Jim Hinojosa: Good morning.

Beth: Good morning.

Stephanie: Morning.

Jim Hinojosa: Am I coming through?

Stephanie: Yes.

Beth: We can hear you, but we can't see you. Oh, there you are.

Jim Hinojosa: I'm there.

Beth: [Laughs]

Stephanie: [Laughs]

Jim Hinojosa: Okay, great okay. Sorry about that.

Beth: That's okay.

Stephanie: That's okay.

Jim Hinojosa: Yeah.

Beth: I'm Beth. This is Steph, we're in Rita's graduate OT class.

Jim Hinojosa: Okay.

Beth: Part of our project is we have to write a historical paper from the 1900s on…about some seminal event or theory or some type of thing in occupational therapy.

Jim Hinojosa: Right.

Beth: We've done, as you know, we've done our fieldwork. So we've seen a bunch of things on the fieldwork, and we always wondered about the assessments evaluations that were used—

Jim Hinojosa: Mhmm.

Beth: ...why some places used some things over others; how do you know that it's good? Things like that. So we decided to write about assessments.

Jim Hinojosa: Mhmm.

Beth: We wrote the first half of the paper from 1900 to 1979. It was hard finding a bunch of research on assessments.

Stephanie: Mhmm.

Jim Hinojosa: Yep.

Beth: They weren't really used during that time.

Stephanie: Yeah.

Beth: The ideas of assessments were there, but the actual assessments themselves were not created yet.

Jim Hinojosa: Correct.

Beth: We read one of your articles “Bottom-Up or Top-Down Evaluation.”

Jim Hinojosa: Mhmm.

Beth: In that article, you talked about…a little about the history of evaluations. We just wanted to know if you could expand on that idea a little bit.

Jim Hinojosa: Right. I think evaluation and assessment has always been an issue in OT. I think you're right, prior to the 1970s, it was kind of part of a clinical reasoning process—

Beth: Mhmm.

Jim Hinojosa: ...and more observation-based. And what was commonly done, is institutions developed their own assessment methods, often taking items from standardized assessments, sometimes just taking standardizations of…like motor behavior, or sensory processing, or whatever. In the 1970s there were a couple of things going on. One was that the treatment approaches that were being used became more theoretically-based, and more grounded in ideas that were very very clear. And with that became the expectation that we would be more scientific, and with it then we would have better evaluation tools. Now, I alluded to the fact that in the profession, it was very different by specialty areas. In mental health, you had the psycho-dynamic approaches and stuff, and they use the typical kind of psychology-based assessments which were probably appropriate in their settings, whether it was group assessments or individual assessment. The leading area was actually pediatrics, and some of that was because of the work of Dr. Jean Ayres. When Jean Ayres came out with an OT instrument essentially, sensory integration…and it became…actually raised the status of practice in pediatrics. Then, at the same time, other areas began to focus on assessment and evaluation. Now, in the 1970s, late 1970s, when I chaired the Commission of Practice, one of our concerns was the sloppiness in which we talked about assessment and evaluation.

Beth: Mhmm.

Jim Hinojosa: And, it was inconsistent. We used those two words interchangeably. Often it was inconsistent with the literature in other professions, and therefore we decided to make it a major focus to try and standardize the evaluation and assessment…use of language at least in OT. So we did a couple of things. One, is that we added it to the Standards of Practice. Prior to that time, it was very brief and it wasn't very specific. And second of all, we decided that we needed to define the terms, but it was too complex to just put out a position paper or something like that. So we decided we should actually propose that AOTA write a book, which ultimately became the evaluation books you've probably seen, which talked about…that evaluation is the overall assessing of an individual or a client. The assessment tool…the assessment is simply the tool that is being used. So, you do an assessment on it…use this assessment or that assessment. With it, at the same time, there was a major movement to have evidence-based practice. And Margo Holmes. of course, did her psycho-lecture [05:13] and really challenged us all to basically…let's start providing evidence that our interventions work. Well obviously, if you don't have your evaluation at the beginning, you can't prove that it worked at the end. That's logical. What

happened, which I think is really interesting, is OTs took that time to say "Well, if we're using instruments from other professions, we're really not assessing the areas that we're concerned with. We're concerned with function, we're concerned with occupation, and so what we need to do is to develop functionally-based or occupation-based assessments." And through the 80s and the 90s to currently, you've seen that expansion of occupation- or function-based assessments. Initially it was in the areas of ADL, probably because that was more an important area and one that we're obviously considered experts in. And then from there, it moved to more specific kinds of tools.

