

The American Occupational Therapy Association
April 10, 2017

OT Practice[®]

Class Acts

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- Using School Routines to Build Transition Skills
- Early Intervention Through Cultural Competency and Coaching



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Editor's Note

Leading the Way

Leadership can take many forms, as seen with a number of articles in this issue. Certainly, within schools there is the potential pathway for more occupational therapists to become administrators (p. 7), including coordinators, supervisors, or directors of special education or related services; principals; and superintendents. Restrictions currently in place within a number of states create some challenges to this, but overcoming them would offer great benefits for the profession.

"School leaders have the greatest impact on students' educational life, after their teachers," according to author Joan Sauvigne-Kirsch. "If occupational therapists attain formal special education leadership roles, they would have a greater impact on their work and their work in the public schools."

Along with the more official forms of leadership is the influence occupational therapy practitioners can have within their professional communities by developing innovative programs, as seen with the article on page 10 on a modified version of community-based instruction for students with autism. Conducted within the school, the program allows the entire student body to contribute to and learn from a wide variety of activities.

"The entire school community benefits," author Deborah B. Schwind notes. "They see that our students in this classroom can do many things. They see their difficulties and develop empathy for them; more importantly, they see that our students in the self-contained classroom are very capable and contribute to our school community."

Additionally, the OT Month special section on page 20 highlights a few of the many occupational therapy advocacy projects occurring in universities, health care facilities, and communities across the country and throughout the year. Many of these projects involve occupational therapy students, who of course are the future leaders of the profession. For students interested in additional ideas for developing their leadership skills, creating community projects, and more, AOTA has posted a number of related articles at <https://goo.gl/zlPx0X>. Additionally, AOTA's leadership database, at www.aota.org/cool, provides information on all of the many volunteer leadership opportunities available within AOTA.



Best regards,

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.
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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.

ACOTE Seeks New Accreditation Evaluators

The Accreditation Council for Occupational Therapy Education (ACOTE®) is seeking new members for the Roster of Accreditation Evaluators (RAE). RAE members evaluate the compliance of more than 500 occupational therapy (OT) and occupational therapy assistant educational (OTA) programs with ACOTE Accreditation Standards through onsite evaluations and online reviews. Their work provides ACOTE with the necessary information to make accreditation decisions, and it helps to ensure the competency of future occupational therapy practitioners.

ACOTE is placing a strategic emphasis on expanding the diversity of the practice and education settings and education levels represented on the RAE. OTAs are especially needed and are strongly encouraged to apply.

To be eligible for consideration, an applicant must:

- Have at least 5 years of experience as an OTA or OT, including 3 years of experience in an RAE area of representation (OTA-, OTM-, or OTD-level education; OTA or OT practice; OTA or OT fieldwork education, or other specialization)
- Be a member of AOTA in good standing
- NOT hold concurrent positions on any AOTA policy-making or decision-making body, including the Representative Assembly (Representative or Alternate), Board of Directors, or Ethics Commission. In addition, RAE members may not hold a position in a credentialing capacity (e.g., National Board for Certification in Occupational Therapy Executive Board member, Certification Examination Item Writer).

Applicants selected for membership to the RAE must attend the 2 1/2-day Accreditation Evaluator Workshop in November 2017 for training on how to evaluate programs and use ACOTE Online. Newly trained evaluators will begin a 3 1/2-year RAE membership term on January 1, 2018. RAE members are expected to participate in onsite accreditation evaluations and complete online reviews as scheduled.

Onsite evaluations are typically conducted over 2 1/2 days, and travel expenses related to these visits are reimbursable. The hours required to complete online reviews depend on the type of review, the quality of the report being reviewed, and the experience of the reviewer. Members are also expected to participate in ongoing educational trainings and remain in compliance with all ACOTE volunteer policies.

If you or someone you know would be well suited for this volunteer position, download the Educator or Practitioner Application for Membership from the ACOTE website at www.acoteonline.org. Applications should be completed electronically and returned to accred@aota.org no later than June 20.

