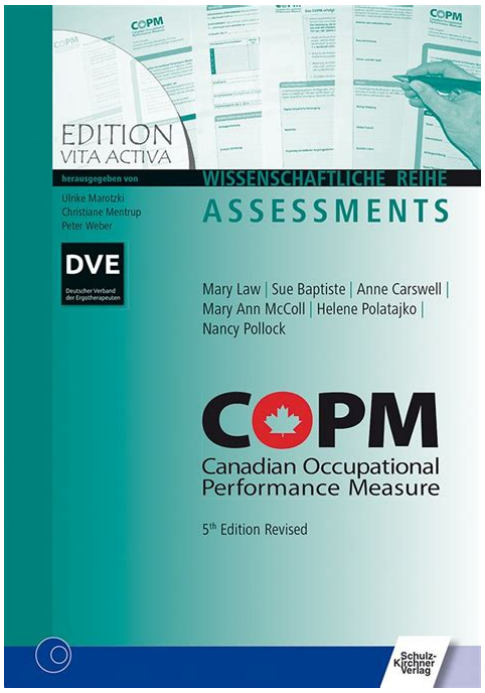
Canadian occupational performance measure manual 4th edition



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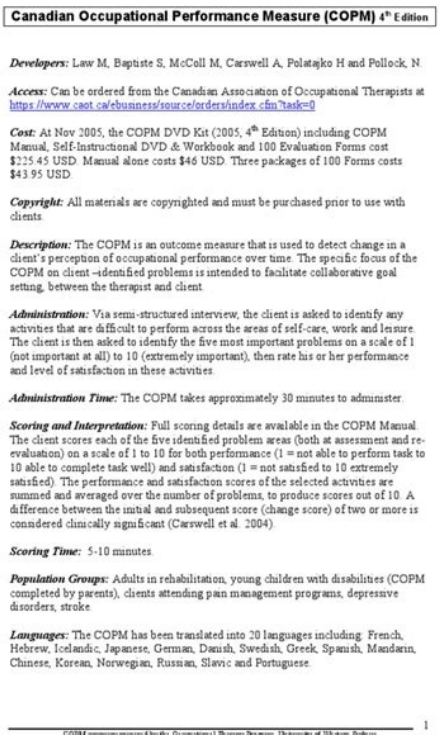

Canadian Occupational Performance Measure (COPM) 4th Edition

Developers: Law M, Baptiste S, McColl M, Carswell A, Polatajko H and Pollock, N

Access: Can be ordered from the Canadian Association of Occupational Therapists at https://www.caot.ca/ebusiness/source/orders/index.cfm?task=0

Cost: At Nov 2005, the COPM DVD Kit (2005, 4th Edition) including COPM Manual, Self-Instructional DVD & Workbook and 100 Evaluation Forms cost $225.45 USD. Manual alone costs $46 USD. Three packages of 100 Forms costs $43.95 USD.

Copyright: All materials are copyrighted and must be purchased prior to use with clients.

Description: The COPM is an outcome measure that is used to detect change in a client's perception of occupational performance over time. The specific focus of the COPM on client –identified problems is intended to facilitate collaborative goal setting, between the therapist and client.

Administration: Via semi-structured interview, the client is asked to identify any activities that are difficult to perform across the areas of self-care, work and leisure. The client is then asked to identify the five most important problems on a scale of 1 (not important at all) to 10 (extremely important), then rate his or her performance and level of satisfaction in these activities.

Administration Time: The COPM takes approximately 30 minutes to administer.

Scoring and Interpretation: Full scoring details are available in the COPM Manual. The client scores each of the five identified problem areas (both at assessment and re-evaluation) on a scale of 1 to 10 for both performance (1 = not able to perform task to 10 able to complete task well) and satisfaction (1 = not satisfied to 10 extremely satisfied). The performance and satisfaction scores of the selected activities are summed and averaged over the number of problems, to produce scores out of 10. A difference between the initial and subsequent score (change score) of two or more is considered clinically significant (Carswell et al. 2004).

Scoring Time: 5-10 minutes.

Population Groups: Adults in rehabilitation, young children with disabilities (COPM completed by parents), clients attending pain management programs, depressive disorders, stroke.

Languages: The COPM has been translated into 20 languages including: French, Hebrew, Icelandic, Japanese, German, Danish, Swedish, Greek, Spanish, Mandarin, Chinese, Korean, Norwegian, Russian, Slavic and Portuguese.