Stephanie: Okay.

Beth: Awesome. I just, this just occurred to me when you were talking about it, did anything…our development of assessments, did that have anything to with competition from other interdisciplinary teams? Or was it just, kind of, OT on itself, wanting to grow as a profession?

Jim Hinojosa: It may have in individual clinics been that. But I think, the focus, since it was coming from the association and from at the same time that AOTA was doing that, the Foundation made research priority assessments in the development of specific assessment tools for OT. Then it really came down to the fact that you can't do evidence-based practice if you're not assessing what you're really trying to change.

Beth: Right.

Jim Hinojosa: I mean, it's very simple. And how are we going to develop those particular tools? And it took us a while to get there. But there, also, was no need to get there because the accountability standards were not very strong after World War II.

Beth: Right.

Jim Hinojosa: They really didn't become much greater until the reimbursement pressures of the 80s and 90s. And, so, if there was an external pressure, it really was reimbursement.

Steph: Okay, makes sense. What else, let me see. So, as far as in your profession so far, can you give any assessments or evaluations that you're most familiar with or used most often…that you've seen benefits in that are possibly function- and/or occupation-based?

Jim Hinojosa: Well, I'm in pediatrics.

Beth: Okay.

Jim Hinojosa: [Laughs] And my particular perspective comes from the frame of reference which, you know, is the theoretically-based guideline.

Beth: Mhmm.

Jim Hinojosa: Because of that, I think that the evaluation tool should be consistent with the frame of reference that you're using.

Beth: Okay.

Jim Hinojosa: So, it there a one that I like better than the other? Obviously, if it's sensory integration map…if it's earlier by Miller…Ayers, of course, is the strongest one for sensory

integration. I think, in terms of functional assessments, there are very few actual, other than observation and checklists, ADL evaluations for young children yet.

Beth: Okay.

Jim Hinojosa: And I think you see people, like Ann Fischer and others, beginning to develop those tools.

Beth: Mhmm.

Jim Hinojosa: AMPS. The AMPS, for example, for children. Or in school-aged children, of course, you have the School Assessment.

Beth: Right.

Jim Hinojosa: So there are all these assessments that are coming out, but they're very specific to the environment that I think they're kind of emerging…become very specific now. In pediatrics, it was too easy to use developmental checklists.

Beth: Mhmm. [Laughs]

Jim Hinojosa: [Laughs] Right?

Beth: Yeah.

Jim Hinojosa: You know, they can roll. Okay? And then go from there.

Beth: Right. I know we talked about evidence-based—

Jim Hinojosa: Mhmm.

Beth: …and making standardized assessments, but how did you feel about the non-standardized assessments? Do you think that they still are as encompassing as standardized assessments are… how do you feel about things like just using observation, or…?

Jim Hinojosa: Well, I think observation is critical for OTs because we're interested in real life occupations, what they do in real life.

Beth: Mhmm.

Jim Hinojosa: I support both standardized and non-standardized evaluations. I think the issue with non-standardized evaluations is that you have to be very clear about what you're observing and what you're documenting.

Beth: Mhmm.

Jim Hinojosa: It can't just be open-ended kind of, you know, write to your diary kind of thing.

Beth: Mhmm.

