

The American Occupational Therapy Association
July 9, 2018



OT Practice[®]

Sensory Focus

Support for Kids and Families

Also in This Issue

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Spinal Cord Injuries

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2 Editor's Note

3 News

9 Capital Briefing

New Patient-Driven Payment Model Will Change SNF PPS Payment

20 Fieldwork Issues

Reflections From Fieldwork Educators in Specialty Practice: Aligning Experiences to Generalist Student Outcomes

23 In the Classroom

Supporting Participation for Children With Sensory Processing Differences in an Early Childhood Center

26 In the Community

The Lions Club and Occupational Therapy: Working Together to Address Low Vision

29 Continuing Education Opportunities

32 Employment Opportunities



Cover Story

10 Family Engagement

Supporting Children With Sensory Processing Differences

Children and their caregivers should be involved in all phases of the occupational therapy process to set goals, prioritize interventions, and plan for discharge.

By Stacey Reynolds and Lauren Andelin

16 Strong Support

Determining Functional, Cognitive Status in Elderly Clients With Spinal Cord Conditions

Comorbidities in combination with a SCI are most effectively addressed using a client-centered, holistic, and collaborative approach.

By Marcelo Silva



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Mission statement: The American Occupational Therapy Association advances occupational therapy practice, education, and research through standard setting and advocacy on behalf of its members, the profession, and the public.

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Editor's Note

Supporting Clients' Needs

This issue highlights the support occupational therapy provides to clients and their families in a few different areas. For kids with sensory processing issues and their families, a couple of articles lay out steps occupational therapy practitioners working in schools and in the home may take to help students achieve their very best in play, self-care, and learning. For older clients, articles include how occupational therapists may best assess spinal cord injury (p. 16), and a volunteer effort in Connecticut between the international service organization Lions Club and occupational therapists trained to assist clients with low vision issues (p. 26).

What do you look for in a magazine or other type of publication? It may basically just be to find out what other people are doing—in your profession (like in a trade or professional magazine, such as *OT Practice*); in the worlds of entertainment or culture (like in *US Weekly* or *Vogue*); or in the areas of politics and economics (like in *Time* or *The Economist*). Along with the growing Practitioners in the News section (remember to send your items to news@aota.org), *OT Practice* is launching a couple of additional practitioner-centric departments: “Ask the Expert,” to complement a popular addition this year in Salt Lake City to the AOTA area of the Annual Conference Exhibit Hall, and “Member Spotlight,” to feature occupational therapy practitioners for their professional accomplishments, interesting or notable hobbies or backgrounds ... or what have you! See the related news item on p. 5 and email your questions and suggestions to otpractice@aota.org.

Also discussed in this issue is AOTA's participation in the Choosing Wisely® initiative, which works to ensure that interventions and assessments are supported by evidence, not duplicative of other tests or procedures already received, free from harm, and truly necessary. For more on this, see the related item on page 6.



Best regards,

Ted McKenna

Ted McKenna, Editor, *OT Practice*, tmckenna@aota.org

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 - Send email regarding editorial content to otpractice@aota.org.
 - Go to www.aota.org/otpractice to read *OT Practice* online.
 - Visit our Web site at www.aota.org for contributor guidelines, and additional news and information.

OT Practice serves as a comprehensive source for practical information to help occupational therapists and occupational therapy assistants to succeed professionally. *OT Practice* encourages a dialogue among members on professional concerns and views. The opinions and positions expressed by contributors are their own and not necessarily those of *OT Practice*'s editors or AOTA.

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Back issues are available prepaid from AOTA's Membership department for \$16 each for AOTA members and \$24.75 each for non-members (U.S. and Canada) while supplies last.

Proposed Changes to Quality Reporting for the 2019 Inpatient Rehabilitation Facility Prospective Payment System Rule

The fiscal year (FY) 2019 Inpatient Rehabilitation Facility Prospective Payment System (IRF PPS) proposes significant changes with regard to quality reporting for an IRF. The Centers for Medicare & Medicaid Services (CMS) propose removing the Functional Independence Measure (FIMTM) Instrument and associated function modifiers from the Inpatient Rehabilitation Facility Patient Assessment Instrument (IRF PAI) in FY 2020. CMS proposes to replace the FIMTM with function data collected pursuant to the Improving Medicare Post-Acute Care Transformation Act of 2014 (IMPACT Act) known as Section GG, which the agency refers to as the data items from the Quality

Indicators section of the IRF PAI, as the new basis of the Case Mix Groups (CMGs) for the IRF PPS.

AOTA supports IMPACT Act implementation and the broader goal of standardized data collection across post-acute care settings but also commented in support of CMS-sponsored trainings and additional educational preparation opportunities to minimize disruption and confusion among IRF staff. Although CMS believes that collecting the FIMTM items and associated function modifiers is no longer necessary and that the continued collection of FIMTM items, in addition to the IMPACT Act functional data reporting, places undue burden on IRFs, AOTA also understands that this will be a significant administrative and opera-

tional change for the IRF industry, likely requiring preparation, training, and transition time.

Further, AOTA recognizes that there are concerns with the sensitivity of some items in Section GG. In addition, AOTA is analyzing a provision in the proposed rule that would allow the rehabilitation physician to lead the interdisciplinary team meeting remotely, without additional documentation requirements, to allow flexibility and convenience. AOTA is considering whether this flexibility should be extended to other interdisciplinary team members, including occupational therapists, and whether existing technology would allow for these types of remote interactions.

AOTA is currently developing comments about the proposed changes. AOTA encourages practitioners to review the CMS factsheet on IRF PPS Proposed Rule and the Section GG Quality reporting Program Provider Training at <https://go.cms.gov/2jdxcnW>. For updates on this and other Federal Regulatory Affairs issues, visit www.aota.org/advocacy-policy/federal-reg-affairs. For questions, email regulatory@aota.org.



ILLUSTRATION © BEI_NORIE / GETTY IMAGES

Survey on Effects of Technology on Well-Being

Occupational therapy practitioners, managers of occupational therapy services, students, educators, and researchers are invited to participate in a survey by Online Technology for Occupational Therapy and the World Federation of Occupational Therapists to explore the role of occupational therapy in supporting well-being in a “tech-saturated world.” The survey, which takes about 10 minutes to complete, is available at www.surveymonkey.com/r/Techworld_Wellbeing.



ILLUSTRATION © CATHAL STAHLER / GETTY IMAGES

Cooper Hewitt Museum Exhibit on Accessibility Includes OT

A new exhibit at the Cooper Hewitt Museum in New York City on the subject of accessibility mentions the related value of occupational therapy. Curators consulted with occupational therapists in deciding which items to include in the exhibit, which runs through September 3. See the article in the *Washington Post* at <https://wapo.st/2I0ev0Z> and find out more about the exhibit at www.cooperhewitt.org/channel/access-ability.



Several dozen AOTA members, shown here, were among the approximately 2,000 delegates attending the World Federation of Occupational Therapists (WFOT) Congress 2018, held in May in Cape Town, South Africa. For highlights, including links to videos of the opening keynote and plenary presentations, visit <http://wfotcongress.org/>.

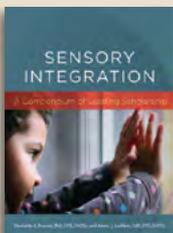
—PHOTO COURTESY OF KAREN JACOBS.

Resource

SAMHSA Course Available for Specialists Addressing Mental Health

The Substance Abuse and Mental Health Services Administration (SAMHSA) Recovery to Practice eLearning course “Information for Peer Specialists Serving People with Mental Health Conditions Experiencing Homelessness” is now available at <https://adobe.ly/2Ja7i3L>.

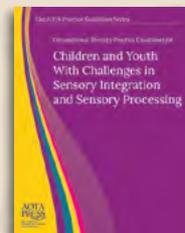
AOTA for You



Sensory Integration: A Compendium of Leading Scholarship
C. B. Royeen & A. J. Luebben

This book collects the latest research on, debates about, and trends for this timely topic and is ideal

for occupational therapy clinicians, students, and researchers, as well as other health care professionals. **\$39 for members, \$49 for nonmembers.** Order #1248.



Practice Guidelines for Children and Youth With Challenges in Sensory Integration and Sensory Processing
R. Watling, H. Kuhaneck, D. Parham, & R. Schaaf

This book defines the occupational therapy domain,

process, and interventions within the boundaries of best practice and makes recommendations for specific methods of care. eBook **\$59 for members, \$99 for nonmembers.** Order #900483.



To Order: <http://store.aota.org> (enter order # preferred) or call 800-729-2682

Academic News



Cynthia S. Bell, PhD, OTR/L, FAOTA, an Associate Professor and Chair of the Occupational Therapy Program at Winston-Salem State University (WSSU), in North Carolina, was awarded the 2018 Board of Governors Award for Excellence in Teaching, which included a commemorative bronze medallion and a \$12,500 cash prize.



Glen Gillen, EdD, OTR, FAOTA, was named Director of the Programs in Occupational Therapy, Vice-Chair of the Department of Rehabilitation and Regenerative Medicine, and Assistant Dean of the Vagelos College of Physicians and Surgeons of Columbia University, in New York City. He will begin this new role on September 1, succeeding Janet Falk-Kessler, who is retiring. Gillen most recently was a Professor and Associate Program Director for Occupational Therapy at Columbia.

Winston-Salem State University received a \$2.4 million grant from the U.S. Department of Education HBCU (Historically Black Colleges and Universities) Graduate Fellowship for scholarships, tutoring, and support for students and faculty in six STEM (science, technology, engineering, and mathematics) and health care graduate programs, including occupational therapy. For the spring semester, the grant funded 15 master of occupational therapy fellowships and scholarships.



The inaugural class at **Walsh University's Master of Occupational Therapy Program**, in North Canton, Ohio, partnered with a local therapist, **Amy Smith**, OTR/L, CEAS, to run a CarFit station at the 2018 Senior Summit, hosted by the county probate court. The students learned CarFit principles on campus prior to the event and are now officially trained CarFit technicians.

New OT Practice Columns on the Horizon

Ask the Expert

Got a quick question about practice, the workplace, or any other aspect of client care or/and occupational therapy life? *OT Practice* is launching a new column called "Ask the Expert." Email otpractice@aota.org to have your questions considered for a future issue of the magazine by members of the Special Interest Section Standing Committees and other subject matter experts!

Member Spotlight

Know an AOTA member who deserves to be highlighted in the magazine for their work in occupational therapy? Email suggestions to otpractice@aota.org for a new *OT Practice* column highlighting AOTA members!



Online Course: Sensory Processing Concepts and Applications in Practice
W. Dunn
Earn .2 AOTA CEU (2.5 NBCOT PDUs/2 contact hours). Participants in this new program from AOTA will examine the core concepts

of sensory processing, based on Dunn's Model of Sensory Processing. **\$65 for members**, \$89 for nonmembers. Order #OL4834.



A Contemporary Occupational Performance Approach to Pediatric Self-Regulation Part II: Self-Regulation Intervention Framework and Strategies
T. Henry & M. Gronski
Earn .1 AOTA CEU (1.25 NBCOT PDUs/1 contact hour).

This course presents a theoretically sound, evidence-based, developmentally driven method for approaching each individual child's self-regulation needs. **\$24.99 for members**, \$34.99 for nonmembers. Order #OL4931.



Questions?: 800-SAY-AOTA (members); 301-652-AOTA (nonmembers and local callers)

AOTA Joins Choosing Wisely Campaign

AOTA recently published “Five Things Patients and Providers Should Question” through the ABIM Foundation (American Board of Internal Medicine) Choosing Wisely initiative. Choosing Wisely aims to promote meaningful conversations between practitioners and clients to ensure that appropriate and quality care is being provided. Specifically, the aims of this initiative are to ensure that interventions and assessments are supported by evidence, not duplicative of other tests or procedures already received, free from harm, and truly necessary.

The 5 recommendations are:

1 **Don't provide intervention activities that are non-purposeful (e.g., cones, pegs, shoulder arc, arm bike).** Purposeful activities—tasks that are part of daily routines and hold meaning, relevance, and perceived utility such as personal care, home management, school, and work—are a core premise of occupational therapy. Research shows that using purposeful activity (occupation) in interventions is an intrinsic motivator for patients. Such activities can increase attention, endurance, motor performance, pain tolerance, and engagement, resulting in better patient outcomes. Purposeful activities build on a person's ability and lead to achievement of personal and functional goals. Conversely, non-purposeful activities do not stimulate interest or motivation, resulting in reduced patient participation and suboptimal outcomes.

2 **Don't provide sensory-based interventions to individual children or youth without documented assessment results of difficulties processing or integrating sensory information.** Many children and youth are affected by challenges in processing and integrating sensations that negatively affect their ability to participate in meaningful and valued occupations. Processing and integrating sensations are complex and result in individualized patterns of dysfunction that must be addressed in personalized ways. Interventions that do not target the documented patterns of dysfunction can produce ineffective or negative results. Therefore, it is imperative to assess and document specific sensory difficulties before providing sensory-based interventions such as Ayres Sensory Integration®, weighted vests, listening programs, or sensory diets.

3 **Don't use physical agent modalities (PAMs) without providing purposeful and occupation-based intervention activities.** The exclusive use of PAMs (e.g., superficial thermal agents, deep thermal agents, electrotherapeutic agents, mechanical devices) as a therapeutic intervention without direct application to occupational performance is not considered occupational therapy. PAMs provided with a functional component can lead to more positive health outcomes. PAMs should be integrated into a broader occupational therapy program and intervention



An initiative of the ABIM Foundation

plan in preparation for or concurrently with purposeful activities or interventions that ultimately enhance engagement in occupation.