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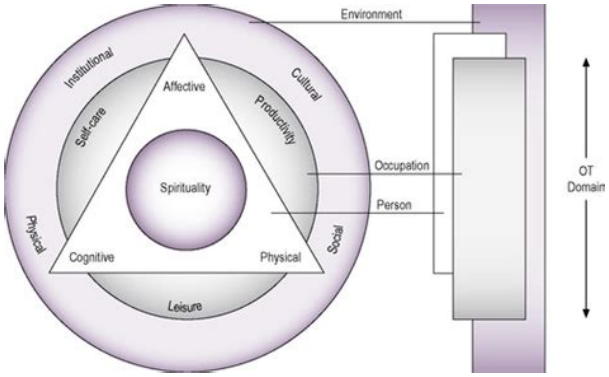

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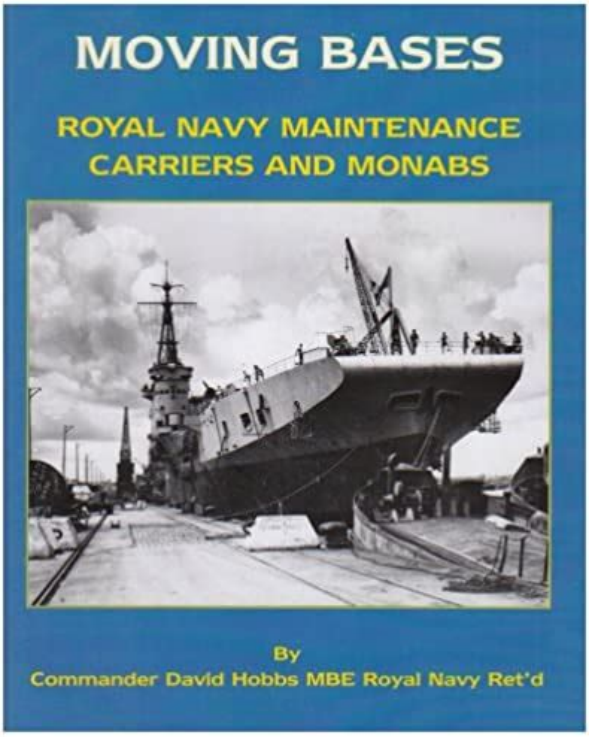

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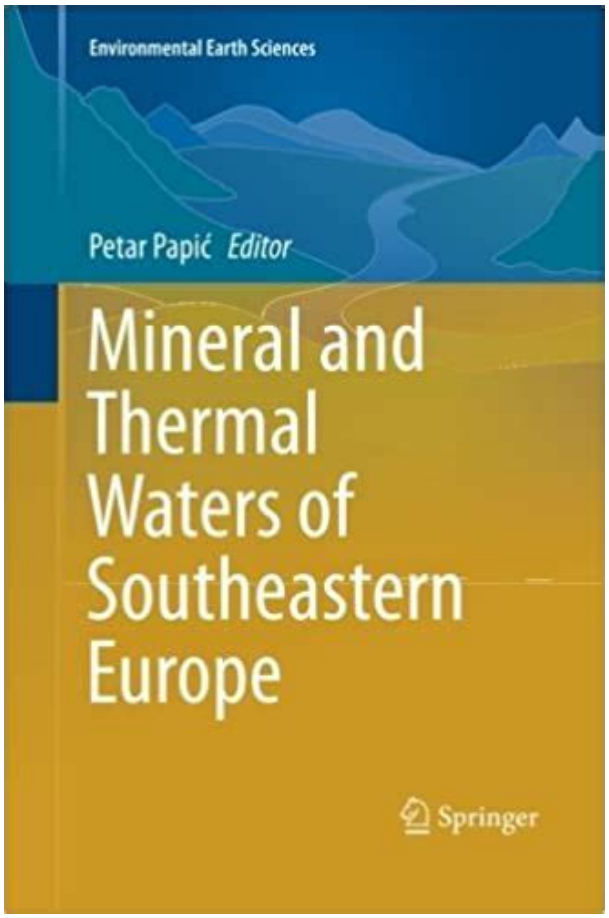

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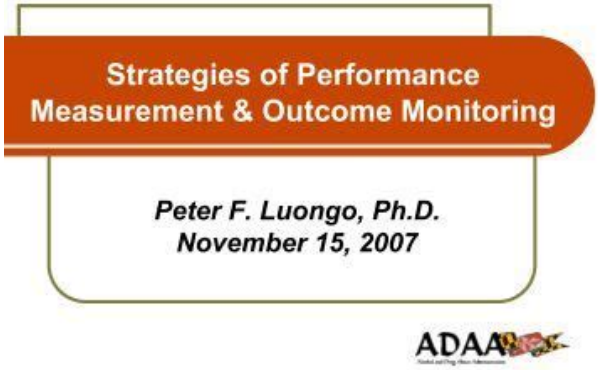