Applications will be accepted by the AOTA Accreditation Department until June 20. The ACOTE Executive Committee, in collaboration with AOTA Accreditation staff, will review all applications for eligibility. A final list of eligible applicants will be reviewed by ACOTE, and all applicants, whether selected or not, will be informed of ACOTE's decision in August 2017.

Centennial Spotlight

1918, WWI: Helping Soldiers With Shell Shock, Physical Injuries

The year following the founding of the occupational therapy profession, four women were sent to France as neuropsychiatry “civilian aides” to help World War I soldiers recuperate from “shell shock” and “war neurosis”—what’s now commonly referred to as posttraumatic brain injury, and the origins of the profession’s expertise in mental health. Additionally, several women were sent as reconstruction aides (RAs) to work with soldiers with physical injuries. RAs provided “diversion from pain and situation” and worked toward “recovery of function and specific deficits.”

For more on notable events within the profession over the past 100 years, click on the “Events” tabs on the OT Centennial website, at www.otcentennial.org.



Advocating for OT and Mental Health

From federally supported Certified Community Behavioral Health Centers to innovative state and local community mental health services, there are increasing opportunities for occupational therapy practitioners to be a part of recovery-oriented, community-based behavioral health programs.

A new webpage from AOTA provides a variety of resources for practitioners in this area, including links to tools and tactics for advocating for particular states to recognize occupational therapy practitioners as Qualified Mental Health Providers, working to get occupational therapy services in mental health settings reimbursed under Medicaid, and persuading local programs to add occupational therapy to their available services. For more information, visit <https://goo.gl/ZYywTU>.

New CATs: Musculoskeletal Disorders, Alzheimer's Disease, ASI Use

As discussed in a recent systematic review on musculoskeletal disorders, there is strong evidence to support using virtual reality techniques during dressing changes and other pain-producing therapeutic interventions for individuals rehabilitating from severe burns. Read results of the musculoskeletal systematic review featured in the Critically Appraised Topics (CATs) at <https://goo.gl/jGG3Vr>.

Another recent AOTA systematic review found strong evidence for multicomponent psychoeducational intervention for caregivers of people with dementia to improve quality of life and self-efficacy, and decrease their depression and sense of burden. For this and other CATs related to Alzheimer's and related disorders, visit <https://goo.gl/SfjvAr>.

A recent systematic review also demonstrates strong evidence to support using Ayers Sensory Integration® for gains in individualized goals, as measured by goal attainment scaling, among children. For more, visit <https://goo.gl/Qq2lP2>.

Preventing Falls in the Home: Tips From AOTA, NCOA

According to the National Council on Aging (NCOA), more than 75% of falls take place inside or in close proximity of the home.

To mark NCOA's National Falls Prevention Awareness Day, Scott A. Trudeau, PhD, OTR/L, AOTA's program manager for Productive Aging and Interprofessional Collaboration, developed a video in collaboration with NCOA that offers tips for preventing falls, including:

- Increase lighting in and around the home.
- In the bathroom, secure throw rugs and use rubber mats in the shower or tub.
- Keep stairs clutter-free.
- Consider adding a bed rail to assist when getting out of bed.
- Put everyday items on the lowest shelves in the kitchen to avoid standing on stools and chairs.

For more details and to see the video, visit <https://goo.gl/QjWVYv>.



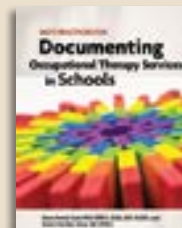
AOTA for You



Collaborating for Student Success: A Guide for School-Based Occupational Therapy, 2nd Edition

B. Hanft & J. Shepherd
This exciting update provides real-world guidance on how to collaborate with students, families, and

school personnel to support student performance, participation, and success. **\$79 for members, \$112 for nonmembers.** Order #900384.