4 **Don't use pulleys for individuals with a hemiplegic shoulder.** Use of an overhead pulley for individuals with a hemiplegic shoulder resulting from a stroke or other clinical condition is considered too aggressive and should be avoided, as it presents the highest risk of the patient developing shoulder pain. Gentler and controlled range of motion exercises and activities are preferred.

5 **Don't provide cognitive-based interventions (e.g., paper-and-pencil tasks, table-top tasks, cognitive training software) without direct application to occupational performance.** To improve occupational performance, cognitive-based interventions should be embedded in an occupation relevant to the patient. Examples of cognitive-based interventions include awareness approaches, strategy training, task training, environmental modifications, and assistive technology. The use of cognitive-based interventions not based on occupational performance will result in suboptimal patient outcomes.

These items are provided solely for informational purposes and are not intended as a substitute for consultation with a medical professional. Patients with any specific questions about the items on this list or their individual situation should consult their health care provider.

How This List Was Created

Led by Project Champion Glen Gillen, EdD, OTR, FAOTA, Associate Director and Professor of Rehabilitation and Regenerative Medicine (Occupational Therapy) at Columbia University Medical Center, the American Occupational Therapy Association (AOTA) conducted a three-phase project to develop the final Choosing Wisely recommendations of services that occupational therapy practitioners should not provide. The phases of the project included Phase I—building member awareness and support, Phase II—soliciting member input, and Phase III—dissemination of the final items. Phase I was accomplished through presentations to AOTA member and volunteer groups, a Town Hall session at AOTA Annual Conference, an online webinar and related materials, and coverage in AOTA publications. Phase I was completed with an online member survey that resulted in 328 responses. Following the elimination of duplicate responses and items outside the scope of occupational therapy practice, the list was narrowed down to 62 items. Additional input was received from AOTA Special Interest Section volunteer leaders to rank the items based on established criteria. An extensive literature search was conducted on the highest ranked strategies. Phase II involved an online member survey presenting 12 items for evaluation with a goal of picking the top 5. This survey resulted in 4,860 responses that were analyzed, resulting in the final 5 items. These items were reviewed by the AOTA Board of Directors. Phase III included the development of a communication and dissemination plan.

AOTA's disclosure and conflict of interest policy can be found at www.aota.org.

AOTA is committed to helping OT practitioners implement the recommendations in practice and to facilitating ongoing dialogue about the campaign. All related information and opportunities about the campaign will be posted on the AOTA website at <http://www.aota.org/Practice/Researchers/choosing-wisely.aspx>.

Sources

- American Occupational Therapy Association. (2014). *Occupational therapy practice framework: Domain and process (3rd ed.)*. *American Journal of Occupational Therapy*, 68(Suppl. 1), S1–S48. <https://doi.org/10.5014/ajot.2014.682006>
- Hinojosa, J., & Blount, M. (Eds.). (2017). *The texture of life: Occupations and related activities*. Bethesda, MD: AOTA Press.
- Hsieh, C. L., Nelson, D. L., Smith, D. A., & Peterson, C. Q. (1996). A comparison of performance in added-purpose occupations and rote exercise for dynamic standing balance in persons with hemiplegia. *American Journal of Occupational Therapy*, 50, 10–16. <https://doi.org/10.5014/ajot.50.1.10>
- Lin, K., Wu, C., Tickle-Degnen, L., & Coster, W. (1997). Enhancing occupational performance through occupationally embedded exercise: A meta-analytic review. *Occupational Therapy Journal of Research*, 17(1), 25–47. <https://doi.org/10.1177/153944929701700102>
- Steinbeck, T. (1986). Purposeful activity and performance. *American Journal of Occupational Therapy*, 40, 529–534. <https://doi.org/10.5014/ajot.40.8.529>
- Bodison, S. C., & Parham, L. D. (2018). Specific sensory techniques and sensory environmental modifications for children and youth with sensory integration difficulties: A systematic review. *American Journal of Occupational Therapy*, 72, 7201190040. <https://doi.org/10.5014/ajot.2018.029413>
- Council for Exceptional Children. (2014). *Council for Exceptional Children standards for evidence-based practices in special education*. Retrieved from <http://www.cec.sped.org/~media/Files/Standards/Evidence%20based%20Practices%20and%20Practice/EBP%20FINAL.pdf>
- Council for Exceptional Children. (2015). CEC's standards for classifying the evidence base of practices in special education. *Remedial and Special Education*, 36, 220–234.
- Pfeiffer, B., May-Benson, T. A., & Bodison, S. C. (2018). Guest Editorial—State of the science of sensory integration research with children and youth. *American Journal of Occupational Therapy*, 72, 7201170010. <https://doi.org/10.5014/ajot.2018.721003>
- Schaaf, R. C., Dumont, R. L., Arbesman, M., & May-Benson, T. A. (2018). Efficacy of occupational therapy using Ayres Sensory Integration®: A systematic review. *American Journal of Occupational Therapy*, 72, 7201190010. <https://doi.org/10.5014/ajot.2018.028431>
- Schaaf, R., & Mailloux, Z. (2015). *Clinician's guide for implementing Ayres Sensory Integration®: Promoting participation for children with autism*. Bethesda, MD: AOTA Press.
- Watling, R., Kuhaneck, H., Parham, D., & Schaaf, R. (2018). *Occupational therapy practice guidelines for children and youth with challenges in sensory processing and sensory integration*. Bethesda, MD: AOTA Press.
- American Occupational Therapy Association. (2012). Physical agent modalities: A position paper. *American Journal of Occupational Therapy*, 66(6_Suppl.), S78–S80. <https://doi.org/10.5014/ajot.2012.66S78>
- Bracciano, A. G. (2008). *Physical agent modalities: Theory and application for the occupational therapist (2nd ed.)*. Thorofare, NJ: Slack.
- Kim S. H., Park J. H., Jung M. Y., & Yoo, E. Y. (2016). Effects of task-oriented training as an added treatment to electromyogram-triggered neuromuscular stimulation on upper extremity function in chronic stroke patients. *Occupational Therapy International*, 23, 165–174. <https://doi.org/10.1002/oti.1421>
- Nakano, J., Yamabayashi, C., Scott, A., & Reid, W. D. (2012). The effect of heat applied with stretch to increase range of motion: A systematic review. *Physical Therapy in Sport*, 13, 180–188. <https://doi.org/10.1016/j.ptsp.2011.11.003>
- Cotoi, A., Viana, R., Wilson, R., Chae, J., Miller, T., Foley, N., & Teasell, R. (2016). Painful hemiplegic shoulder. In R. Teasell, N. Hussein, N. Foley, & A. Cotoi (Eds.), *Evidence-based review of stroke rehabilitation (17th ed., pp. 1–56)*. Ontario: Canadian Partnership for Stroke Rehabilitation.
- Kumar, R., Metter, E. J., Mehta, A. J., & Chew, T. (1990). Shoulder pain in hemiplegia: The role of exercise. *Archives of Physical Medicine and Rehabilitation*, 69, 205–208.
- American Occupational Therapy Association. (2013). Cognition, cognitive rehabilitation, and occupational performance. *American Journal of Occupational Therapy*, 67(6 Suppl.), S9–S31. <http://doi.org/10.5014/ajot.2013.67S9>
- Cicerone, K. D., Langenbahn, D. M., Braden, C., Malec, J. F., Kalmar, K., Fraas, M., . . . Ashman, T. (2011). Evidence-based cognitive rehabilitation: Updated review of the literature from 2003 through 2008. *Archives of Physical Medicine and Rehabilitation*, 92(4), 519–530. <http://doi.org/10.1016/j.apmr.2010.11.015>
- Gillen, G., Nilsen, D. M., Attridge, J., Banakos, E., Morgan, M., Winterbottom, L., & York, W. (2015). Effectiveness of interventions to improve occupational performance of people with cognitive impairments after stroke: An evidence-based review. *American Journal of Occupational Therapy*, 69(1), 6901180040. <http://doi.org/10.5014/ajot.2015.012138>
- Smallfield, S., & Heckenlaible, C. (2017). Effectiveness of occupational therapy interventions to enhance occupational performance for adults with Alzheimer's disease and related major neurocognitive disorders: A systematic review. *American Journal of Occupational Therapy*, 71(5), 7105180010. <http://doi.org/10.5014/ajot.2017.024752>

Practitioners in the News

Lucia Arellano, OTR/L, was featured in an ABC-7 Chicago report (<https://abc7.ws/2MIqT94>) for her work at La Rabida Children’s Hospital in its new therapy kitchen.

Peggy P. Barco, OTD, an Assistant Professor of Occupational Therapy and Medicine at Washington University Medical School in St. Louis, contributed an essay on “The Older Driver” to the free, nonprofit, non-commercial MerckManuals.com, an online version of the Merck Manuals medical reference books.

Patty Coker-Bolt, PhD, OTR/L, FAOTA, a Professor of Occupational Therapy at the Medical University of South Carolina, in Charleston, recently provided a workshop (pictured below) on pediatric constraint-induced movement therapy to physicians and therapists in Vietnam. This training was part of the U.S. Agency for International Development’s (USAID) Advancing Medical Care and Rehabilitation Education project, which aims to enhance the health and well-being of Vietnamese persons with disabilities by providing higher quality and sustainable services. Coker-Bolt was part of the team that developed USAID’s new Rehabilitation Guidelines for the Management of Children with Cerebral Palsy.



Karen Dobyns, OTD, MOT, OTR/L published a picture book called *The Centipede Who Couldn’t Tie His Shoes*, which has an occupational therapist in the storyline. She also had a craft, “Activity Dice,” published in the June 2018 issue of *Highlights for Children* magazine.

Susan Denham, EdD, OTR/L, CHT, an Assistant Professor of Occupational Therapy at Alabama State University, was quoted in an Associated Press article about the need for a growing number of health care professionals to serve Alabama’s aging population.

Joy Doll, OTD, OTR/L, Associate Professor of Occupational Therapy and Executive Director of the Center for Interprofessional Practice, Education, and Research at Creighton University, recently gave a TEDx talk on “Collaboration in Health Care: The Journey of an Accidental Expert?” (<https://bit.ly/2I78M9s>).

Bill Janes, OTD, MSCI, OTR/L, was featured in an article on *emissourian.com* on creating a motorized toy truck to provide mobility for a child with spastic quadriplegic cerebral palsy.



David Goldstein, MS, OTR/L, was named a Public Health Analyst at the Centers for Medicare & Medicaid Services’ Center for Medicare and Medicaid Innovation, which entails managing and evaluating public health programs, projects, and study activities.

Erin Muston-Firsch, MS, OTR, was featured in a KUSA-TV NBC 9 (Colorado) piece on how adaptive gaming is making an impact on therapy (<https://on9news.tv/2JQcMgq>).

Susan Orloff, OTR/L, FAOTA, was interviewed for a news segment on a local CBS station in Atlanta about the value of specialized occupational therapy summer camps for children with special needs.

Anne Zachry, PhD, OTR/L, an Assistant Professor of Occupational Therapy at the University of Tennessee Health Science Center, is quoted in the *New York Times* in an article about Tummy Time for babies (<https://nyti.ms/2toO937>).

AOTA alerts

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AOTPAAC Board Vacancies: The Volunteer Leadership Development Committee seeks applications by July 13 for American Occupational Therapy Political Action Committee (AOTPAAC) Directors in Regions II, III, and IV.

Advocacy Update: Read about how your colleagues are advocating with Congress and NIH to expand rehab research efforts.

Evidence Byte: Interested in incorporating more evidence into your practice? Learn to

overcome common obstacles and set yourself up for success.

Digital Badges: Share your learning achievements with AOTA’s Digital Badges. We recently launched two new badges—low vision and fieldwork educators.

New Online Community: Check out AOTA’s new online community, CommunOT, where you can interact and share with your fellow AOTA members. Log in and participate in the conversations happening now.

New Patient-Driven Payment Model Will Change SNF PPS Payment

A proposed revision of the Patient-Driven Payment Model would rely on patient characteristics and remove therapy minutes as a determinant of SNF payment.

Jennifer Bogenrief

On May 8, 2018, the Centers for Medicare & Medicaid Services (CMS) published its proposed rule for the FY 2019 Skilled Nursing Facility (SNF) Prospective Payment System (PPS) (see <https://bit.ly/2HH9BX7>). The proposal includes a revised case-mix methodology called the Patient-Driven Payment Model (PDPM) to replace RUG-IV on October 1, 2019. The PDPM is a revision of last year's draft Resident Classification System, Version I (RCS-I). The PDPM would rely on patient characteristics and remove therapy minutes as a determinant of SNF payment. AOTA believes that important revisions are needed to improve the PDPM and protect patient access to care. AOTA submitted comments by the due date of June 26, 2018. We also drafted a template letter for occupational therapy practitioners to use to submit their own comments to CMS (see <https://bit.ly/2t51e2m>). Details of the CMS SNF PPS Payment Model Research, including TEP summaries, technical reports, and recommendations, can be found on the project page at <https://goo.gl/Jtl2tz>.

How Would PDPM Affect Access to OT Services?

Although AOTA recognizes the need for payment reform in SNFs, AOTA's primary concern with the PDPM is that patients may not have access to medically necessary occupational therapy services because of the model design. AOTA included the following points in our comments:

- We strongly support the separation of occupational therapy and physical therapy into two separate case-mix classifications to recognize the distinct differences between these therapies.
- CMS must continue to capture the minutes of individual, group, and concurrent therapy in the MDS Section O in order to ensure patient access to medically necessary occupational therapy. Therapists'

clinical judgment must be the deciding factor in determining the appropriate type of therapy for each individual patient.