Jim Hinojosa: It has to be very very specific. I think there's more strength, actually, in the current researches being done with ipsilateral…kind of evaluations. And there are like evaluations that are coming out of Canada, the Scope evaluation out of Australia. These are evaluations that are standardized only in terms of procedure, they're not standardized in what you view. So they're

really standardized evaluations, so they evaluate in terms of context and often in terms of the patient priorities.

Beth: Okay.

Jim Hinojosa: They probably are emerging more in countries that have socialized medicine than in the United States because they're not under as much pressure—

Beth: Mhmm.

Jim Hinojosa: …to substantiate their validity or their usefulness in terms of a treatment approach. But I think they're being used more and more in the United States. We'll begin to use more and more of those kinds of assessments. So they're in between the standardized, non-standardized. But their procedures for collecting data are observational. It's very very standardized.

Steph: Okay. You talked a little bit about the reimbursement and the external forces. We kind of want to talk a little bit about that…extremely concentrated on the past, like 10 years or so.

Jim Hinojosa: Mhmm.

Beth: So can you talk a little bit more about how that's influencing our evaluations as a profession?

Jim Hinojosa: Yep. How far back do you want me to go, 1970?

Beth: [Laughs]

Stephanie: [Laughs]

Jim Hinojosa: I will start, let me start, historically though. Prior to World War II, OT was considered a medical service.

Beth: Mhmm.

Jim Hinojosa: And therefore, it was bundled into healthcare costs. You went to the hospital, you got OT, it didn't matter about reimbursement. It was just like nursing or—

Beth: Mhmm.

Jim Hinojosa: …or other care. With the…beginning or Medicare and Medicaid in the 1940s…1945, really, after World War II, there began to be an un-bundling of healthcare services and the services then began to be billed individually. At the same time, certain reimbursements began to be written into the federal law for the first time. And it wasn't in the Vocational Rehabilitation Act in the early years, because it was a medical service it didn't need to be. But it became a specialized service after the war. Reimbursors, I think primarily third-party reimbursors, unbundled it completely. And with the unbundling, then there became pressure for accountability.

Beth: Mhmm.

Jim Hinojosa: Because I'm not going to pay for something if I don't know that is has a meaningful outcome.

Beth: Mhmm.

Jim Hinojosa: And at that point, I think we became under a lot of pressure to provide it, and that's in the healthcare arena. At the same time, in the early…after World War II, of course, we had the Polio epidemic and we had children that needed treatment. OTs and PTs were very active in treating children with Polio. And with this work with children with Polio, there also began then to provide services that directly related to children with disabilities in the schools. Now remember before the World War II, before there was Penicillin, children with disabilities usually didn't live to be that old.

Beth: Mhmm.

Jim Hinojosa: They usually passed away due to infections or other reasons. Now all of a sudden, we had this group of children who were basically school-aged, who needed to be functioning in school. And in order to function in school, they need positioning, they need the lap trays, they need all of these writing devices, and all of these things then began to merge into what would become school-based practice, because we were there indirectly.

Beth: Right.

Jim Hinojosa: So that would become education-related services in the Right to Education Act. So…well, at that point, if…again in the schools, if we were going to become a legitimate service in the schools, we had to have assessment tools. Because everything in schools is pretty much "you're graded." Right?

Beth: Mhmm.

Jim Hinojosa: You've been graded your whole life. You know it!

Beth: [Laughs]

Jim Hinojosa: And likewise, you had to have those criteria in schools. So at the same time that you have all of these pressures going on in physical disabilities—

Beth: Mhmm.

Jim Hinojosa: …which you can really identify in the schools who had a gradual change, and with this change then became again that accountability expert. And, again, then the tools became primarily beginning in preschools, again, with Miller Assessment and others. School-aged with, of course, Ayers. But then you also have this School Function Assessment and others that began to be developed in the 80s and 90s, which is kind of where we're at now.

Beth: Okay.

Jim Hinojosa: And I think now you're seeing even more specific tools being developed by OTs that relate to writing activities that relate particular…specifically to reading and other areas of academic success.