Best Practices for Documenting Occupational Therapy Services in Schools

G. Clark & D. Handley-More
This timely resource provides practical information on documenting occupational therapy services while meeting federal, state,

and district requirements for screening and evaluation, intervention, outcomes and program evaluation, and OTA supervision. **\$49 for members, \$69 for nonmembers.** Order #900399.



To Order: <http://store.aota.org> (enter order # preferred) or call 877-404-AOTA

Resources

New Level I Fieldwork Competency Evaluation Tool

AOTA recently posted the Level I Fieldwork Competency Evaluation for OT and OTA Students, which complements the AOTA Fieldwork Performance Evaluation for the OT Student and for the OTA Student and is designed to assess performance skills that build a foundation for successful completion of Level II fieldwork. This tool is divided into five sections:

1. Fundamentals of Practice
2. Foundations of Occupational Therapy
3. Professional Behaviors
4. Screening and Evaluation
5. Intervention

For this and links to other fieldwork resources, including steps to starting a fieldwork program, strategies for creative fieldwork opportunities, answers to frequently asked questions about fieldwork, and more, visit www.aota.org/education-careers/fieldwork.

Latest OTA Leadership Podcast Available

The most recent podcast in the OT Leadership Live Podcast series is now available as part of the OTA Leadership Toolkit, available at www.aota.org/practice/ot-assistants/ota-leadership. Along with "OT Leadership Live Podcast: OTAs in Leadership," resources within the toolkit includes links for suggested reading for developing leadership skills, national and state leadership and advocacy opportunities, personal stories from OTA leaders, and more.

AOTA alerts Get the latest updates at www.aota.org/alerts

Draft Standards: Provide comments on the first draft of the revised ACOTE® standards by April 15.

New OT Evaluation Codes: Find all of our educational resources on the new CPT® OT evaluation codes, including a new FAQ for pediatric clients.

Send news items to otpractice@aota.org.



Introduction to Evaluation and Treatment of Children With Eating and Feeding Disorders (Online Course)
D. Reigstad
 Earn .5 AOTA CEUs (5 NBCOT PDUs/5 contact hours).
 This course helps pediatric therapists develop the

foundational skills to provide comprehensive evaluation and treatment within an interdisciplinary setting. **\$75 for members, \$120 for non-members.** Order #0L4980.



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

This course presents an evidence-based, developmentally driven method for approaching each individual child's self-regulation needs. **\$24.99 for members, \$34.99 for non-members.** Order #0L4931.



Practitioners in the News

Erin Dolan, EdD, OTR/L, contributed an opinion piece to the *San Jose Mercury News* (<https://goo.gl/0SevzH>) on how cursive handwriting helps learning in a broad range of areas.

Penny Moyers Cleveland, PhD, OTR/L, FAOTA, was featured in a *Minneapolis Post* article (<https://goo.gl/c3KnJ2>) on how occupational therapists specialize in treating addiction and mental health.

Staff members at **Stephen R. Egidi Hand & Occupational Therapy**, in Clifton Springs, New York, were featured in an article in the *Daily Messenger* that recounted activities held on March 15 to commemorate the founding of the occupational therapy profession at Clifton Springs' Consolation House. As part of the commemoration, the Clifton Springs mayor issued a proclamation honoring the profession's founders, the article reported.

Jacquelyn M. Sample, DrOT, MEd, OTR/L, was noted in a report by NBC news channel KOMU-8 in Missouri (<https://goo.gl/XuzXCW>) as being a leading supporter of newly introduced state legislation that would require insurance companies to cover more treatment, including

occupational therapy, for children with developmental disabilities.

Dana Howell, PhD, OTD, OTR/L, **Cindy Hayden**, DHEd, OTR/L, CHT, and **Renee Causey-Upton**, OTD, MS, OTR/L, professors in the Department of Occupational Science and Occupational Therapy at Eastern Kentucky University, in Richmond, on April 1 launched the open access, peer-reviewed online journal called the *Journal of Occupational Therapy Education* (<http://encompass.eku.edu/jote/>). Howell is editor and Hayden and Causey-Upton are associate editors of the new journal.