- The proposed combined 25% limit on group and concurrent therapy for each discipline is reasonable and supported by previous policy. Group therapy should be defined as two to four patients, to allow patients in small or rural SNFs access to the benefits of group therapy.
- The PDPM does not reference cognition or feeding/swallowing in the occupational therapy payment component. This exclusion could inappropriately limit occupational therapy practitioners' roles in addressing these areas.
- The PDPM does not include co-morbidities in determining the occupational therapy or physical therapy payment components and does not even contemplate the effect of cumulative co-morbidities on patient needs and costs.
- CMS should include an evaluation of need for therapy services at appropriate intervals to support clinical judgment.
- The clinical reason for a resident's SNF stay plays a critical role in the PDPM. CMS must ensure that SNFs have access to timely and accurate information to complete this information and rely on it for payment purposes.
- PDPM implementation could be very confusing and burdensome. CMS should set forth a clear transition period. The PDPM should include provisions to allow future addition of improved and more frequent assessments and quality measures to better reflect patient status and therapy outcomes.

Please go to www.aota.org/advocacy-policy/federal-reg-affairs for more information and updates. 📄

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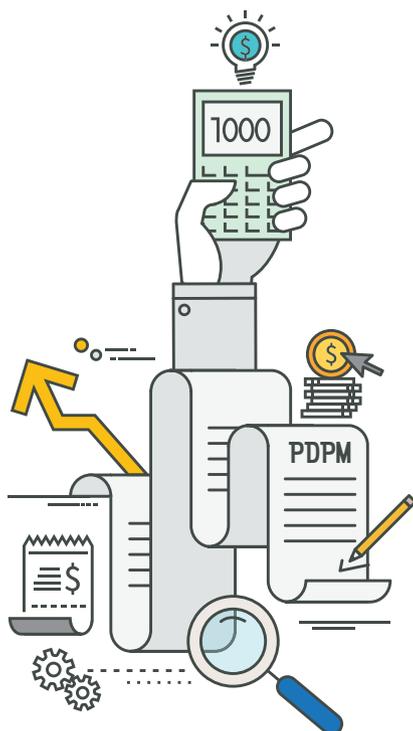


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Supporting Children With Sensory
Processing Differences

Family Engagement



Children and their caregivers should be involved in all phases of the occupational therapy process to set goals, prioritize interventions, and plan for discharge.

by Stacey Reynolds and Lauren Andelin

At 6 years of age, Isaac found the world to be confusing and overwhelming: sounds were too loud, things didn't feel right when he touched them, and his body just never seemed to do what he wanted it to. For Isaac, it was usually easier to not participate in activities, because when he did, he was often unsuccessful. For example, he avoided swings on the playground and games requiring climbing. Isaac's mom saw how much he was struggling and took him to see an occupational therapist (OT) at the Children's Hospital of Richmond at Virginia Commonwealth University. A thorough evaluation established that Isaac had difficulties in his ability to process and integrate sensory information and that these difficulties were affecting multiple areas of occupation, including self-care, play, and academic engagement. It was determined that Isaac would benefit from occupational therapy services to increase his participation in meaningful tasks and improve his overall organization of behavior. Goals were collaboratively established that focused on increasing Isaac's participation in gross motor play and self-care tasks as well as reducing the frequency and duration of meltdowns that occurred when he became anxious and overwhelmed. An initial plan of care was established that recommended occupational therapy outpatient services for Isaac and additional education and support for his caregivers.

Differences in Sensory Processing and Integration

Approximately 5% to 14% of typically developing children have some difficulties in sensory processing (Ahn et al., 2004), and this statistic is even higher in children, like Isaac, with autism spectrum disorder (Baranek et al., 2006). Difficulties in sensory processing can lead to poor modulation of sensory information from the environment as well as deficits in postural stability, visual-motor control, and motor planning (Bundy & Murray, 2002). Importantly, these deficits can affect functional participation and engagement in meaningful occupations. As such, occupational therapy practitioners are widely recognized as the professionals who are best suited to address difficulties in sensory processing and their effect on behavior and motor performance (Reynolds et al., 2012).

The process of working with children who have difficulties in sensory processing involves (1) conducting a comprehensive evaluation to assess and document specific sensory issues, (2) developing functional



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goals based on the child's needs and values, (3) implementing an intervention plan, and (4) reviewing progress toward functional goals and increased participation (Reynolds et al., 2017). In the case of Isaac, the comprehensive evaluation included caregiver-report questionnaires, a therapist-administered standardized motor assessment, and clinical observations based on sensory integration theory (Blanche, 2002). An occupational history was gathered through a semi-structured interview with Isaac and his mom. The OT was not able to observe Isaac at home or in the community, but his mother provided verbal descriptions of challenges and strengths during the evaluation and throughout the therapy process. Goal setting was done in conjunction with Isaac's family and Isaac himself; long-term goals focused on outcomes important for his participation in meaningful tasks, such as playing outside with others and transitioning into the school classroom each morning.

Child and Family Intervention Supports

When determining what interventions to use with children who have difficulties in sensory processing and integration, research supports using three primary intervention types: child-focused interventions, caregiver-focused interventions,

and environmental supports and modifications (Reynolds et al., 2017). Within each of these intervention types, multiple approaches may be considered. For example, child-focused interventions for a child with poor sensory modulation abilities may include sensory integration intervention (also known as Ayres Sensory Integration®) or sensory-based approaches that provide the child with the sensory input needed to elicit desired changes in behavior. Cognitive strategies may also be incorporated to help children understand how their sensory processing differences affect arousal and emotional states; programs that integrate these types of cognitive strategies with sensory integration theory include the Alert Program for Self-Regulation (Williams & Shellenberger, 1996) and the Zones of Regulation (Kuypers, 2011). For children with sensory-based motor disorders, child-focused interventions may also incorporate other tactics, such as biomechanical approaches for core strengthening, cognitive strategies for thinking through motor plans, and practice techniques for developmental skill building.

Caregiver-focused interventions are another integral part of supporting children with difficulties in sensory processing. These types of interventions may include educating caregivers about difficulties in sensory processing and how they affect observable behaviors. They may also

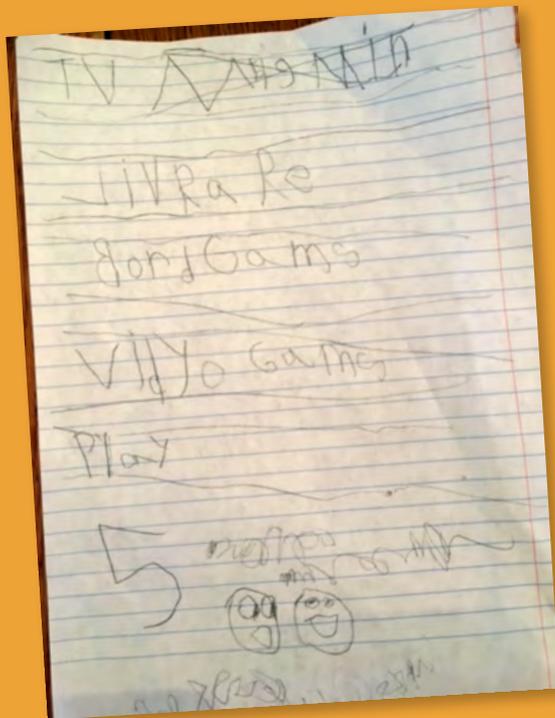
include coaching caregivers to carry over interventions at home, developing home programs for caregivers to implement, or making recommendations to caregivers about how a child can get needed sensory input throughout their day in a safe and age-appropriate manner. Caregiver-focused interventions may also be applied in school settings, with occupational therapy practitioners working with and coaching teachers and aides on how to provide supports throughout the school day.

Environmental supports and adaptations are those changes made to the physical, social, cultural, temporal, and/or virtual environments that enhance the child's success or active participation (American Occupational Therapy Association, 2014). Because differences in sensory processing can affect a child across multiple environments, ways in which the environment can be adapted or modified are limitless. Some examples include using tools to reduce environmental sensory stimulation (e.g., headphones, light covers); adapting clothing items (e.g., compression clothing, adapting fasteners); modifying seating or positioning; or posting visual schedules to help children understand task expectations and anticipate transitions (Reynolds et al., 2017). Importantly, although occupational therapy practitioners may work to modify environments for one specific child, research suggests that environmental modifications to classrooms and other health care environments may benefit all children, including those with differences in sensory processing (Cermak et al., 2015; Kinnealey et al., 2012).

Isaac, Part 2: Implementing an Intervention Plan

Isaac attended weekly, 1-hour outpatient occupational therapy services for 9 months. During these sessions, the OT primarily used a sensory integration intervention approach in which enhanced sensory experiences were presented in the context of meaningful and active play-based tasks. These child-focused sessions often incorporated obstacle courses or other sensory-motor tasks that provided Isaac with somatosensory and vestibular input that helped him know where his body was in space as well as attain an optimal state of arousal. Isaac also found it helpful to organize his sessions by writing a plan on a whiteboard and crossing off tasks as they

Figure 1. Visual Schedule Made by Isaac on Snow Day



were accomplished. Tasks were presented at the just-right challenge and in a play-based context so Isaac could gain confidence by trying out new motor tasks in a safe and supportive environment (Ayres, 1972). As Isaac's confidence and coordination improved, he began to generalize these skills into real world settings, like playing with his brother and peers on the playground.

The OT also introduced Isaac to the Alert Program for Self-Regulation (Williams & Shellenberger, 1996), and worked through the stages outlined in that program. Isaac used the concept of his body as a car's engine to understand his arousal levels and to make choices in his occupational therapy sessions about how to change those arousal levels. During one occupational therapy session, Isaac made a paper engine gauge that he brought home to share with his brother and dad. Isaac's mom also started making a point to talk about her own engine levels as well as identify engine levels in book or television characters so Isaac could readily incorporate the engine terminology into his everyday interactions and routines. Carryover at home began to lead to improvements in Isaac's ability to transition from the car into the school building each morning, because he was able to use engine terms and strategies to help him regulate his arousal state. The engine terminology

also gave Isaac and his family a way to communicate about his state of arousal that made sense to everyone. According to Isaac's mom, the supports provided in occupational therapy helped her "read my child and communicate with him about how he's feeling. I have learned what I can take on, and what Isaac can take on, and I have the tools to explain that to others."

In addition to implementing home-based strategies, Isaac's mom observed and participated in every outpatient occupational therapy session. Early on, she used strategies from sensory integration theory to help Isaac with his arousal levels. For example, the OT gave her a list of heavy jobs from the *Tools for Parents Handbook* (Henry & Wheeler, 2001) that Isaac could complete during daily tasks and routines. His mom immediately noticed a difference in Isaac's ability to participate during routine tasks such as grocery shopping when she used some of these strategies. For example, he started pushing the cart at the store for heavy work and lifting heavy cans and bags off the shelf to put in the grocery cart. He also started helping bring in the grocery bags from the car at the end of the trip. After seeing these improvements, his family began incorporating heavy jobs into more of their daily routines. For example, when the family watched

American Ninja Warrior together, Isaac's dad encouraged Isaac and his brother to do push-ups whenever someone fell in the water. Isaac also took ownership of chores, such as pushing and pulling the garbage can to the curb and carrying in bags of groceries with his mom. During one occupational therapy session, Isaac's mom noted that "there are so many [heavy jobs] that we can do as a family, and we do lots of activities that support Isaac without even realizing it now."

Observation during occupational therapy sessions also helped Isaac's mom appreciate how well Isaac responded to having lists and routines; she began making lists more frequently at home to help prepare Isaac for upcoming tasks and to plan out his day. Eventually, Isaac began using this strategy by himself to structure his time when he felt overstimulated or disorganized. Figure 1 shows a list Isaac made for himself when school was cancelled one day because of snow; his list includes TV (no Megamind), library, board games, video games, play, and 5 minutes of free time at the end to fill his unplanned time off school.

Through talking with and observing the OT, Isaac's mom also learned about how Isaac's difficulties in sensory processing affected his ability to function in certain environments. In particular, she noticed

Table 1. Intervention Plan and Outcomes for Isaac

Intervention Type	Intervention Approach	Outcomes
Child-focused Interventions	Sensory integration intervention	Isaac played on the playground with his peers and younger brother; not being afraid of swings or novel equipment
	Sensory-based Interventions	Isaac demonstrated confidence in his ability to engage in motor activities, whereas before he was afraid to try and frequently avoided these activities
	Cognitive approaches	Isaac joined a soccer team
Caregiver-focused Interventions	Parent/teacher education	Parent explained Isaac’s sensory processing differences to others, including Isaac’s teachers
	Parent coaching and participation during weekly sessions	Parent incorporated sensory diet activities throughout the week to help regulate arousal Parent started carrying around different foods (e.g., crunchy or chewy) so Isaac could ask for an appropriate snack when he needed something to help self-regulate Parent using the engine terminology to talk to Isaac during states of over-arousal—including transitioning into his classroom
	Environmental Supports and Adaptations	Both Isaac and his mom made a visual schedule to help structure his day, which led to fewer behavioral meltdowns Isaac was seated on the outside of the room at school to allow for taking breaks or standing at his desk

**Note: Table adapted from Reynolds et al., 2017*

that he had difficulty focusing in stimulating environments with a lot of noise or visual distractions. She also noticed that when Isaac was excited or nervous about an event or activity, he would ask to go to the bathroom frequently as an avoidance tactic. Isaac’s mom brought these insights to the individualized education program team’s attention, and when Isaac started first grade, she asked them to tape an engine gauge on his desk so he could remember to alert someone when he needed a break or an environmental change. Isaac’s mom said he was really excited when he came home from his first day of first grade to tell her that he had an engine on his desk. The school individualized education program team also worked with Isaac’s family to incorporate strategies at school to help with self-regulation; these included allowing Isaac to stand up at his desk or do jumping exercises near his seat when he needed a break. Throughout the year, when the teacher changed students’ seating within the classroom, she always made sure Isaac’s seat was on the outside of the room so he could take these breaks without disturbing others. (For more the intervention plan and outcomes, see Table 1.)