The default reserve fine schedule will apply to overdue returns. Copyright labels are affixed to the tool items as a reminder. The following conditions applyThis group may borrow items from the tool collection under the same conditions outlined above with the following additional requirements. From highquality clinical care and groundbreaking research to community programs that improve quality of life, philanthropic support drives our mission and vision. In 2020, your cash gifts may also favorably impact your taxes, thanks to provisions in the CARES Act. Apply now for a pilot project. Also available in Pediatric, French, Hebrew, Icelandic, Japanese, German, Danish, Swedish, Greek, Spanish, Mandarin Chinese, Korean, Russian, Slavic, Italian, Portuguese and Norwegian versions. These recommendations were developed by a panel of research and clinical experts using a modified Delphi process. For detailed information about how recommendations were made, please visit However, the interview process is not standardized and both the quality and adequacy of information obtained from interviews may vary considerably between interviewers. Twenty six children with ischemic or hemorrhagic stroke 516 years of age participated in this study to identify the functional tasks of concern and identify the most valued functional activities as measured by the COPM when completed by the children and by the parents. The satisfaction and performance parts of the COPM were not administered. A total of 103 goals were identified. Please email us ! Individual performance scores on the COPM were significantly related to scores on the matched HAQ components and matched HAQ activitiesDuring the initial COPM interview 115 problems were identified. In the second interview 112 problems were identified. 64 problems 56% mentioned in the first interview were also mentioned in the second interview. This study evaluated 49 community dwelling individuals mean age of 59.67 14.14, 72 58.

8 months post stroke to determine if there was a correlation between sensory discrimination TouchTest, similar to Semmes Weinstein Monofilaments and valued activities functional

performance on the COMP. Find it on PubMed. Find it on PubMed. Find it on PubMed Australian occupational therapy journal. 573152 8. Find it on PubMed Topics in stroke rehabilitation. 21433946. Find it on PubMed. Find it on PubMed Find it on PubMed. Journal of Rehabilitation Research and Development, 515, 72746. Find on PubMed. Clinical Rehabilitation, 2011, 980988. If this is an emergency, please dial 911. Please enable it to take advantage of the complete set of features!Get the latest public health information from CDC. Get the latest research from NIH. Find NCBI SARSCoV2 literature, sequence, and clinical content.In that time there has been a remarkable growth in its acceptance as an outcome measure within the occupational therapy practice and research.Eightyeight papers that met the inclusion criteria were reviewed, 86% of which examined the COPM in relation to its psychometric properties 19 papers, research outcomes 33 papers or practice 33 papers. To establish the construct validity of the Danish version of the Canadian Occupational Performance Measure COPM. Methods. A crosssectional study was performed in two settings, a regional hospital and a rehabilitation centre in a community. Including adult clients with a variety of diagnoses, we assessed construct validity by correlating the COPM to the Occupational SelfAssessment OSA, the fiveitem World Health Organization WellBeing Index WHO5, and the EuroQolfive domainfive level questionnaire EQ5D5L. Further examination of the comparability of the OSA and the COPM was performed in two ways. First, an interrater agreement of the theoretical correlation of the 21 OSA items and the three areas of the COPM was conducted.

Secondly, we examined the compliance between the prioritized occupational performance issues OPIs and items of the OSA prioritized for change. Results. The study included a total sample of 112 participants with more than half of the participants 56% recruited from the hospital. 109 participants had measurements for both COPM and OSA 44% males with a mean age of 64.7 years range 1696 years. All correlations, between the COPM and the OSA, the WHO5, and the EQ5D5L, were low or negligible . Manual examination confirmed a difference in the constructs of the OSA and the COPM. This was demonstrated by a negligible interrater agreement between the items of the OSA and the areas of the COPM, and differences in the prioritized OPIs and OSA items, even if there were some resemblances, were found. Conclusions. This study suggests that the construct of the COPM provides data different to those obtained with the standardized measurements included for comparison. In the COPM, the clients identify their OPIs of which they prioritize up to five to be the focus of the intervention. This helps to understand which occupations the clients' value and shed light to how the clients perceive their occupational competencies. This perspective includes the assumption that a connection exits between being engaged in and performing occupations and the status of humans' health and sense of wellbeing. Internationally, the clinimetric properties of the COPM have been widely examined. However, as the former Danish versions were not crossculturally validated, this study is part of a crosscultural validation initiated by the Danish association of occupational therapists in 2015 with the release of the 5 th version of the COPM. To overcome this, Baker et al. Since the COPM examines a construct, occupational performance, determined by individual and cultural perceptions, especially examining the cultural equivalence of the COPM in Danish seemed important.