Beth: Have the recent health care changes with the Affordable Care Act done anything with assessments for occupational therapy? It may be too early to tell because it hasn't really been-—

Jim Hinojosa: Well, the Affordable Care Act is more accessibility in health care. If it's done anything…there are two aspects of the Act that are really important for OTs, and I'm not sure we're there yet. I think the first part is the accountability issue, right?

Beth: Mhmm.

Jim Hinojosa: And that we're kind of addressing. In the healthcare act, there is also prevention. And, as I've talked about in the past, we aren't very good about assessing for prevention, we're not really good about addressing prevention in general.

Beth: Mhmm.

Jim Hinojosa: For example, and the one that I use all the time is, a big priority has been weight loss.

Beth: Mm.

Jim Hinojosa: You know, and we talk about it. You hear PT exploiting it extremely well with exercise and its help. At the same time, we hear nothing about OTs, when…if it's daily life activity, routines, involvement in recreational activities, and other vocational kinds of activities, would also help contribute to help promotion and weight reduction, right? But we haven't done a very…we haven't gotten there yet, it's not a priority. We also don't have the manpower…we hardly can meet the needs that we now have, in both the schools and the healthcare system.

Steph: Mhmm. Wow, that's interesting.

Beth: In the one, you talked about going back a little bit to the history. I know we…you mentioned you…as AOTA had to create…I know we talked about the Uniform Terminology. There were documents before that, and then the OTPF came out. And we were reading—

Jim Hinojosa: Mhmm.

Beth: ... in your book the OTPF still doesn't really specify…it talks about the evaluation process, but it doesn't really talk about what should be assessed, what we should look at. It just says it's an important part to do.

Jim Hinojosa: Right.

Beth: How—

Jim Hinojosa: One of my major criticisms of the Framework has been the idea that an occupational profile is an adequate assessment. I think you have to do the occupational profile. I'm not arguing against the occupational profile at all, but I think that there needs to be a recognition, if this to be the kind of document they claim it's to be, that they also need to make accountability of the specific kinds of tools or areas that need to be assessed in areas of practice. And they need to recognize the importance of standardized and other kind of…non-standardized tools beyond the occupational profile.

Beth: Mhmm.

Jim Hinojosa: It's just too…it just doesn't sound, to me, if we're going to be a science-based profession, that we can say that we ground our intervention coming from our understanding of the individual. You know, it's more than that. It's their performance, their ability to engage, their

ability to participate, and how do we assess those in a manner that we can then say that we're doing it in an accountable way?

Beth: Mhmm. Are there…because there have been revisions to Uniform Terminology and to OTPF, is there any work to try to get that idea into practice?

Jim Hinojosa: I have…I have no idea.

Beth: No? Okay.

Jim Hinojosa: I mean, I would hope so. You know, when we developed…because I was on the original Uniform Terminology group. Uniform Terminology…it was never intended to be a document to describe the scope of practice. It was to be a document…first of all it came out of reimbursement.

Beth: Mhmm.

Jim Hinojosa: In the 1970s, somewhere, the federal government decided that they wanted a product output reporting system. And the product output reporting system was to determine what should the reimbursement be based on what you do? For example, should you pay a therapist giving ADL, the same as you would a therapist doing sensory integration? And the federal government was sent into this whole debate that…that no, that in fact, you know, doing ADL could be done by a COTA. It primarily was practice, repetition, you know, kind of a simplistic view of ADL, but their view of it at the time. And that if you were doing something like hand practice or sensory integration, it required advanced knowledge, it required more space, it required more utilization of things that cost money. So they made this mandate that the professions come up with a product output reporting system. Well, OTs being the good profession that we are, went ahead and started to develop this. And we developed it based upon, you don't need all the detail, but there are varying criteria like space, knowledge that was needed, so forth and so on were taken into it. Well, the only way that you can do that system is to have a way of defining what it is that we do. Right?

Beth: Mhmm.