Supporting Children to be Discharged From Occupational Therapy

Determining when to discharge a child from occupational therapy services requires collaboration among the OT, the child, caregivers, and possibly other members of the medical or school team. Ideally, a plan for discharge is established during the initial evaluation and/or goal-setting session with the client; this helps both the therapist and the client understand the start and end parameters of the intervention (Bailes et al., 2008). Decisions about discharge, however, may be influenced by various factors, including the family’s insurance reimbursement, the child’s progress toward their goals, and the priorities of the child and the family. Some children with difficulties in sensory processing require attention during their daily routines and throughout their lifespan (Schaaf & Smith Roley, 2006). Discharge from occupational therapy services may be most appropriate when caregivers feel equipped to support the child’s sensory needs independently, and the child is able to participate more fully across home, school, and community-based settings. Support for a child with difficulties in sensory processing

may still continue in the form of periodic (“as needed”) or consultative services.

Isaac, Part 3: Review and Discharge

Throughout the intervention process, the OT continuously monitored progress toward Isaac’s therapy goals and solicited feedback from his mom about how changes observed in occupational therapy sessions were translating to home, school, and community settings. At the end of the summer (6 months into therapy), Isaac had made major progress toward his motor participation and self-regulation goals and was participating more successfully in home and community settings. However, Isaac’s mom was anticipating the start of the first grade school year and the need for putting supports in place to help with the transition. During the previous school year, Isaac had an extremely difficult time transitioning into his kindergarten classroom for at least 2 months. His mom had learned from observing the occupational therapy sessions that trying new things and transitions were much easier for Isaac when he was in an optimal state of arousal. For example, while Isaac had previously avoided swings and

other playground equipment, he had been able to try these things in a safe environment during times of optimal arousal in occupational therapy sessions. Based on Isaac's success in occupational therapy, these activities were not overstimulating, and he could now participate in them across environments. His mom extrapolated and realized these principles could apply to all new and challenging situations. She decided to bring Isaac to the new classroom to meet his new teacher at a time when no other students were in the building (outside of regular orientation hours) so he could get accustomed to the new environment without being overstimulated, which made walking into the new classroom much easier for Isaac on the first day of school.

After a very successful transition to the new school year, Isaac's mom and his OT started discussing his progress in therapy and what new goals the family were interested in pursuing. Although Isaac continued to have occasional difficulties in new situations, as well as episodes where he became overstimulated, his mom expressed confidence in the tools that Isaac and his family had learned throughout his time in occupational therapy. Based on the family's priorities and the success of the home programming, Isaac's mom and his OT agreed that he would continue with weekly sessions until the winter break at school. At that point, they decided that sessions would be on hold and Isaac's initial plan of care would remain open for 3 months in case new concerns arose or the family wanted to have a check-in appointment. For Isaac's last occupational therapy session before the break, his mom made a list of the top five priority areas for Isaac, and his OT made a list of activities to work on in each priority area through home programming. After the final session, Isaac's mom noted, "Over the past year during Isaac's time in occupational therapy, I have gotten the tools to fall back on to help my child succeed. And I have confidence in talking with others about what Isaac needs. I understand my child and how he feels, and that's a gift."

Conclusion

Supporting children with sensory processing difficulties includes providing various supports to them, their family, and other caregivers so outcomes can be carried over from the clinic into real world environments. To facilitate this process, children and their caregivers should be involved in

all phases of the occupational therapy process to set goals, prioritize interventions, and plan for discharge. 📌

References

- Ahn, R., Miller, L. J., Milberger, S., & McIntosh, D. (2004). Prevalence of parents' perceptions of sensory processing disorders among kindergarten children. *American Journal of Occupational Therapy*, 58, 287–293. <https://doi.org/10.5014/ajot.58.3.287>
- American Occupational Therapy Association. (2014). Occupational therapy practice framework: Domain and process (3rd ed.). *American Journal of Occupational Therapy*, 68(Suppl. 1), S1–S48. <https://doi.org/10.5014/ajot.2014.68.2006>
- Ayres, A. J. (1972). *Sensory integration and learning disorders*. Los Angeles: Western Psychological Services.
- Bailes, A., Reder, R., & Burch, C. (2008). Development of guidelines for determining frequency of therapy services in a pediatric medical setting. *Pediatric Physical Therapy*, 20, 194–198.
- Baranek, G. T., David, F. J., Poe, M. D., Stone, W. L., & Watson, L. R. (2006). Sensory Experiences Questionnaire: Discriminating sensory features in young children with autism, developmental delays, and typical development. *Journal of Child Psychology and Psychiatry*, 47, 591–601. <https://doi.org/10.1111/j.1469-7610.2005.01546.x>
- Blanche, E. I. (2002). *Observations based on sensory integration theory*. Torrance, CA: Pediatric Therapy Network.
- Bundy, A. C., & Murray, E. A. (2002). Sensory integration: A Jean Ayres' theory revisited. In A. C. Bundy, S. J. Lane, & E. A. Murray (Eds.), *Sensory integration theory and practice* (2nd ed.; pp. 3–29). Philadelphia: F. A. Davis.
- Cermak, S. A., Stein Duker, L. I., Williams, M. E., Lane, C. J., Dawson, M. E., Borreson, A. E., & Polido, J. C. (2015). Feasibility of a sensory-adapted dental environment for children with autism. *American Journal of Occupational Therapy*, 69, 6903220020p1–6903220020p10. <https://doi.org/10.5014/ajot.2015.013714>
- Henry, D., & Wheeler, T. (2001). *Tools for parents: A handbook to bring sensory integration into the home*. Glendale, AZ: Henry Occupational Therapy Services.
- Kinnealey, M., Pfeiffer, B., Miller, J., Roan, C., Shoener, R., & Ellner, M. L. (2012). Effect of classroom modification on attention and engagement of students with autism or dyspraxia. *American Journal of Occupational Therapy*, 66, 511–519. <https://doi.org/10.5014/ajot.2012.004010>
- Kuypers, L. M. (2011). *The Zones of Regulation®: A curriculum designed to foster self-regulation and emotional control*. San Jose, CA: Social Thinking Publishing.
- Reynolds, S., Glennon, T. J., Ausderau, K., Bendixen, R. M., Kuhaneck, H. M., Pfeiffer, B., ... Bodison, S. C. (2017). Using a multifaceted approach to working with children who have differences in sensory processing and integration. *American Journal of Occupational Therapy*, 71, 7102360010p1–7102360010p10. <https://doi.org/10.5014/ajot.2017.019281>
- Reynolds, S., Watling, R., Zapletal, A. L., & May-Benson, T. (2012, December). Sensory integration in entry-level occupational therapy education: A preliminary report. *Sensory Integration Special Interest Section Quarterly*, 35(4), 1–4.
- Schaaf, R. C., & Smith Roley, S. (2006). *SI: Applying clinical reasoning to practice with diverse populations*. San Antonio: PsychCorp.
- Williams, M. S., & Shellenberger, S. (1996). *How does your engine run? A leader's guide to the Alert Program for Self-Regulation*. Albuquerque, NM: Therapy-Works.

For More Information



AOTA Sensory Integration & Processing Special Interest Section

www.aota.org/Practice/Manage/SIS/Sensory-Integration-Processing



Official Document: Occupational Therapy for Children and Youth Using Sensory Integration Theory and Methods in School-Based Practice

<https://doi.org/10.5014/ajot.2015.69.6S04>



Online Course: A Contemporary Occupational Performance Approach to Pediatric Self-Regulation Part I: Theoretical Framework and Evaluation Considerations

By T. Henry & M. Gronski, 2016. Bethesda, MD: American Occupational Therapy Association. Earn .1 AOTA CEUs [1.25 NBCOT PDUs, 1 contact hour]. \$24.99 for members, \$34.99 for nonmembers. Order #0L4930.



Online Course: Sensory Processing Concepts and Applications in Practice

By W. Dunn, 2009. Bethesda, MD: American Occupational Therapy Association. Earn .2 AOTA CEUs [2.5 NBCOT PDUs, 2 contact hours]. \$65 for members, \$89 for nonmembers. Order #0L4834.



Occupational Therapy Practice Guidelines for Children and Youth With Challenges in Sensory Integration and Sensory Processing

By R. Watling, H. Miller Kuhaneck, D. Parham, & R. C. Schaaf, 2018. Bethesda, MD: AOTA Press. eBook: \$59 for members, \$99 for nonmembers. Order# 900483.



Sensory Integration: A Compendium of Leading Scholarship

By C. Royeen & A. Luebben, 2009. Bethesda, MD: AOTA Press. \$39 for members, \$49 for nonmembers. Order #1248.

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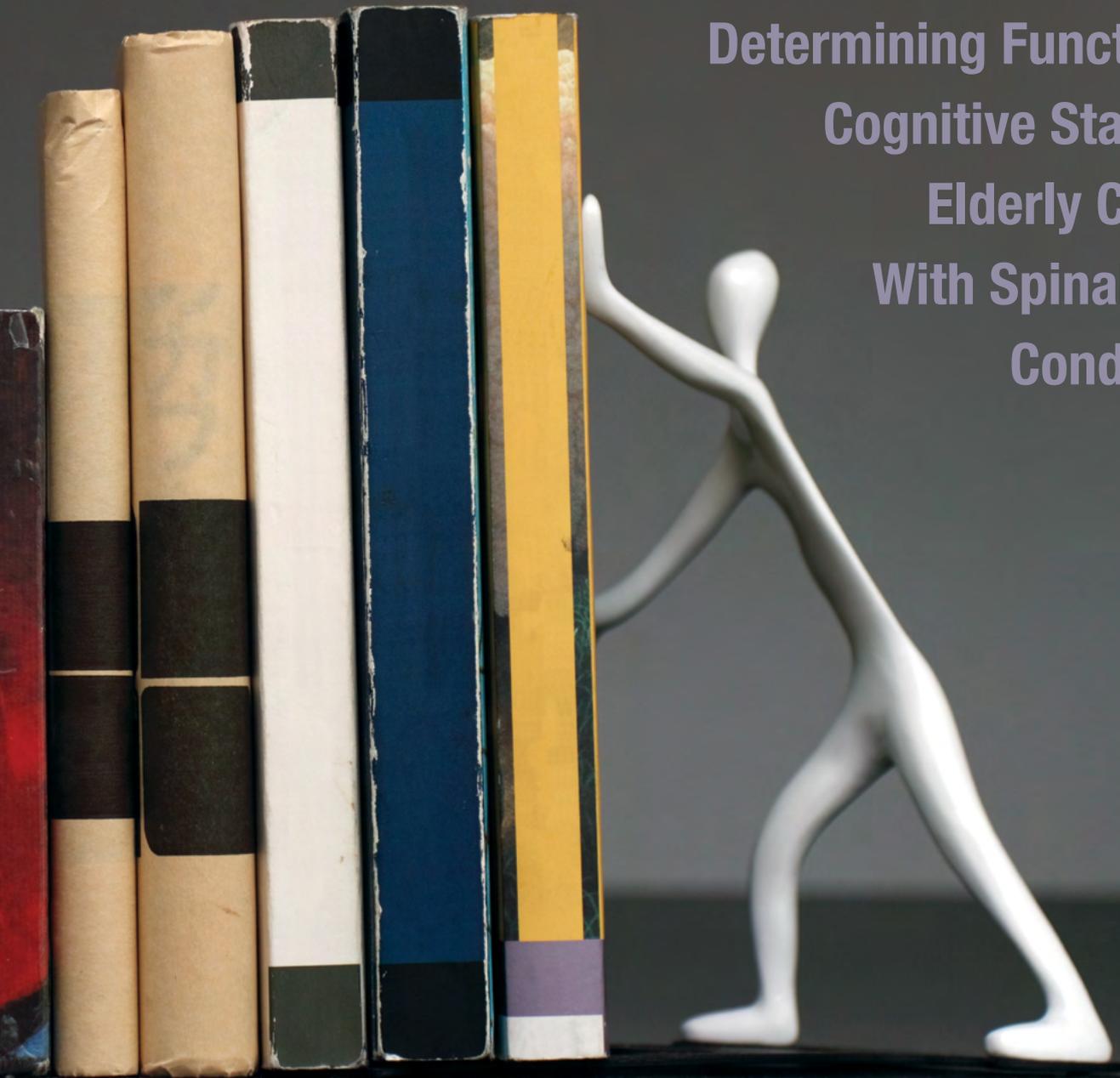
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Strong

by Marcelo Silva

Support

Determining Functional,
Cognitive Status in
Elderly Clients
With Spinal Cord
Conditions



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Comorbidities in combination with a spinal cord injury are most effectively addressed using a client-centered, holistic, and collaborative approach.

The rise of the aging population in the United States and the complexity of older adults' care needs have brought challenges to the current health care system, with its emphasis on decreasing costs while increasing client satisfaction, showing positive outcomes, and enhancing quality of life. Older individuals have an increased susceptibility to sustaining a spinal cord injury (SCI). In fact, falls are the leading cause of SCIs in the 65-year-and-older age group (Ikpeze & Mesfin, 2017). Having an SCI later in life further complicates the functional, cognitive, and psychosocial declines that many older individuals already face simply from longevity. Krause and colleagues (2015) reported that "individuals with SCI face significant challenges in maintaining longevity" (p. 196). They show a higher percentage of chronic complications, such as bowel and bladder elimination problems, chronic pain, skin integrity issues, and musculoskeletal problems (Ikpeze & Mesfin, 2017). These are conditions that may limit occupational participation and functional independence and can be addressed during treatment by occupational therapy practitioners.