Sara Story, OTD, OTR/L, BCG, CAPS, an assistant professor of occupational therapy at Spalding University, was named as a university partner for funding from the Centers for Medicare & Medicaid Services for a program to be used in 20 Kentucky nursing homes. The program, called Bingocize, uses an interdisciplinary approach to improve aspects of functional performance in adults experiencing dementia.

occupational therapy at Spalding University, was named as a university partner for funding from the Centers for Medicare & Medicaid Services for a program to be used in 20 Kentucky nursing homes. The program, called Bingocize, uses an interdisciplinary approach to improve aspects of functional performance in adults experiencing dementia.

Questions?: 800-SAY-AOTA (members); 301-652-AOTA (nonmembers and local callers); TDD: 800-377-8555.

Associations Press for Continued HHS Support for Rehabilitation and Habilitation

Come what may with ACA changes, AOTA, APTA, and ASHA seek ongoing inclusion of their respective professions for rehabilitation and habilitation services and devices.

Laura Hooper

In March, AOTA joined with the American Speech-Language-Hearing Association (ASHA) and the American Physical Therapy Association (APTA) in a letter to Thomas E. Price, the new secretary of the U.S. Department of Health and Human Services (HHS), in support of the guarantee that health care plans sold to individuals and small groups cover rehabilitation and habilitation. The letter notes:

To improve current access, we strongly advise the inclusion of coverage of occupational therapy, physical therapy, and speech-language pathology for the purposes of both habilitation and rehabilitation services and devices in any action to reform the individual and small group markets.

Rehabilitative and habilitative services and devices are among the 10 categories of essential health benefits (EHBs) that the Affordable Care Act (ACA) requires individual and small group plans to cover. We expect that Congress will try to reverse the EHBs and other ACA market rules this year, leaving it to states to determine whether rehabilitative or habilitative services will continue to be required benefits. AOTA is prepared to work with state occupational therapy advocates if federal laws change and states must step in to reshape their individual marketplaces.

However, since many of the details about how to implement the EHBs were done through federal regulations, not laws, they can be changed or reversed through regulations. For example, HHS recently sent a letter to governors urging them to seek waivers for some of the ACA's provisions. The new leaders at HHS will use their waiver authority more liberally

than their predecessors. In addition, the new secretary could use regulations or administrative actions to loosen the EHB standards by rescinding a regulation requiring separate visit limits for rehabilitation and habilitation.

That is why we joined with our counterparts at ASHA and APTA to express our strong support for continued consumer access to both rehabilitative and habilitative services provided by occupational therapy practitioners, physical therapists, and speech-language pathologists. As lawmakers and regulators weigh the value of a comprehensive benefit package (i.e., the EHBs) versus a more *a la carte* approach, AOTA will work to highlight how the occupational therapy profession is helping their constituents.

The joint letter to the HHS secretary shared case examples from each therapy discipline to illustrate how our services maximize health, function, and independence:

- James, a 7-year-old boy with stuttering disorder, received habilitative speech-language treatment to become a more fluid and confident speaker.
- Kent, a 42-year-old man who cracked his pelvis after falling at home, received rehabilitative physical therapy to get back his ability to walk.
- Ann, a 32-year-old new mother with multiple sclerosis, received habilitative occupational therapy to learn new baby care skills along with skills to manage falls risk, poor balance, and fatigue. An occupational therapist instructed her on strategies for safely holding, feeding, and bathing her infant and worked with her to modify and eliminate hazards in her home that posed a risk for falls.

To read the letter, visit <https://goo.gl/ytY8II>. AOTA will continue to promote the value of occupational therapy as an integral part of a package of EHBs to both legislative and regulatory decision makers. 📄

Laura Hooper is AOTA's manager of Health Policy.