One of these was, that when administering the COPM, the OTs should have their clients address issues of occupational performance, despite that the authors provided examples of tasks in the Appendix A of the 5 th version of the COPM manual. In our understanding, determining issues on the level of task might affect the measurement's content validity. Another comment was for the OTs to keep their clients from scoring occupations that the clients had not yet performed, as this might affect the measurement reliability. The first of these is operational equivalence. The next step is to

examine measurement equivalence, i.e., the clinimetric properties of the translated version. Since the COPM's clinimetric properties have been examined worldwide with good results, one could argue that these findings were applicable in a Danish context. However, recalling the findings of issues in our first study that might negatively influence the validity and the reliability of the measurement, we thought it most optimal to continue our crosscultural translation process with the COPMDK. We included the two latter measurements based on the assumption that performing and engaging in occupations' influence but is not the same as health and wellbeing; thus, we expected some although low correlations. However, even if the study of Stuber et al.Thus, to substantiate our findings, we included a more indepth analysis of the correlation of the OSA and the COPM. This led to the following research questionsLikewise, low correlations were expected between the COPMS and the WHO5 and the COPMS and the two affective components of EQ5D5L 2 To which degree are the constructs of the OSA and the COPM comparable. This examination was based on the following two questions. The study took place in two settings in the capital region of Denmark. The first setting A was a regional hospital, including participants from a hand and a knee surgery department, i.e., the populations referred to as AH and AK.

The second setting R was a communitybased rehabilitation centre, including participants from in and outpatient departments, i.e., the populations referred to as RI and RO. The participants were included subsequently after being referred to rehabilitation. The inclusion criteria were age above 18 years and able to speak and understand Danish and to participate in the data collection. Four OTs from each of the two settings offered to volunteer in the study eight in total. Two OT research assistants, not employed at the settings, were included to administer the OSA. Thus, together with the first author, a total of 11 OTs participated as assessors in the study. Together with the first author, another 11 OTs from different regions of Denmark were invited to participate as raters. In this study, examination of the COPMDK's validity was based on how the participants scored the prioritized OPIs concerning their performance of the OPIs the COPMP, and how satisfied they were with these performances the COPMS. Both scores are VAS scores going from "1" representing the lowest performance or satisfaction to "10" representing the highest performance or satisfaction. Volition includes values, likes and dislikes, and selfknowledge, including items like "performs activities I like" and "work towards my goals". Habituation includes how human capacity routinely and efficiently contributes to complete daily occupations, including items like "relax and find myself comfortable" and "do what I need to do". In the MoHO, the environment includes external matters like objects, others, and context. In the initiate development of the OSA, the environment scales showed inadequate separation statistics, and the OT practitioners did not really used it. In the OSA, the participants evaluated their competences the OSAC through responses to 21 statements, followed by rating the values the OSAV they inflicted on these statements.

In rating competencies, the participants were asked to score each statement on a fourpoint Likert scale ranging from "1" "I have a problem doing this" to "4" "I do this well". When rating the values, the participants scored each statement on a fourpoint Likert scale ranging from "1" "this is not so important to me" to "4" "this is the most important to me". The participants looked over their responses and identified four areas they considered their priorities for change OSAP. The participants were asked to rate how well each of the five statements applied to them within the last 14 days on a sixpoint Likert scale from "5" "all of the time" to "0" "none of the time". Adding the five ratings together, the sum score can range from 0 "absence of wellbeing" to 25 "maximal wellbeing". The EQ5D5L has been developed to improve the instrument's sensitivity and to reduce ceiling effects, as compared to the EQ5D3L. Since no Danish norms have been published so far, making it impossible to combine the five items into a total score, we considered each dimension of the descriptive system on its own. Permission to use the EQ5D paper version has been granted with the ID no 32886. The participants were asked to respond to each dimension within the included five levels with "1" "no problems", "2" "slight problems", "3" "moderate problems", "4" "severe

problems", and "5" "extreme problems". This led to an individual EQ5D health state expressed with a fivedigit health profile by combining the levels on each of the five dimensions. Prior to the recruitment of clients, the assessors were informed of the study procedure in a oneday course held by the first author at each setting. This included detailed oral and written information of the study aim and the study procedure, including what the assessors were expected to do, if the clients gave their written consent to participate.