Chronic comorbidities in combination with an SCI must be effectively addressed by the health care team in a well-coordinated manner and use a client-centered, holistic, and collaborative approach. Occupational therapy practitioners, through their emphasis on maximizing functional outcomes, are tasked with using the available evidence to guide services with this population, aiming at increasing "health, well-being,

and quality of life," as the American Occupational Therapy Association's (AOTA's) *Vision 2025* (AOTA, 2017) states.

Occupational Therapy's Distinct Value in Geriatric SCI

Collaboration among the interdisciplinary health care team becomes crucial when working with older clients with an SCI, given the more complex medical and personal care needs that they may require. Occupational therapy practitioners provide a distinct skill contribution to the interdisciplinary team, such as observing the client's function and environment from a comprehensive and integrative approach. Through formally assessing and analyzing the client's activity performance in their home environment, occupational therapists (OTs) determine what skills are needed to meet the demands of this environment, through an analytic process best reflected in the Person–Environment–Occupation Model (Law et al., 1996).

The result of the analytic process and dynamic interactions (among the person, environment, and occupation) help give the clients, their family, and the health care team accurate information that can be used to guide recommendations about the level of client independence, the modifications needed in the home environment, the equipment necessary to meet caregiving needs, and ease the burden of care required to ensure that the clients' needs are met. The recommendations that OTs provide, along with information from other health care professionals, such as physicians, nurses, psychologists, social workers,

and others, help build an overall picture of what services clients will need, where those services can be best provided, and who provides them. Interprofessional collaboration, as previously noted, then becomes key to ensuring the best outcomes for aging clients, especially those whose decision-making capacity is compromised.

Outcome Measure Tools to Guide Occupational Therapy Services in SCI

Evidence-based outcome tools are the gold standard in providing quantitative and qualitative information to health care professionals to guide their practice. Chan and colleagues (2017) compiled a list of 33 outcome measures to be used with clients with an SCI in the following clinical areas: "pain, sexuality and reproduction, lower limb and walking, self-care/activities of daily living, skin health, upper limb, community re-integration, quality of life, mental health, spasticity, neurologic impairment and secondary conditions, wheeled mobility, and assistive technology" (p. 123–124). In addition, various other tools, although not specifically tested with clients with an SCI, have been developed to measure functional as well as cognitive status, such as the Functional Independence Measure (FIM; Stineman et al., 1996), Montreal Cognitive Assessment (MoCA; Nasreddine et al., 2005), and Executive Functional Performance Test (EFPT; Baum et al., 2008).

The following case example shows how we used the MoCA, FIM, and EFPT to assist with determining the functional and cognitive status of an elderly client

with an SCI. It also used an informal living environment accessibility evaluation to determine the client's environmental modifications and equipment needs. The results of these assessments led to developing a discharge plan that maximized the client's functional and cognitive capabilities as well as matched her skills with the demands of the environment.

with the assistance that they were able to provide. The information provided by the family regarding Gabriella's difficulties managing her activities, in addition to inpatient staff observation of her skills, were used to ascertain her recent baseline and help guide the process of evaluation, intervention, and discharge planning and recommendation.

evaluation consisting of a functional cognition assessment to help determine her current level of performance and to assist with recommendations for discharge.

Gabriella's medical and mental status had been stabilized before completing the occupational therapy evaluation and treatment. To objectively assess her strengths and weaknesses, the OT administered the FIM, MoCA, and EFPT. These assessments have been validated for use to measure the areas they are meant to test: functional status and burden of care (Stineman et al., 1996), cognitive impairment (Nasreddine et al., 2005), and executive function (Baum et al., 2008).

The results of the FIM showed that Gabriella was modified independent with all her basic self-care skills with the use of adaptive equipment, except bathing, for which she needed supervision for cues to shower thoroughly. She also walked household distances with a rolling walker at the modified independent level. The MoCA was used to gather preliminary findings of potential cognitive deficits, to understand how they might affect her ability to do ADLs and IADLs. Gabriella scored 17/30 on the MoCA, which indicated likely potential for cognitive impairment. A low score with this screening tool justified additional cognitive tests with occupational therapy and psychology. The EFPT was then administered to gather information about Gabriella's initiation, organization, sequencing, judgement and safety, and completion constructs through the following four tasks: simple cooking, telephone use, medication management, and bill payment (Baum et al., 2003). Results of the EFPT showed Gabriella needed assistance, ranging from gestural guidance and verbal direct instructions, to physical assistance with organization, sequencing, judgement and safety, and completing many IADL tasks, such as cooking, telephone use, medication management, and money management.

The results of these screenings and assessments were discussed with Gabriella and her interdisciplinary medical team. Functionally, the OT indicated that Gabriella needed daily supervision with bathing and many other higher-level tasks (e.g., cooking, taking medication,

“Evidence-based outcome tools are the gold standard in providing quantitative and qualitative information to health care professionals to guide their practice.”

Case Example: Gabriella

Gabriella was a 77-year-old woman who lived with incomplete tetraplegia for several years from trauma to the spinal cord after surgical resection of a benign tumor in her cervical spine. She was admitted to the hospital because of failure to thrive and altered mental status as a result of a urinary tract infection. She was previously living at home alone, but her family reported she had been showing signs of decline over the past year, such as getting lost in her neighborhood, spilling food in the house and neglecting to clean it up, not paying bills, not tracking her medications, and leaving the stove on. There were also concerns about her ability to drive safely, as her family mentioned she had been in a minor car accident and gotten lost in the past year. Family members sought to provide as much assistance to Gabriella as possible, but they could not assist as much as they would have liked because of their own personal and work obligations. Functional and cognitive declines reported by her family, coupled with her recent admission to the hospital, strengthened the concerns that Gabriella was not managing well

Based on the preliminary findings, Gabriella's SCI physician recommended an occupational therapy evaluation to determine her current level of function with self-care (ADL) and home management (IADL) skills. This evaluation was done to gather more objective information to assist Gabriella and her interdisciplinary medical team (consisting of an SCI physician, social worker, psychiatrist, psychologist, and OT) to determine her care needs and identify a discharge location where she would be safest and function at her maximum occupational level.

Gabriella's medical history included cognitive impairment, incomplete tetraplegia, neuropathic pain, dysthymic disorder, and diabetes mellitus. Her prior level of function could not be initially determined during the evaluation because of her cognitive deficits and poor history account. However, the team was able to use her family's reports of their multiple concerns. Gabriella acknowledged she was having difficulties managing her medications and her money without oversight. She denied any feelings of low mood and openly agreed to an occupational therapy

managing finances) to ensure thorough completion as well as safety and well-being. There were no concerns about Gabriella's ability to perform basic self-care skills (beyond bathing), as identified in the FIM and with Gabriella consistently demonstrating her ability to complete them without assistance during her inpatient hospitalization. Cognitively, the results of the screenings and assessments supported the presentation and report of cognitive deficits from Gabriella's family. In consultation with the OT, who helped plan her community mobility, Gabriella voluntarily decided to stop driving with the social worker, in collaboration with Gabriella's family, assisting with arranging alternative means of transportation.

The discussions about Gabriella's functional and cognitive status established that her care would be best provided in a living environment where she would have daily supervision and assistance, such as in an assisted living facility or a group home. A group home was identified where a full-time caregiver would be available to assist with Gabriella's care needs. A family member agreed to assist with Gabriella's financial management and community mobility, and to oversee her overall care (including medication management) at the group home. Respect for Gabriella's autonomy was considered throughout this process, and she showed good insight into her deficits, agreeing with the established plan. Before her discharge, a home environment accessibility evaluation was completed to determine environmental alteration and durable medical equipment needs at the group home. The result of this evaluation indicated that the home needed a portable ramp and automatic door opener at the front door for wheelchair accessibility, as well as a transfer bench, grab bars, a handheld shower, and a raised toilet seat in the bathroom. In addition, in collaboration with Gabriella and her family, a fall monitor with "nurse call" feature was provided to ensure the caregiver could be promptly alerted to her needs at night time. All of the home alterations were installed and equipment was provided prior to discharge. Caregiver education and training were also completed to ensure the caregiver was comfortable and competent to support Gabriella's care needs.

The ability for Gabriella to perform her basic self-care skills and voice her wishes regarding the care she received were emphasized to ensure that assistance was only provided for the areas in which she showed limitations. This also enabled her to have a certain amount of autonomy regarding her function and health. Her family remained involved throughout this process, providing oversight of the services being provided.

Conclusion

This article and case example show the important role that occupational therapy plays in determining the functional and functional-cognitive status of aging clients with SCIs and disorders. These individuals usually require high and complex levels of care that must be well coordinated by the interdisciplinary health care team and the client's social network to ensure success. OTs use client-centered, evidence-based, and holistic approaches when evaluating, providing treatment strategies, and making recommendations to these clients, with the aim of helping them age safely in the least restrictive, safest, and most functional environment through identifying and bridging the gap between abilities, the demands of the environment, and occupational participation and independence. This becomes even more important when working with clients who have compromised decision-making capacity. Occupational therapy practitioners provide a piece of the puzzle as key players on the inter-professional health care team, building a complete picture of what is necessary to ensure the well-being of individuals being served. 🍷

References

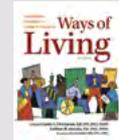
- American Occupational Therapy Association. (2017). Vision 2025. *American Journal of Occupational Therapy*, 71, 7103420010p1. <https://doi.org/10.5014/ajot.2017.713002>
- Baum, C., Morrison, T., Hahn, M., & Edwards, D. (2003). *Executive Function Performance Test: Test protocol booklet*. St. Louis: Program in Occupational Therapy, Washington University School of Medicine.
- Baum, C. M., Connor, L. T., Morrison, T., Hahn, M., Dromerick, A. W., & Edwards, D. F. (2008). Reliability, validity, and clinical utility of the Executive Function Performance Test: A measure of executive function in a sample of people with stroke. *American Journal of Occupational Therapy*, 62, 446–455. <https://doi.org/10.5014/ajot.62.4.446>
- Chan, C. W. L., Miller, W. C., Querée, M., Noonan, V. K., Wolfe, D. L., & the SCIRE

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- Research Team. (2017). The development of an outcome measures toolkit for spinal cord injury rehabilitation. *Canadian Journal of Occupational Therapy*, 84, 119–129. <https://doi.org/10.1177/0008417417690170>
- Ikpeze, T. C., & Mesfin, A. (2017). Spinal cord injury in the geriatric population: Risk factors, treatment options, and long-term management. *Geriatric Orthopaedic Surgery & Rehabilitation*, 8, 115–118. <https://doi.org/10.1177/2151458517696680>
- Krause, J. S., Clark, J. M., & Saunders, L. L. (2015). SCI longitudinal aging study: 40 years of research. *Topics in Spinal Cord Injury Rehabilitation*, 21, 189–200. <https://doi.org/10.1310/sci2103-189>
- Law, M., Cooper, B., Strong, S., Stewart, D., Rigby, P., & Letts, L. (1996). The Person-Environment-Occupation model: A transactive approach to occupational performance. *Canadian Journal of Occupational Therapy*, 63(1), 9–23. <https://doi.org/10.1177/000841749606300103>
- Nasreddine, Z. S., Phillips, N. A., Bédirian, V., Charbonneau, S., Whitehead, V., Collin, I., ... Chertkow, H. (2005). The Montreal Cognitive Assessment, MoCA: A brief screening tool for mild cognitive impairment. *Journal of the American Geriatrics Society*, 53, 695–699.
- Stineman, M. G., Shea, J. A., Jette, A., Tassoni, C. J., Ottenbacher, K. J., Fiedler, R., & Granger, C. V. (1996). The Functional Independence Measure: Tests of scaling assumptions, structure, and reliability across 20 diverse impairment categories. *Archives of Physical Medicine and Rehabilitation*, 77, 1101–1108. [http://dx.doi.org/10.1016/S0003-9993\(96\)90130-6](http://dx.doi.org/10.1016/S0003-9993(96)90130-6)

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Reflections From Fieldwork Educators in Specialty Practice

Aligning Experiences to Generalist Student Outcomes

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The American Occupational Therapy Association (AOTA) outlines the purpose of fieldwork education as to “propel each generation of occupational therapy practitioners from the role of student to that of practitioner” (AOTA, 2016, p. 1). In particular, it is the expectation of academic programs that by the conclusion of occupational therapy curricula instruction, the fieldwork experiences will “develop competent, entry-level, generalist” practitioners (Accreditation Council for Occupational Therapy Education [ACOTE®], 2012). Defining competent, entry-level generalists is necessary yet can be a challenge (Wallingford et al., 2016).

Often, academic fieldwork coordinators, academic faculty, and site administrators have to navigate how to tailor experiences to meet the expected requirements for the occupational therapy program, site education programs, and ACOTE. Collaboration among stakeholders is essential when adjusting and adapting fieldwork rotation experiences to ensure accurate reflection of the school’s, the site’s, and ACOTE’s goals during the rotation (ACOTE, 2012).

Creating quality fieldwork experiences requires developing site objectives and goals that reflect the site’s vision and philosophy, and that integrate the curriculum design of the partnership school (ACOTE, 2012). Challenges with generalist, entry-level development can arise when fieldwork educators practice within a specialty area, and lines begin to blur between entry-level and advanced practice expectations. Evidence suggests that, in general, fieldwork educators expect higher performance from their students now than they have in the past, often as a direct reflection of site environments and their demands as well as practitioners’ experiences and expertise (Vogel et al., 2004). With increased clinical expertise and excellence among fieldwork educators may come increased expectations regarding student performance and skill sets, which can create misalignment among the student, site administrators, and academic institution fieldwork experience requirements and expectations. The ability to objectively define entry-level generalist expectations despite these variables is key to a successful fieldwork experience.