Jim Hinojosa: So, define the domain, our area of expertise. And that's what Uniform Terminology came out to be. It was to support the product output reporting system. The federal government decided this is not a good idea, we're just going to pay for services. They pay for services, we then had the Uniform Terminology, which people love because it was a taxonomy, and it was clear, and you could, you know, actually go down and say these are the areas of occupation, these are the components, this is where they match. Therefore, this is relevant to OT and it supports our being there. All part of what should've been with the original document. It's only purpose was to be…to define our areas of expertise and to define it.

Beth: Mhmm.

Jim Hinojosa: Unfortunately, I think, this is my own view. When they went to the Framework, they expanded it to become almost a theoretical document and to define not only our domain of practice, but our scope of practice. And now they're talking about…this is all this inclusive of OT. In my opinion, that's dangerous, because it limits the growth. When you start talking about—

Beth: Mm.

Jim Hinojosa: …this is what we're only including in it, it's not a definition of terms any longer. It becomes a definition of the profession itself. And then you have to keep redefining it, but it also can stagnate the outer edge…the fringe edges of OT. We probably would never be in schools if we had a framework for OT that was done in the 1950s, right?

Beth: Right.

Stephanie: Right. Makes sense.

Jim Hinojosa: So, that's my view of it. And, you know, my hope would be…is that they would reconsider the document, go back to using it as a domain of concern and not a theoretical document, or a conceptual document, because it doesn't have any conceptual relationships really in it. And then it would be used more to support the progression rather than a document to define curriculums and intervention approaches and whatever, because it doesn't really do that.

Beth: Okay. And I never really looked at it that way, I guess. When, you know, we're taught freshman year, the OTPF, this is the Bible of your profession. You don't really—

Jim Hinojosa: And that's the problem!

Beth: [Laughs]

Stephanie: [Laughs]

Steph: Yeah, it is. I just wanted to ask one more thing, a little bit about…so we talked, again, about the reimbursement fees and the external factors, even talking about clinics themselves…the internal factors, maybe their productivity levels, different things like that. How…what do you think is important to our profession to try and keep the evaluations and assessments that we have developed functionally-based, because we have seen some evaluations used in our fieldworks that haven't really been functionally-based and we feel that is the basic foundation of OT.

Jim Hinojosa: I think you're absolutely on target. I think the challenge is how do we keep those functionally-based assessments?

Beth: Mhmm.

Jim Hinojosa: And how do we continue to refine them?

Beth: Mhmm.

Jim Hinojosa: I think the interesting thing with OT assessments is that we have to make sure they're OT assessments. And, just because we label something OT, doesn't necessarily make it OT.

Beth: Mhmm.

Jim Hinojosa: It may overlap with nursing, it may overlap with another profession. In general, that's okay, as long as there's a core that is either…we could label occupation-based or functionally-based. But we're not the only function-based profession—

Beth: Mhmm.

Jim Hinojosa: …and we have to realize that. Nursing is functionally-based now. And so, what we need to do is more, I think, in our settings, clearly define what it is that is our area of expertise, and how does it relate to participation in life.

Beth: Mhmm.

Jim Hinojosa: Whether it's participation in life in the hospital, participation in life as a student, participation in life in a community. And it's…if we don't capture that participation part, we're going to have trouble distinguishing ourselves between PT, OT, nursing, and speech. As they all see themselves functional—

Beth: Mm.

Jim Hinojosa: …because the federal government says you have to be functional in order to be funded.

Beth: Mhmm.

Jim Hinojosa: Well, what's different? You know, when it really comes down to it, is that participation aspect. That…can we do things in our life that give meaning? Can we interact with others? Can we do those kinds of things? And maybe we need to move away from measuring small component pieces, and work towards some broader areas—

Beth: Mhmm.

Jim Hinojosa: ...of participation.

Beth: So that kind of goes along with the bottom-up and top-down approaches—

Jim Hinojosa: Mhmm.

Beth: …that you were talking about.

Jim Hinojosa: Right.

Beth: So it seems…top-down seems to be…well, I guess, your opinion on it. What do we think in order to get the best assessment, which one should we follow?