Promoting OCCUPATIONAL THERAPISTS AS School Administrators



Joan Sauvigne-Kirsch

Since the passage of the Education for all Handicapped Children Act of 1975, occupational therapy has experienced a dynamic and expanding role in school settings. Currently, occupational therapy practitioners are recognized as essential members of special education teams (Brandenburger-Shasby, 2005; Spenser, Turkett, Vaughan, & Koenig, 2005). Despite this, occupational therapists are among a small group of school professionals who are restricted in their advancement into formal special education leadership roles in schools. Many state departments of education (SDEs) do not provide the same credentialing granted to other health professionals (e.g., speech-language pathologists, social workers, psychologists). This exclusion from SDE credentialing seems to have restricted occupational therapy practitioners from moving through administrative training and applying for formal special education leadership positions.

Yet, with nearly one fourth of occupational therapists working in public schools (American Occupational Therapy Association [AOTA], 2015), it is essential for members of the profession to explore their impact on schools; special education; and, specifically, the potential to become formal special education leaders. This would include coordinators, supervisors, or directors of special education or related services; principals; superintendents; or SDE professionals.

As part of my doctoral dissertation, I completed qualitative research to answer the questions:

1. What perceived barrier/facilitators exist for occupational therapists to become special education leaders?
2. What perceived leadership qualities do occupational therapists possess or could be developed to be effective special education leaders?

Formal special education leadership positions have generally not been available to occupational therapists, and the occupational therapy profession has not pursued the field of education as an area for increased focus and professional opportunity. Thus, my research study sought to identify the appropriateness of the profession of occupational therapy for development as formal special education leaders. I applied an advocacy and participatory philosophical base to the research, along with an overlay of professionalization and reflective practice models. Although other states were reviewed, the state of Connecticut was used as a case study. Historical research data was gathered through the AOTA national and the Connecticut Occupational Therapy Association archives, Connecticut SDE archives, and interviews with five occupational therapists in school leadership positions (e.g., supervision of therapy departments).

Barriers Identified

Thematic analysis of the data gathered identified and recorded patterns that surfaced (Boyatzis, 1998). The data synthesis resulted in a narrative that identified barriers, including a complex history of the occupational therapy profession's various objectives. These include the topics of gaining licensure in every state, the role delineation of occupational therapists versus occupational therapy assistants, and medically based reimbursement. In addition, state-level barriers were identified, including lack of knowledge of education legislation and legislation regarding credentialing, and lack of knowledge of school curriculum. Facilitators included occupational therapy's expertise in child development as well as practitioners' understanding of intersecting systems of support and standardized testing. Leadership qualities that surfaced consisted of participants' application and provision of management systems within their roles. At the same

time, participants voiced concerns that they were not able to bridge or step into formal special education leadership roles beyond their current positions.

State-level awareness and interest in this topic varies considerably. A few states (including Colorado, New Jersey, Washington, and Wisconsin) require credentialing for occupational therapists through their state boards of medicine (or their equivalents) and SDE to work in the public schools (Colorado Department of Education, 2016; State of New Jersey, 2014; State of Washington, 2014; Wisconsin Department of Public Instruction, 2011). In most states, licensure with state regulatory boards, such as the board of medicine (or its equivalents), requires proof of graduation from an Accreditation Council for Occupational Therapy Education (ACOTE®)-accredited program in occupational therapy, National Board for Certification in Occupational Therapy certification, and payment of a fee.

Additionally, basic SDE credentialing requirements in those states range from paying an additional fee, background checks, and fingerprinting, to enhanced coursework and proof of experience in schools. In Colorado, the Department of Education requires a "special service provider" license (Colorado Department of Education, 2016). Similarly, in New Jersey, school occupational therapists must get a basic license and then pay an additional fee to their SDE to practice as an "educational service provider" (State of New Jersey, 2014). Other educational service providers include physical therapists, speech-language pathologists, social workers, reading specialists, school nurses, school psychologists, library media specialists, and interpreters. In Washington state, certification as an "educational staff associate" is required of occupational therapists, physical therapists, social workers, school psychologists, school counselors, school nurses, and audiologists (State of Washington, 2014). This SDE license requires completion of one approved course (30 clock hours) or proof of 3 years of school experience.