Survey of Generalist and Specialty Fieldwork Educators

Six academic fieldwork coordinators representing six master of occupational



therapy programs in Texas (including the authors), conducted a survey targeting a convenience sample of fieldwork educators ($N=27$) from various settings to discover: (1) perceptions of entry-level practice skills, (2) fieldwork supervision strategies within specialty practice settings, and (3) variations in teaching styles and student learning objectives. The responses were analyzed using a qualitative method of open coding and verified through a peer review. Preliminary findings were presented to an additional group of occupational therapy practitioners ($N=30$) at a state occupational therapy conference and made open for comment and revision.

Supervision Styles

Results from the surveys found several trends in supervision styles in different fieldwork settings. In settings that were identified as focused on generalist occupational therapy services, students often required less supervision as the fieldwork progressed. Initially, the student practiced basic therapy skills with close supervision and works toward independence. Toward the end of their rotation, they were able to problem solve and use critical thinking skills when working with complex client cases. In settings identified as specialized occupational therapy services, students often needed more supervision throughout the fieldwork rotation. Specialty sites often preferred a level of proficiency with basic skills before starting the rotation. During the rotation, specialty sites often had more time to address specialized techniques in client care. Complete, independent transition of a full caseload to the student did not always occur in a specialty rotation, primarily because of the complex nature of the experience—not the student's performance.

Entry-Level vs. Specialist Skills

Entry-level skills are foundational student skills obtained in the classroom or during fieldwork, whereas *specialist skills* reflect advanced practice and experiences. In our survey, educators identified skills and settings as either entry level or as those that exceed entry level. Results of the survey indicated that educators view the following skills as entry level:

- Understand the role and scope of occupational therapy practice
- Apply and implement the *Occupational Therapy Practice Framework: Domain and Process* (3rd ed.; AOTA, 2014)
- Participate and function independently when practicing
- Thoroughly understand and be able to provide safe, ethical services
- Actively and accurately implement site policies, billing procedures, and client privacy
- Effectively and appropriately communicate and collaborate with clients, caregivers, and team members
- Demonstrate an independent thirst for more knowledge and seek opportunities to advance practice
- Perform client evaluations

Results from the survey also provided insight into the types of skills and settings educators view as specialty or advanced. In general, the educators indicated that these advanced circumstances exceed generalist practice and would require adjustments in fieldwork expectations and objectives.

Educators identified the following skills as exceeding entry level:

- Neuro development treatment handling or advanced handling techniques
- Myofascial release, lymphedema, or similar manipulation techniques
- Advanced sensory integration application or techniques
- Disability-specific assessments
- Understanding the prognosis and progression of specific condition-specific progression prognosis and progression (e.g., cancer, degenerative diseases, medically fragile/complex diagnoses, multiple lines/trachs, wound care)
- Adapting or adjusting wheelchairs
- Direct relationships and consultations with physicians
- Feeding interventions
- Hand clinic evaluations and interventions; advanced splinting

They identified the following specialty settings:

- Palliative and oncology care
- Pain clinics
- Traumatic brain injury services

- Cardiac and intensive care units
- Sensory integration clinics
- Hand clinics
- Home health (primarily because of increased autonomy)

Teaching and Learning Styles

Educator and student teaching and learning styles can often be a major factor in successful fieldwork rotations. Students and educators are urged to take time to reflect on their respective styles and discuss strategies to facilitate learning experiences during the first week of rotations. In our survey, educators provided insight into the most commonly used teaching methods and adaptations to student learning styles during rotations. Adaptations to teaching included strategies for students who were successful and for those having challenges while on fieldwork rotations.

Educators indicated that they use these teaching methods during rotations:

- Skills and simulation practice through various methods
- Hand-on training
- Observation and collaboration with other disciplines
- Case study development and accessibility to resources in the clinic
- Journal clubs and presentations
- Questions and experiences to facilitate critical thinking and clinical reasoning

When asked how they adapt their teaching strategies to meet the needs of students, educators provided similar comments, reflecting an overarching theme of adjusting teaching to match student needs. Educators also shared that they often increase direct feedback and suggestions. In situations when their adaptations did not meet a student's needs, educators reported reaching out to the school for supports.

Direct questions regarding adaptations and instruction for struggling students targeted more detailed responses from educators. Although they still reported adjusting their teaching style as the main supportive strategy, other targeted methods included:

- Providing direct instruction and assignments in areas of weakness and narrowing the focus of content
- Providing additional resources and extra learning opportunities to support specific needs

- Changing the pace or expectations
- Expanding the fieldwork experience to include other therapists, to change teaching styles and personalities

Developing Objectives: Generalized vs. Specialized

Academic programs are required to develop student objectives for fieldwork rotations (ACOTE, 2012). Site-specific objectives are intended to reflect the student's educational expectations and outcomes during the rotation. These objectives often are a merge between the AOTA Fieldwork Performance Evaluations (FWPEs; AOTA, 2002a, 2002b) and the distinct experiences at a specific location. When developing objectives for specialized rotations, educators and coordinators are encouraged to scale back the expectations and tightly align experiences to reflect the tenets on the AOTA FWPEs. Reflecting on the generalist outcomes on this evaluation measure can help target generalist skill sets versus those in specialty practice, regardless of the setting. 🔄

References

- Accreditation Council for Occupational Therapy Education. (2012). 2011 Accreditation Council for Occupational Therapy Education (ACOTE®) Standards. *American Journal of Occupational Therapy*, 66(Suppl. 6), S6–S74. <https://doi.org/10.5014/ajot.2012.66S6>
- American Occupational Therapy Association. (2002a). *Fieldwork performance evaluation for the occupational therapy student*. Bethesda, MD: AOTA Press.
- American Occupational Therapy Association. (2002b). *Fieldwork performance evaluation for the occupational therapy assistant student*. Bethesda, MD: AOTA Press.
- American Occupational Therapy Association. (2014). Occupational therapy practice framework: Domain and process (3rd ed.). *American Journal of Occupational Therapy*, 68(Suppl. 1), S1–S48. <https://doi.org/10.5014/ajot.2014.682006>
- American Occupational Therapy Association. (2016). Occupational therapy fieldwork education: Value and purpose. *American Journal of Occupational Therapy*, 70(Suppl. 2), 7012410060p1–7012410060p2. <https://doi.org/10.5014/ajot.2016.706S06>
- Vogel, K. A., Grice, K. O., Hill, S., & Moody, J. (2004). Supervisor and student expectations of level II fieldwork. *Occupational Therapy in Health Care*, 18(1–2), 5–19. https://doi.org/10.1080/J003v18n01_02
- Wallingford, M., Knecht-Sabres, L. J., Lee, M. M., & St. Amand, L. E. (2016). OT practitioners' and OT students' perceptions of entry-level competency for occupational therapy practice. *Open Journal of Occupational Therapy*, 4(4), Article 10. <https://doi.org/10.15453/2168-6408.1243>

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Supporting Participation for Children With Sensory Processing Differences in an Early Childhood Center

Divya Sood
Gail LoCure
Caren Schranz
Carol Morrison

This article discusses a program, designed and implemented by occupational therapists in an early childhood center, to coach teachers to support participation and inclusion of pre-school age children who had challenges in participation as a result of issues in processing and integrating sensory information.

Evidence suggests that up to 16% of typically developing children demonstrate difficulties with sensory processing (Ben-Sasson, Carter, et al., 2009; Ben-Sasson, Hen, et al., 2009). Having difficulties with processing and integrating sensory information can interfere with a child's ability to perform school tasks, develop

social relationships, and participate in age-appropriate activities, to name just a few adverse effects (American Occupational Therapy Association [AOTA], 2017). The Model of Sensory Processing explains that the neurological thresholds and behavioral responses of an individual interact with each other on a continuum, resulting in four descriptions of sensory behavioral patterns (Dunn, 2008). The four patterns are low registration, sensory sensitivity, sensation seeking, and sensation avoiding. Sensory processing is an intervention approach that emphasizes adapting or modifying activities or contexts to better support an individual based on their unique patterns of sensory processing and integration (AOTA, 2017). This means that occupational therapists (OTs) can use a sensory processing approach to identify and modify task and environmental barriers that are affecting a child's ability to participate in meaningful occupations. Therapists can collaborate with teachers and staff to help them develop strategies that can be used within school environments or routines that can "stimulate children's learning within a context that is more synchronous to the children's sensory needs" (Dunn, 2008, p. 138). Because occupational therapy practitioners have a deep understanding of concepts related to sensory processing, they ensure that the learning environments and routines of children accommodate sensory needs, thereby prompting participation (Dunn, 2008).

Behavioral Challenges at Early Childhood Center

The Family Development Center (FDC) is part of a university that provides early childhood education programs to families and their children and offers child care for children ages birth to 5 years, full- and



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half-day preschool for children ages 3 to 5 years, and after-school care for school-age children. The FDC director faced a challenge: A notable number of children with challenges in social participation were enrolled in the center. The full-day pre-school-age classrooms included many children who had a difficult time participating in the curriculum, concentrating on classroom tasks, and regulating themselves to settle down for a nap or participate in gym or circle time.

The director looked for ways to assist the teachers in better classroom management and investigated resources available through the university. She found short-term solutions, such as consulting with colleagues from special education and physical therapy, but she continued to search for long-term solutions to support

although the teachers were familiar with the concept of sensory processing, their knowledge about the topic was limited, as most associated SPD only with sensory-seeking or sensory-avoiding behavioral patterns. The therapists identified a need to provide resources to educate teachers on topics related to sensory processing and its effect on classroom participation. Thus, the Partnership to Support Early Childhood Educators Program (PSP) was created by co-authors Gail LoCure and Divya Sood.

Several existing models, such as the Person-Environment-Occupation-Performance Model (PEOP; Baum et al., 2015) and the Occupational Performance Coaching (OPC) model (Graham et al., 2013) guided us in developing the PSP. The PEOP model highlights the need to

participation of children identified as having SPD. The teachers further informed and discussed the strategies with the parents.

The PSP was implemented in several steps with the teachers:

Step 1: Knowledge building. The OTs shared information with teachers on topics related to sensory processing and SPD by developing a manual that also described the effects of SPD on children's involvement in activities within a school environment.

Step 2: Evaluation. The OT visited the classroom and observed teacher-child interaction. Teachers were asked to fill out the School Companion Sensory Profile assessment tool (Dunn, 1999) on children already assessed and identified as having sensory difficulties.

“Evidence suggests that up to 16% of typically developing children demonstrate difficulties with sensory processing.”

the teachers and children. Later, the director connected with faculty members in the occupational therapy program at a nearby university and requested they provide consultation on how to better meet student and teacher needs. The OTs visited the center to observe the interactions among children and teachers in the classrooms and devised a plan to first identify the issue and then develop a solution to address the issue.

Conducting a Needs Assessment

To better understand the supports that teachers at FDC required to support the children with sensory processing disorder (SPD), the OTs conducted a needs assessment survey. Twenty teachers who worked with children ages birth to 5 years responded. The survey results indicated that the majority of the teachers were familiar with the concept of sensory processing and could identify certain characteristics of a child with SPD. Most indicated that they wanted access to and required more information on SPD in the near future. Based on the survey findings, the OTs determined that

consider person- and environment-related resources or barriers that influence an individual's ability to perform meaningful activities, tasks, and roles (Baum et al., 2015). The OPC model uses “coaching in which a goal-focused conversational format is used to guide clients to examine their goals in detail and identify changes to the performance context that improve goal achievement” (Graham et al., 2013, p. 11).

The PSP Model

The PSP was specifically designed for teachers who work with children in preschool settings. The aim of the PSP is to develop a collaborative partnership between OTs and teachers to facilitate the participation of children with sensory differences in the context of early childhood education programs. In this particular situation, the objectives of the program were to educate the teachers about SPD and its manifestation within a classroom setting, discuss strategies to help them identify children who should be assessed for SPD within classroom settings, and discuss strategies to help them enhance classroom

Step 3: Joint analysis. In partnership, the OT and teacher identified child factors (e.g., sensory, motor, cognitive, social-emotional) and environmental factors (e.g., classroom space, classroom design, noise level, lighting) that influenced classroom participation. The teacher identified goals that she wanted to help the child accomplish.

Step 4: Strategy generation. The OT, in partnership with the teacher, generated strategies or solutions to accomplish the goals. Strategies included adapting the environment, tasks, or routines to be more synchronous with the needs of the child.

Step 5: Implementation. The teacher executed the strategies with the child identified with SPD within the classroom environment.

Step 6: Reflection. The teacher shared her perceptions related to implementing strategies used with the child identified with SPD.

Case Example: Zack

Zack was a 4-year-old boy enrolled in the full-day pre-kindergarten program. According to his teacher, Zack had

difficulty concentrating on tasks during classroom activities, frequently bumped into others, and continuously sought movement by jumping and running around the classroom. As a result of these behaviors, the teacher was concerned about Zack's ability to participate in group activities, such as circle time.

First, the OT educated the teacher on topics related to SPD; then she observed Zack and his teacher interacting in the classroom. The therapist asked the teacher to fill out a School Companion Sensory Profile questionnaire on Zack. The therapist and teacher collaborated to identify factors and behaviors that influenced Zack's participation in classroom activities. The scores on the Sensory Profile suggested that Zack presented with sensation-seeking behavioral patterns, which meant he was interested in sensory experiences, especially movement. As part of the ongoing goals discussed in consultation with Zack's parent, the teacher expressed that she wanted Zack to improve his ability to concentrate for 8 to 10 minutes on activities during structured circle time.