Jim Hinojosa: I think the answer has to be, what is your clinical practice?

Beth: Okay.

Jim Hinojosa: And I think if you're in hand practice, you better be bottom-up.

Beth: Mhmm.

Jim Hinojosa: You better focus on the skeleton, you better focus on those tendons, you got to focus on those muscles. That's where that all the reimbursement is at, that's where all the value is.

Beth: Mhmm.

Jim Hinojosa: I don't think they should stop there. Okay? I think it's only the focus. I think every…really, a good evaluation will include all aspects of that. So, a person that's in hand

practice, definitely will have to start with the components, that's what they're paid for, but at some point, it will shift…it will be, can I use my hands for what I need to do with it? Can I—

Beth: Mm.

Jim Hinojosa: …participate in what I need to do? Can I engage in those activities I want to engage in? And without that, it isn't really, then, an OT…a comprehensive OT evaluation. Okay? The assessment though, would begin at the bottom.

Beth: Right.

Jim Hinojosa: Okay? In a school, that's…you know, they've argued, "well it has to be top-down." Well yeah, in some ways it does, because the first obligation of any school is socialization of a citizen, right? That's what schools are about.

Beth: Mhmm.

Jim Hinojosa: And if the child doesn't fit into that broader environment, then of course that's kind of where intervention gets to be. So, you assess that first, then it's going to narrow down to, can they write?

Beth: Mhmm.

Jim Hinojosa: Right? And that's going to be the bottom focus, whether you want it or not.

Beth: Mhmm.

Jim Hinojosa: Do they have adequate scapula mobility? Do they have enough, you know, mobility in their hands in terms of grasp to be able to use the utensil? What is the sensory kinesthetic or perceptive aspects? Those are all bottom, so it's not…what I was trying to argue in the article, is it's where the focus begins, where it's appropriate in your particular clinical practice.

Beth: Mhmm.

Jim Hinojosa: In the middle, in community-based kinds of practice…kind of, you have to go in more open-ended, you don't know which direction you're going to go.

Beth: Right.

Jim Hinojosa: In community mental health, right? It may end up being very specific to the…their routines at home.

Beth: Mhmm.

Jim Hinojosa: Or it may be very specific to a psychiatric symptom that you're going to have to deal with, specifically.

Beth: Right.

Jim Hinojosa: So, you know.

Steph: Okay. I guess, kind of, almost in closing, Rita wanted us to address maybe some important lessons that you have learned throughout your OT career, or how any of these seminal events regarding evaluations or assessments have influenced your career.

Jim Hinojosa: Probably, because I argued so much for assessment evaluation, I think that it…in some ways, I am considered the expert, when I'm really not, in evaluation.

Steph: [Laughs]

Jim Hinojosa: So, that part, I think, has been very valuable. I think the most important part for me is that I think as Chair of the Commission and in some of my publications, I make people at least think about what they're assessing and why they're assessing particular things. And looking at the evaluation process as a more clinically-based reasoning process, and not just doing an assessment or instrument or giving it to an individual and saying I completed the evaluation. That it's broader than that.

Beth: Mhmm.

Jim Hinojosa: Some of the new stuff that I'm writing, will be talking about more from a philosophical point of view, because I think we have to go back at some point, and ground our whole idea of our clinical reasoning, and how we make clinical judgments in a more sound box about what that process it.

Beth: Mhmm.

Jim Hinojosa: And I think it's the evolution of the profession that we're gradually shifting and changing, and I think that's healthy.

Beth: So, for us in our future practice, aside from not just doing an evaluation to do the evaluation. We need to focus on the client itself and picking a frame of reference to go with that client, and then picking the assessment. That's kind of the message that I'm taking away from what you're giving us in our future practice.

Jim Hinojosa: But I would also add context.

Beth: Mhmm.

Jim Hinojosa: Right?

Beth: Right.

