policies. The consent form must be written in language that can easily be read by the subject population and any use of jargon or technical language should be avoided. **The consent form should be written at no higher than an 8th grade reading level**, and it is recommended that it be written in the third person (please see the example on the RD&C website). A two inch by two inch blank space must be left on the bottom of each page of the consent form for the IRB approval stamp.

Necessary attachments:

- ☒ Signed Student Consent to Release of Educational Record Form (students only);
- ☒ Investigator Letter of Assurance of Compliance;
- ☒ Consent form, or Waiver or Alteration of Informed Consent Requirements (Form IC 702-B)
- ☒ Surveys, interview questions, etc. (if applicable);
- ☐ Printed web screens (if survey is over the Internet); and
- ☐ Advertisements.

By signing below, you are verifying that the information provided in the Human Subjects Review Form and attached information is accurate and that the project will be completed as indicated.

Signatures: Lauren Harvey Christopher Hoarman 06/27/2014

(Principal Investigator) Date:

Breann C. Lambarn 6/30/2014

(Student Advisor) Date:

All students and medical residents must list a faculty member as a student advisor on the first page of the application and must have that person sign the application.

Requirements for submitting proposals:
Additional information can be found on the IRB website at: http://und.edu/research/resources/human-subjects/index.cfm

Original, signed proposals and all attachments, along with the necessary number of copies (see below), should be submitted to: Institutional Review Board, 264 Centennial Drive Stop 7134, Grand Forks, ND 58202-7134, or brought to Room 106, Twamley Hall.

Required Number of Copies:

- Expedited Review: Submit the signed original and 1 copy of the entire proposal.
- Full Board Review: Submit the signed original and 22 copies of the entire proposal by the deadline listed on the IRB website: http://und.edu/research/resources/human-subjects/meeting-schedule.cfm
- Clinical Medical Subcommittee and Full Board Review: Submit the signed original and 24 copies of the entire proposal by the deadline listed on the IRB website: http://und.edu/research/resources/human-subjects/meeting-schedule.cfm

Prior to receiving IRB approval, researchers must complete the required IRB human subjects' education. Please go to: http://und.edu/research/resources/human-subjects/human-subject-education.cfm

The criteria for determining what category your proposal will be reviewed under is listed on page 3 of the IRB Checklist. Your reviewer will assign a review category to your proposal. Should your protocol require full Board review, you will need to provide additional copies. Further information can be found on the IRB website regarding required copies and IRB review categories, or you may call the IRB office at 701 777-4279.

In cases where the proposed work is part of a proposal to a potential funding source, one copy of the completed proposal to the funding agency (agreement/contract if there is no proposal) must be attached to the completed Human Subjects Review Form if the proposal is non-clinical; 5 copies if the proposal is clinical-medical. If the proposed work is being conducted for a pharmaceutical company, 5 copies of the company's protocol must be provided.

WAIVER OR ALTERATION OF INFORMED CONSENT REQUIREMENTS

IC 702-B 10/19/09

University of North Dakota Application for Waiver or Alteration of Informed Consent Requirements

Principal Investigator: Lauren Harvey and Christopher Greenman

Project Title: Current Knowledge of Occupational Therapists in Wyoming Regarding the Affordable Care Act: A Quantitative Pilot Study

Written documentation of informed consent that embodies all the required elements of informed consent, as described in 45 CFR 46.116, is required for all research subjects. With sufficient justification, the IRB may approve a consent process that does not include, or which alters, some or all of the elements of informed consent provided that it finds and documents specific requirements. Choose **EITHER** option A or B below and complete that section. Sign the form and submit it with your application to IRB.

A. If requesting a waiver or alteration of the requirements to obtain informed consent, justify such in accordance with each of the following four criteria established under 45 CFR 46.116(d) (1-4). (This option not allowed for FDA regulated research)

1. The research involves no more than minimal risk* to the subjects;

2. The waiver or alteration will not adversely affect the rights and welfare of the subjects;

3. The research could not practicably** be carried out without the waiver or alteration; **AND**

4. Whenever appropriate, the subjects will be provided with additional pertinent information after participation.

B. If requesting a waiver or alteration from the requirements for written documentation of informed consent, justify such in accordance with at least one of the criteria established under 45 CFR 46.117(c) (1 or 2).

1. The only record linking the subject and the research would be the consent document and the principal risk would be potential harm resulting from a breach of confidentiality. In this case, each subject will be asked whether s/he wants documentation linking the subject with the research, and the subject's wishes will govern (this option is not allowed for FDA regulated research); **OR**

This study is an anonymous survey study. No identifying data will be included on the survey; therefore, the only identifying data on the form would be the consent form.

2. The research presents no more than minimal risk of harm to subjects and involves no procedures for which written consent is normally required outside of the research context.

If requesting a waiver of the documentation of consent, attach a verbal consent script and/or a subject information sheet that describes the study and includes the relevant consent form elements.

Lauren Harvey Christopher Greenman 06/27/2014

(Principal Investigator Signature) Date:

(Institutional Review Board Primary Reviewer Signature) Date:

**Minimal risk means that the probability and magnitude of harm or discomfort anticipated in the research are not greater than those ordinarily encountered in daily life or during the performance of routine physical or psychological examinations or tests.*

***Practicable refers to instances in which the additional cost would make the research prohibitively expensive, or where the identification and contact of thousands of potential subjects would not be feasible for the anticipated results of the study. Practicable would not mean an inconvenience or increase in time or expense to the investigator or the research.*

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