After identifying Jack's sensory difficulties, the OT suggested strategies based on the sensory processing approach that emphasizes adapting or modifying activities or contexts to better support an individual based on their unique patterns of sensory processing and integration (AOTA, 2017). Because Zack had high scores on the sensation-seeking quadrant, particularly in terms of movement, he would benefit from opportunities to incorporate movement into the classroom routine. The OT shared strategies for Zack that included having him help the teacher prepare for circle time by pushing a heavy cart of toys and books and getting a movement break during circle time.

The teacher executed the strategies with Zack for 2 weeks. Afterward, the teacher shared with the OT that Zack enjoyed sitting on the seat cushion and was able to remain on it and focus on a task for 5 to 8 minutes, which had not been the case before. The strategies helped Zack remain calm during circle time, during which he was more attentive and could follow 3- to 4-step instructions.

Reflections From the Project

The FDC director acknowledged that behaviors associated with SPD may be interpreted as behavioral dysfunctions; as a result, the interventions used to address these behaviors may not be suitable to also address children's sensory needs. Early childhood educators should partner with occupational therapy practitioners so that, in collaboration, they can determine the reasons for behavioral dysfunctions among children, including evaluation to identify children who have SPD. They will then be able to implement strategies that meet the sensory needs of the child within the natural context. The teachers shared that they had received concrete, hands-on assistance that could be implemented within the school context. One teacher said it was by far the most help she had ever gotten from a consultant. The only downside to this project was that it was short term. As a pilot project, there were time constraints on all participants. The authors recommend that practitioners who implement a collaboration of this type should spend as much time as possible garnering observations and following up with the teacher.

Conclusion

OTs can play a crucial role in the early identification of children with sensory processing dysfunctions as well as in developing strategies to support a child's learning based on sensory needs, in collaboration with teachers. 📧

References

- American Occupational Therapy Association. (2017). *Frequently asked questions (FAQ) about Ayres Sensory Integration®*. Retrieved from <https://www.aota.org/~media/Corporate/Files/Secure/Practice/Children/FAQAyres>
- Baum, C. M., Christiansen, C. H., & Bass, J. D. (2015). The Person-Environment-Occupation-Performance (PEOP) Model. In C. H. Christiansen, C. M. Baum, & J. D. Bass (Eds.), *Occupational therapy: Performance, participation, and well-being* (4th ed., pp. 49–55). Thorofare, NJ: Slack.
- Ben-Sasson, A., Carter, A. S., & Briggs-Gowan, M. J. (2009). Sensory over-responsivity in elementary school: Prevalence and social-emotional correlates. *Journal of Abnormal Child Psychology*, 37, 705–716. <https://doi.org/10.1007/s10802-008-9295-8>
- Ben-Sasson, A., Hen, L., Fluss, R., Cermak, S. A., Engel-Yeger, B., & Gal, E. (2009). A meta-analysis of sensory modulation symptoms in individuals with autism spectrum disorders. *Journal of Autism and Developmental Disorders*, 39, 1–11. <https://doi.org/10.1007/s10803-008-0593-3>
- Dunn, W. (1999). *The Sensory Profile: User's manual*. San Antonio: Psychological Corporation.
- Dunn, W. (2008). Sensory processing as an evidence-based practice at school. *Physical & Occupational Therapy in Pediatrics*, 28, 137–140.
- Graham, F., Rodger, S., & Ziviani, J. (2013). Effectiveness of occupational performance coaching in improving children's and mothers' performance and mothers' self-competence. *American Journal of Occupational Therapy*, 67, 10–18. <http://dx.doi.org/10.5014/ajot.2013.004648>

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The Lions Club and Occupational Therapy

Working Together to Address Low Vision

Carolyn Brown

Occupational therapy's role in low vision is not a new service trend. However, the collaboration between an international service organization and occupational therapy is an innovative way to practice that is not well known across the United States. The purpose of this article is to introduce the Lions Low Vision Centers of Connecticut, a novel approach to servicing individuals with low vision that has the potential of being replicated in other states.

History of the Lions Club

In 1917, Melvin Jones, a Chicago business leader, challenged members of his business club to look beyond everyday issues and address the betterment of communities

(Lions Club International, n.d.b). After joining with similar business groups in other states, the "Association of Lions Clubs" was born. One hundred years later, Lions Club International has spread to more than 200 countries and geographic areas (Lions Club International, n.d.b), focusing resources on health, youth, the elderly, the environment, and disaster relief.

The Lions' mission was deepened in 1925 by the inspiration of Helen Keller, who challenged them to become "knights of the blind in the crusade against darkness" (Lions Club International, n.d.a). The Lions have met Keller's challenge by recycling eye glasses, helping eye banks that support sight-saving surgeries, promoting vision screening, and providing eye health programs for children and adults with blindness or low vision.

Low Vision

According to the National Eye Institute (2016), low vision is defined as best corrected visual acuity between 20/70 and 20/200 and an inability to engage in purposeful activity using one's vision despite the use of corrective lenses, medication, or surgery. Nearly 21 million Americans report experiencing vision impairment or blindness (Blackwell et al., 2014). Disorders causing low vision include age-related macular degeneration, diabetic retinopathy, glaucoma, cataracts, acquired brain injury, multiple sclerosis, and pediatric conditions such as amblyopia, cerebral palsy, and autism. According to the World Health Organization (2014), 81% of people who are blind or have moderate to severe vision impairment are age 50 years and older. There has been a global reduction in the prevalence of low vision, yet population growth and decreased mortality rates (leading to more age-related cases) are causing a substantial increase in



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“Although occupational therapy low vision intervention is covered in most states, the low vision devices and adaptive equipment are not.”

the number of people affected (Bourne et al. 2017). The increase in the number of people affected with low vision produces a financial strain on communities (Yip et al., 2014).

Individuals with low vision must learn to compensate for sight loss to maximize safety and independence with ADLs, IADLs, education, work, play, leisure, and social participation. Occupational therapy practitioners instruct clients in using relevant low vision aids that assist with magnification, illumination, reducing glare, providing sensory substitution, and enhancing contrast. Medicare, Medicaid, and private health insurance companies in most states cover occupational therapy services with a medical prescription. Although occupational therapy low vision intervention is covered in most states, the low vision devices and adaptive equipment are not. The additional out-of-pocket costs of handheld magnification aids range from \$30 to \$75, illumination aids from \$40 to \$150, wearable anti-glare shields from \$40 to \$50, and other basic low vision aids from \$10 to \$50. These simple devices can be the key to a client's independence but are unaffordable to many.

The Lions Low Vision Centers of Connecticut

Through a partnership between the Connecticut Lions Clubs and occupational therapy practitioners, clients' needs for basic low vision aids are being met. Lions Low Vision Centers (LLVCs) have been opening in hospital systems across Connecticut since 2000. David William Parke, a Connecticut ophthalmologist and President of his Lions Club, played an integral role in the initial planning stages of the Connecticut LLVCs. His experience working with occupational therapy students and practitioners led to

his interest in promoting occupational therapy in LLVCs.

Most centers in Connecticut are overseen by occupational therapists who have completed relevant continuing education coursework pertaining to low vision, have been observed in an established LLVC for 10 or more hours, and have received training by a Lions Club member in the equipment inventory process. One LLVC in Connecticut is housed at a university where occupational therapy faculty treat clients with low vision and facilitate student learning.

The process of integrating a LLVC into an established hospital system involves a contract between the Lions Club and the hospital system. Opening a new LLVC may take 1 to 12 months, depending on the amount of preparation required. Occupational therapy practitioners and hospital personnel should first acquaint themselves with members of the local Lions Club to discuss a viable collaboration. To facilitate this collaboration, practitioners may need to develop a business plan, request financial assistance for continuing education coursework, and organize space to house inventory. Members of the Lions Club can help facilitate this process. Practitioners are also responsible for tracking incoming and outgoing low vision inventory. Therefore, integrating a computerized inventory process is recommended. Hospital-based prescription forms may be developed, and occupational therapy documentation forms can be modified to include low vision assessments. Marketing the new LLVC to area eye care specialists, physicians, and community members can be a group effort between Lions Club members and hospital staff. Historically, the Lions Clubs have an excellent connection to the community and have been

very supportive in marketing. LLVC brochures, flyers, posters, and business cards with the Lions Club logo are some examples of marketing tools.

For a client to be seen at a LLVC, a prescription from an eye care specialist or physician for “occupational therapy low vision evaluation and treatment” is required. Inpatient referrals are similar, with physician orders required. During the initial evaluation, an occupational therapist administers relevant low vision and occupational performance assessments, then they develop a treatment plan pertaining to the client's occupational goals, with applicable low vision devices issued as part of the client's intervention plan. Because of the Lions Club's fundraising efforts, the low vision devices and adaptive equipment issued at the LLVC are at no cost to the client. Clients do not have to prove financial hardship to receive low vision devices.

Case Example

John was an 80-year-old man with a history of age-related macular degeneration and cataracts. He lived alone in a single family home. John depended on his son for transportation because he was no longer able to drive. During his initial evaluation, John reported his primary goal was to be able to read the newspaper, as his vision has declined significantly, making this task difficult. Further evaluation of John's occupational performance identified that he was unable to manage his medications because of difficulty reading the prescription bottles. He was also unable to see the numbers on his stove dials and had occasionally left the burners on after he finished cooking. In addition to reading, John loved to garden but complained of eye pain because of glare from outdoor light. He enjoyed playing

cards, but he had difficulty viewing the card face. Additional low vision assessments confirmed that John presented with 20/100 near visual acuity, reduced contrast sensitivity, and impaired depth perception.

Occupational therapy intervention involved educating John in eccentric viewing strategies while using a high-power illuminated stand magnifier to read the newspaper. The eccentric viewing strategies taught John to use his intact peripheral vision to compensate for his impaired central vision. When the occupational therapist placed a raised lap desk under John's newspaper and used a natural-daylight reading lamp for accent lighting, he was able to read the text without difficulty. The occupational therapist also recommended that John modify the room lighting and minimize glare from the window. In addition to addressing leisure reading, the occupational therapist instructed John in using a high-power handheld illuminated magnifier and a voice output medication label reader to maximize his independence with medication management. To increase John's safety and independence with cooking, the occupational therapist showed John and his son how to apply raised sensory bump dots on his stove dials. John also trialed several types of wearable UV shields for low light and bright light to minimize glare and eye pain so he could return to gardening, and he was educated in using large print playing cards so he could resume card-playing with family. After John demonstrated independence using the devices, the occupational therapist issued the applicable magnifiers and low vision aids without charge. Lastly, the occupational therapist provided John with large print handouts pertaining to community, state, and national low vision resources. As an option to reading, John was given information about Connecticut Radio Information System (CRIS) radio, a radio reading service, and Library Services for the Blind and Visually Impaired.

Examples of Low Vision Aids Offered at a Lions Low Vision Center

- Communication aids (large print keyboard, large button phone)
- Handheld illuminated magnifiers

- Illuminated stand magnifiers
- Hands-free magnification aids
- Handwriting aids (writing guides)
- Illumination aids (LED lamps)
- Leisure aids (large print playing cards)
- UV shield sunglasses
- Meal preparation aids (raised bump dots, large print measuring cups)
- Medication management aids
- Money management aids (checkbook overlay)
- Posture and positioning aids (lap desk, book holder)

Examples of Low Vision Training at an LLVC:

- Education in eye movement exercises (scotoma awareness or eccentric viewing skills)
- Education in safety strategies for mobility and emergency preparedness in the home
- Education in low vision computer aids
- Assistance with applications for CRIS, Library Services for the Blind, Bureau of Education Services for the Blind, Fidelco Guide Dogs
- Education in local, state, and national low vision resources

Conclusion

The relationship between the Lions Clubs of Connecticut and occupational therapy practitioners has grown as new partnerships form, with the Lions incorporating practitioners into the Lions low vision support groups, serving as co-presenters with occupational therapists at community events, and providing financial compensation to practitioners for low vision continuing education. In turn, occupational therapy practitioners in the state support the Lions by educating the medical community on the Lions' mission, speaking at Lions forums, and getting involved with the Lions' fundraising efforts.

Kim Downs, OTR/L, was the first occupational therapist to collaborate with her local Lions Club in opening a Connecticut occupational therapist-managed LLVC. Downs said the expansion of the effort to 13 sites is in part because of the open and understanding partnership between the Lions Club and occupational therapy practitioners. Tom Nolan, a member of Downs' local Lions Club, said

that "partnering with occupational therapists in hospitals made good economic sense for the Lions Club."