Jim Hinojosa: And yeah, you need context, you need the individual, you need the assessment, you need the frame of reference…or the theoretical rationale, because it can be occupation-based which may or may not be a frame of reference.

Beth: Mhmm.

Jim Hinojosa: Right?

Beth: Okay.

Jim Hinojosa: It doesn't matter what the approach is, as long as it's appropriate for the context in which you're treating that meets the client's needs.

Beth: Mhmm.

Stephanie: Okay.

Jim Hinojosa: And your expertise, because you can't leave your expertise out of it.

Beth: Right.

Jim Hinojosa: I mean, if you're not trained in sensory integration, you probably shouldn't be giving it to someone.

Beth: Mhmm.

Jim Hinojosa: Right?

Beth: Do you…is that seems to be a problem, competency with assessments and OTs giving them without being competent in them? Does that seem that seem to be a big problem for practice?

Jim Hinojosa: I think in the practice areas, that, and maybe it's just my hopeful way of believing—

Beth: [Laughs]

Jim Hinojosa: …is that OTs, if they're going to use an instrument, do establish competence in the use of that instrument.

Beth: Mhmm.

Jim Hinojosa: And I think there's more focus on fieldwork in some sites on assuring the fact that you're competent in assessing adequately and using the instrument correctly, following standardized procedures. Is there still some sloppiness in it? Yeah. Some of it, again, is out of control of the therapist. Their context which…a lot of pressure to see a lot of clients, and sometimes there are other reasons.

Beth: Okay. For us in our paper, you said you're continuing to do research, but is there any other author you think that we should go into, to get another perspective on?

Jim Hinojosa: I think it's…you might want to look at Ann Fischer's work.

Beth: Okay.

Jim Hinojosa: Especially her publication in…I think it's the *Swedish Journal of Occupational Therapy*, where she talks about occupation-based assessment. It's…I think an interesting alternate approach. I also…I mean, your focus is on the United States, right?

Beth: Right. In the second part of our paper, we're allowed to branch out to international journals—

Jim Hinojosa: Mhmm.

Beth: …and we've been doing that in our research, and it's interesting to see, even from the publications, the different parts of evaluations and assessments that they choose to focus on.

Stephanie: Mhmm.

Beth: But the main purpose is for the United States.

Jim Hinojosa: Right, yeah. Yeah, I would say, the…that would probably be a good one to look at.

Beth: Okay.

Stephanie: Okay.

Jim Hinojosa: Okay?

Steph: I guess that's everything that we have. Is there any questions that you have for us?

Jim Hinojosa: No.

Beth: [Laughs]

Stephanie: [Laughs]

Jim Hinojosa: I hope you enjoyed it.

Beth: We did.

Stephanie: We did, I actually learned a lot. Because I learned a lot of different viewpoints that I never really…I never really looked at the OTPF as you explained it. And like she said, in school ever since day one, I mean we had to know the OTPF forward and backwards.

Jim Hinojosa: I know.

Beth: And now, seeing your viewpoint, it's like "Wow, maybe this isn't…this shouldn't be our whole bible." Because you're right, it doesn't leave much room for expanding.

Jim Hinojosa: Right. You have to expand, trust your own intuition.

Beth: Mhmm.

Jim Hinojosa: And realize that change is going to happen.

Beth: Right.

Jim Hinojosa: And you have to be ready for it. I think that's the thing that's been evident in OT history is that, as demands have changed—

Beth: Mhmm.

Jim Hinojosa: …we dramatically change to adapt to them, sometimes too soon, like we did with the product output reporting system. But I think it's very healthy as a profession that we do that.

Beth: Right, good.

Jim Hinojosa: Okay?

Beth: Alright.

Jim Hinojosa: If you think of any other questions, feel free to email them to me.

Beth: Okay, absolutely.

Stephanie: Thank you so much.

Beth: Thank you.

Jim Hinojosa: Good luck with your paper.

Beth: Thank you so much.

Jim Hinojosa: Alright, bye.

Beth: Bye.