The assessors were also instructed how they should administer the COPM to ensure homogeneity and a uniform procedure. Prior to the inclusion of clients, the two OT research assistants were introduced to the OSA and the study in a threehour course held by the first author. All ten assessors gave their written informed content prior to the start of the study. In the study period, all newcomer clients being referred to rehabilitation were asked to participate in the study and received verbal and written information about the study. If the participants were unable to fill in the questionnaires, the local OT assessors helped them. The COPMDK interviews were administered either by the first author or one of eight local assessors. All the OSA interviews were administered by the two research assistants. The COPMDK and the OSA interviews were performed in random order, so about half of the clients started with the COPMDK interview and half with the OSA interview. The interviews were performed in Danish at the practice settings. Both the COPMDK and the OSA were administered verbally according to the measurement's manual and the training courses, and the assessors and the first authors were blinded for other results than the one they produced themselves. The examination of the comparability of the OSA and the COPM was performed in two tempi. First, alongside with the data collection from the included clients, a theoretical comparison of the two measurements was performed. Together with the first author, the 11 OT raters examined the construct conformity between the COPMDK and the OSA. All raters were given a sheet with the items of the OSA and asked to fit each item within one of the three areas of the COPM S, P, and L. These sheets were combined to enable an examination of the interrater agreement. The second examination was based on the patient data.

For this, the first author manually coded the OPIs from the COPM, dividing all OPIs into the three occupational performance areas as defined by the COPM manual and given each OPI a consecutive number. Similarly, all the OSA items prioritized for change by the clients were gathered. This enabled a descriptive comparison of the individual answers from COPM and the OSA to identify a separate top 10 priority list from each measurement based on all the clients' answers. First, we calculated characteristics , mean, sd, median, and quartiles for all sum scores of the included measurements as described by the manuals. We calculated all sum scores based only on complete cases; i.e., if one or more answers were missing, the participants data were excluded. We further illustrated sum score distributions by histograms. Then, we calculated the Spearman correlation coefficients and corresponding 95% confidence intervals. In all cases, if a sum score was available, the sum scores of the measurements were used. However, since a Danish normbased sum score is not yet available of the EQ5D5L, we compared the score of each item, with the sum score of the COPM. Thus, the correlations were examined in the following groupingsTo demonstrate the theoretical degree of comparability between the OSA and the COPM, we calculated the interrater agreement of the 12 participating OT raters, using the Fleiss' kappa statistic. About half of the participants , 58% were recruited from the regional hospital and the rest , 42% from the rehabilitation centre. The entire study population is displayed in population groups with gender and age in Table 1. Table 1 Sample characteristics of the participants . 3.2. The Correlation of the COPM, the OSA, the WHO5, and the EQ5D5L The descriptive scores mean, SD, range, and median with 25% and 75% quartile of the COPM, the OSA, the WHO5, and the EQ5D5L can be found in Table 2. The COPMP score was out of 10, and the mean COPMS score was .

The score distributions are presented in Figure 1. Table 2 Scores at admission from all the

measurements COPM, OSA, WHO5, and EQ5D5L . The figures of the OSA and the WHO5 show the calculated sum scores. The correlations between the measurements can be seen in Table 3. The analyses of the total population revealed low or negligible correlations between the COPM and all the other measurements including the OSA scales, with the correlation between the COPMP and the OSAC being slightly higher than the correlation between the COPMS and the COPMV, obtaining a negative correlation . Population Correlations COPMP . Table 3 Spearman correlations for each population group and the total population . On 12 of the 21 OSA items, more than six raters agreed on a classification, as follows selfcare was chosen for three items 25%, productivity four times 33%, leisure two times 17%, and for three of these items, the raters agreed on two of the COPM areas selfcare and leisure, however making them belong to group 4 the “undecided” group. Following this, the raters only agreed on how nine of the OSA items could be fitted into one of the three COPM areas. The clients prioritized 495 OPIs in the COPM interviews and 375 items prioritized to change in the OSA interviews. The top ten frequencies of the prioritized OPIs and items to change from the OSA can be seen in Table 4, illustrating differences in the prioritized OPIs and OSA items, even if some resemblances like prioritizing “Shower, taking a bath” the top priority of the COPM and “Taking care of myself” the third most frequent prioritized OSA item are seen. Contrary to our first hypothesis, the correlation of the COPM scales with the OSA was low and negligible, whereas our second hypothesis was confirmed since we found low and negligible correlations between the COPMscales and the WHO5 and the EQ5D5L. Thus, our findings indicate that none of the included measurements’ constructs correlate.