Be it the Lions Club, Rotary Club, Kiwanis Club, Elk's Club, the Scouts, or some other community or business organization, many opportunities exist for partnering with occupational therapy practitioners. It just may take a practitioner having a creative idea and the ambition to reach out to a service organization. 🍷

References

- Blackwell, D. L., Lucas, J. W., & Clarke, T. C. (2014). *Summary health statistics for U.S. adults: National Health Interview Survey, 2012*. Retrieved from http://www.cdc.gov/nchs/data/series/sr_10/sr10_260.pdf
- Bourne, R. R. A., Flaxman, S. R., Braithwaite, T., Cicinelli, M. V., Das, A., Jonas, J. B., ... Taylor, H. (2017). Magnitude, temporal trends, and projections of the global prevalence of blindness and distance and near vision impairment: A systematic review and meta-analysis. *Lancet Global Health*, 5, e888–e897. [https://doi.org/10.1016/S2214-109X\(17\)30293-0](https://doi.org/10.1016/S2214-109X(17)30293-0)
- Lions Club International. (n.d.a). *Helen Keller*. Retrieved from <http://lions100.lionsclubs.org/EN/about/hellen-keller.php>
- Lions Club International. (n.d.b). *Mission and history*. Retrieved from <http://www.lionsclubs.org/EN/who-we-are/mission-and-history/index.php>
- National Eye Institute. (2016). *Living with low vision: What you should know*. Retrieved from <https://nei.nih.gov/sites/default/files/health-pdfs/LivingWithLowVisionBooklet.pdf>
- World Health Organization. (2014). *Visual impairment and blindness fact sheet*. Retrieved from <http://www.who.int/mediacentre/factsheets/fs282/en/>
- Yip, J., Luben, R., Hayat, S., Khawaja, A., Broadway, D., Wareham, N., ... Foster, P. (2014). Area deprivation, individual socioeconomic status and low vision in the EPIC-Norfolk Eye Study. *Journal of Epidemiology and Community Health*, 68, 204–210. Retrieved from <http://www.jstor.org/stable/43281949>

Carolyn Brown, OTR/L, is an Occupational Therapist who has worked in Connecticut Lions Low Vision Centers since 2004. She is currently working at the Hospital for Special Care, in New Britain, Connecticut.

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Introduction to Driver Rehabilitation. This 2-day course is designed for the new driving evaluator. The skills and knowledge needed to establish an adaptive driving program or become a new staff member for an established program will be discussed and shared. The course will also cover the following topics: development of a clinical and on road evaluation, basic training techniques, introduction to adaptive equipment, best practices in documentation and interactions with equipment vendors. 15 ADED/1.5 AOTA hours offered. Contact ADED 866-672-9466. Register online: www.aded.net

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Wichita, KS

APP August 22–25

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SEPTEMBER

Ashton, MD

September 15 & 16

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Orange, CA

APP September 22–23

Eval & Intervention for Visual Processing Deficits in Adult Acquired Brain Injury Part I. Faculty: Mary Warren PhD, OTR/L, SCLV, FAOTA. This updated course has the latest evidence based research. Participants learn a practical, functional reimbursable approach to evaluation, intervention and documentation of visual processing deficits

in adult with acquired brain injury from CVA and TBI. Topics include hemianopsia, visual neglect, eye movement disorders, and reduced acuity. **Also in Kalamazoo, MI, Oct. 20–21, 2018 and Omaha, NE, Nov. 10–11, 2018.** Contact: www.visabilities.com.

OCTOBER

Denver, Colorado

October 5–6

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Atlanta, GA

APP October 12–13

STAR Institute – 3S Symposium. This year's must-see Sensory Processing Disorder (SPD) event has been refreshed with a new format, new speakers and a new theme of Regulation: Foundation to Function. Attendees will enjoy presentations from experts in the field of SPD, networking opportunities and industry expos. **1.15 AOTA Hours.** Professionals may also attend separate pre-symposium workshops for both parents and professionals. Visit: www.spdstar.org or email: education@spdstar.org

Concord, NC

APP October 26–27

The Impact of Disability, Vision & Aging and their Relationship to Driving. This 2-day continuing education course provides a broad overview of the driver rehabilitation process. The course is designed for healthcare providers starting or advancing a driver rehabilitation program as well as those referring individuals to a program. Traffic safety/driver education professionals will benefit from the information that they can apply to their practice. Topics include: acquired, congenital, developmental and progressive disabilities; age-related and visual impairments that affect driving; the driver assessment process; adaptive driving equipment and vehicle modifications and driver licensing issues. 15 ADED/1.5 AOTA hours offered. Contact ADED 866-672-9466. **Register online:** www.aded.net

NOVEMBER

Dobbs Ferry, NY

November 9–10

Optimizing Executive Function: Strategy Based Intervention in Children and Adults. This course will provide in-depth information on treatment of cognitive dysfunction across the lifespan, with a focus on executive function impairments. Case applications of intervention principles across different ages and populations will be discussed. Instructors: Joan Togliola and Izel Obermeyer; Contact: Mercy College, 914-674-7444 for questions, SHNS@mercy.edu for details and registration. Pre-registration \$375 (8/1–9/8); Reg. Registration \$425 (9/9–10/9). AOTA CEU (12 contact hours / 1.2 CEU's). Register at <https://www.mercy.edu/health-and-natural-sciences/>



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Early Intervention & Preschool: Occupational Therapy Participation in the Child Outcomes Summary Process by Lesly W. James, PhD, MPA, OTR/L, FAOTA and Ashley Stoffel, OTD, OTR/L. By the end of this Webcast, learners will know how to: 1) Define the three global functional child outcomes that all early intervention and early childhood programs must measure and report nationally; 2) Identify national tools and resources that support participation in the early childhood outcomes summary process; and 3) Identify at least three strategies to support the occupational therapy practitioner participating in the IFSP and/or IEP team rating process for outcome measures. Earn .075 CEU (1 NBCOT PDU/.75 contact hour).

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Online Course
Low Vision Assessment for Occupational Therapy by Yu-Pin Hsu, EdD, OT, SCLV & Roy G. Cole, OD, FAAO. This program provides instruction on vision screening strategies and assessment tools that occupational therapists can use to identify vision problems and determine how vision loss may be affecting client's activities of daily living (ADL) and instrumental activities of daily living (IADL). Findings from a basic vision assessment help in formulating functional goals and appropriate interventions that address identified impairments and improve client's occupational performance. **Earn .2 AOTA CEU (2.5 NBCOT PDU/2 contact hour).** Order #OL4903. **AOTA Members: \$34.95, Nonmembers: \$49.94.** <http://store.aota.org> ¹²¹⁷

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Medication Related OASIS Items & Drug Regimen Review by Carol Siebert, OTD, OTR/L, FAOTA. The social and economic costs associated with medication nonadherence have prompted requirements and quality initiatives to promote medication adherence and to reduce the risk of medication-associated problems for the population receiving home health services. For home health agencies to meet these requirements, all skilled clinical professionals (registered nurses, occupational therapists, physical therapists, and speech language pathologists) have additional responsibilities to monitor medications and implement efforts to promote medication adherence. This short course addresses medication-related responsibilities for occupational therapists working in home healthcare. Earn .075 AOTA CEUs (.75 NBCOT PDU/.75 contact hour). Order #OL4945. AOTA Members: \$9.95, Nonmembers: \$14.95. <http://store.aota.org> ¹⁰¹⁷

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STAR Institute—Translation of Assessment Findings to Treatment: How Occupational Performance is Impacted by Underlying Sensory and Motor Abilities by Lucy Jane Miller, PhD, OTR, FAOTA and Sarah A. Schoen, PhD, OTR. This course is a recorded Pre-Conference Institute that was hosted by AOTA at the 2017 AOTA Annual Conference & Centennial Celebration. Earn .45 AOTA CEU (5.25 NBCOT PDUs/4.5 contact hours). Order #OL4974. AOTA Members: \$134, Nonmembers \$149. <http://store.aota.org> ⁰⁷¹⁷

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Online Course

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Enhancing Switch Use and Switch Scanning for People with Physical Impairments: Part 1, Order #WA1705

Enhancing Switch Use and Switch Scanning for People with Physical Impairments: Part 2, Order #WA1706

Finding Resources for Andrew's Intervention on the Communication Matrix Community, Order #WA1808

Guiding Teamwork Using Education Tech Point Questions, Order #WA1804

Planning Communication Goals for Andrew and Creating a Custom Report, Order #WA1807

Productivity Is the Name of the Game: Android Apps for Working Smart, Order #WA1709

UDL and Math Tools, Order #1811

Using Technology to Provide Play Opportunities for Children with Disabilities, Order #WA1701

UDL as a Framework for Collaboration Between AT & IT, Order #WA1806

Online Course

Building Oncology Rehabilitation Programs Across the Age-Span and Care Continuum by Brent Brave-man, PhD, OTR/L, FAOTA. This course focuses on critical elements of building successful oncology rehabilitation programs. Strategies for scaling program development efforts including staff training and assessment/development of competencies are provided to help practitioners set priorities for where to put their energies given limited time and resources. Earn .1 AOTA CEU (1.25 NBCOT PDU/1 contact hour). Order #OL56. AOTA Members: \$24.95, Nonmembers: \$39.95. <http://store.aota.org> 0717

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Early Detection of Neuromuscular Disorders in Early Intervention Settings (Module 4 of the Early Identification Series), by Roxanna M. Bendixen, PhD, OTR/L; Kris Barnekow, PhD, OTR/L; Series Editor: Kris Barnekow, PhD, OTR/L. This course provides an overview of neuromuscular disorders (NMD) in infants, toddlers and young children. These disorders vary greatly and manifest themselves through a combination of symptoms based on lower motor and sensory nerve dysfunction. Identification of the initial symptom(s) may be the key element in diagnostic success. Earn .15 CEU (NBCOT 1.88 PDU's/1.5 contact hours). Order #OL4975. AOTA Members: \$65, Nonmembers: \$99. <http://store.aota.org> 0717

CE Article

Applying the Person-Environment-Occupation Model to Improve Dementia Care by Carin Wong, MS and Natalie E. Leland, PhD, OTR/L, BCG, FAOTA. The purpose of this article is to introduce the Person-Environment-Occupation (PEO) Model as a framework to improve dementia care in nursing homes and provide examples from literature that can be framed within the model. The interaction between the person, environment, and occupation is described to promote participation and provide quality care for residents with dementia. The PEO model can be used by occupational therapy practitioners to develop innovative approaches to dementia care and improve quality of life. Earn .1 AOTA CEU (1.25 NBCOT PDU/1 contact hour). Order #CEA0518. \$24.95, Nonmembers: \$34.95. <http://store.aota.org> 0718

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Emergent & Early Literacy: The Role of Occupational Therapy Practitioners in Schools by Gloria Frolek Clark, PhD, OTR/L, SCSS, BCP, FAOTA et. al. Literacy is embedded within a child's daily living activities (writing, reading, listening, speaking). Without these basic means of communication, all aspects of occupational participation can be impacted. Occupational therapy practitioners have a critical role in literacy including supporting the development of literacy and providing professional development at a systems-level; evaluating a child's ability to participate in literacy activities; and providing intervention to enhance participation in literacy activities. This course will offer occupational therapy practitioners working with children the knowledge and skills on emergent and pre-literacy development that can be integrated into OT evaluations and interventions. Earn .15 AOTA CEU (1.88 NBCOT PDU's/1.5 contact hours). Order #OL4979. AOTA Members: \$34.95, Nonmembers: \$49.95. <http://store.aota.org> 0517

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Designing Occupational Therapy Services in a Primary Care Setting: Successful Strategies & Lessons Learned by Dragana (Anna) Krpalek, Ph.D, OTR/L and Heather Javaherian Dysinger, OTD, OTR/L. This course describes the role of occupational therapy in a primary care setting and provides insight into establishing OT services in a medical setting. Earn .15 CEU's, 1.5 Contact Hours, 1.88 NBCOT PDU's. Order # OL4989, AOTA Members \$24.95, Nonmembers: \$34.95. <http://store.aota.org> 0217

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Hand & Upper Extremity Essentials 2.0: The Fundamentals by Wendy Hoogsteden, MHS, OTR/L. This course provides beginner to advanced OT practitioners with information on the anatomy and kinesiology of the upper quarter. You will learn neuroanatomy concepts as related to hand and upper extremity rehabilitation. The course covers basic theory and application of physical agent modalities (PAMs) used in physical agent modalities (PAMs) used in upper extremity rehabilitation as well as an overview of splinting of the upper extremity. Earn .7 AOTA CEUs (8.75 PDU's/7 contact hours). Order #OL4983, AOTA Members \$79.00, Nonmembers \$200.00. <http://store.aota.org> 0217

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Rethinking Safety for Older Adults by Claudia E. Oakes, PhD, OTR/L. This article will review the literature regarding safety to help practitioners better understand the complexity of these issues and communication to help bridge the gap between our perceptions and older adults' perceptions of safety. Earn .1 AOTA CEU (1.25 NBCOT PDU/1 contact hour). Order #CEA0117, AOTA Members: \$24.95, Nonmembers: \$34.95. <http://store.aota.org> 0217

Online Course

Occupational Therapy Practice Guideline for Adults with Traumatic Brain Injury by Steven Wheeler, PhD, OTR/L, CBIS and Amanda Acord-Vira, MOT, OTR/L, CBIS. This course is based on the *Occupational Therapy Practice Guidelines for Adults with Traumatic Brain Injury* and provides an overview of the occupational therapy process for this population. The purpose of this course, in keeping with the purpose of the Practice Guidelines, is to help occupational therapists and occupational therapy assistants, as well as the individuals who manage, reimburse, or set policy regarding occupational therapy services, understand the contribution of occupational therapy in providing services to adults with TBI. Earn 15 CEU (1.88 NBCOT PDU's/1.5 Contact Hours). Order #OL4976, AOTA Members: \$24.95, Nonmembers: \$34.95. <http://store.aota.org> 1216

AOTA Documentation Series: Module 3 - Documentation Essentials for Medicare Part A in SNFs by Melissa Cohn Bernstein, OTR/L, FAOTA and Consultant/Subject Matter Expert: Nancy J. Beckley, MS, MBA, CHC. This intermediate level module is designed to provide a bird's eye overview of the updated regulations, that govern the provision of therapy services and provide insight into how the overall payment system works under the MDS 3.0, specifically reimbursement under Medicare A, including required RUGS-IV assessments, and how therapy services are delivered and captured for Medicare A beneficiaries. Earn .2 AOTA CEU (2.5 NBCOT PDU's/2 contact hours). Order #OL4977, AOTA Members: \$34.95, Nonmembers: \$44.95. <http://store.aota.org> 1216

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Faculty

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