The content of the academic coursework can cover schools and society; human growth, development, and learning; American school law; and legal responsibilities of the educational staff associate. In Wisconsin, school occupational therapists must hold a related license issued by the

Wisconsin Department of Public Instruction (Wisconsin Department of Public Instruction, 2011). This includes a license by the Department of Safety and Professional Services that includes a background check and fingerprinting. In those states, occupational therapists can then take the additional educational leadership coursework required to become school leaders. There are a few instances of these dual licensures resulting in occupational therapists pursuing formal school administration positions.

Other states have educator administrative licenses that allow professionals who are not credentialed with the SDE (including occupational therapists) to become school leaders.

- In Massachusetts, special education administrators and other potential administrators need to pass a Communication and Literacy test and complete either an educator program or an apprenticeship (Massachusetts Department of Elementary and Secondary Education, 2016).
- In Virginia a "School Manager License" is open to occupational therapists but does not open advancement to other administrative credentials (Virginia Department of Education, 2010). In both Massachusetts and Virginia, traditional school occupational therapy practitioners need to only hold the State Board of Medicine license.
- The Occupational Therapy Association of California (2016) is currently advocating for a school-based credentialing initiative and has created a subcommittee and begun to meet with state education leaders on the matter.

In most other states, such as is the case in Connecticut, the SDEs do not provide or require credentialing for occupational therapists. This impacts professional practice in several ways. Occupational therapists who might be interested in formal school leadership positions cannot pursue them without gaining credentials in other professions, such as teaching, speech-language pathology, social work, or school psychology. Doctoral degrees in occupational therapy, education, or educational leadership do not permit administrative credentialing. Occupational therapists currently need to consult their own state credentialing

guidelines, available at SDE websites, to address prerequisites.

Each state has its own procedure for school professional and administrator training. In Connecticut, a grassroots organization would need to work with a state legislator to introduce regulations requiring that occupational therapists seeking administration training gain certification by the SDE at the Connecticut General Assembly.

Professional Evaluations

A related concern is that many occupational therapists are being evaluated by professionals who are not occupational therapists. SDE certification would enhance understanding of our roles within schools. (See also AOTA's *Guidance for Performance Evaluation of School Occupational Therapists* [Waite, 2013]). Additionally, the current Connecticut occupational therapy school-based guidelines were drafted in 1999, but at press time they had yet to be adopted or published through the SDE (McCloskey & Rioux, 2016).

Credentialing through state SDEs could help protect occupational therapy school practice in many ways by encouraging discussions of equity among school professionals.

Meeting Vision 2025

School leaders have the greatest impact on students' educational life, after their teachers. If occupational therapists attain formal special education leadership roles, they would have a greater impact on their work and their work in the public schools. It would also place them in a position to benefit from collective bargaining in regards to salaries, benefits, and professional development. Occupational therapists seeking dual credentialing would need to consider strategic approaches in dealing with a variety of issues to begin conversations. Augmented coursework focusing on education laws, the context of school systems, and curricula would also enhance occupational therapists' readiness to pursue SDE credentialing.

Advancement into formal leadership roles in schools would support the AOTA's Centennial Vision "that occupational therapy is a powerful, widely recognized, science-driven, and evidenced-based profession with a globally connected and diverse workforce meeting society's occupational needs" (AOTA, 2006). It would also

support the recently unveiled Vision 2025, which builds on the work of the Centennial Vision to guide the profession beyond 2017, stating, "Occupational therapy maximizes health, well-being, and quality of life for all people, populations, and communities through effective solutions that facilitate participation in everyday living" (AOTA, 2016). Leadership positions in schools are those that yield the most influence. More occupational therapists serving as formal leaders in education can build the profession's influence in schools and help make it more powerful and widely recognized. 📞

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For More Information



Brochure for School Administrators: What is the Role of the School-Based Occupational Therapy Practitioner?
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Using Typical School Routines

to Build Transition Skills

A Paradigm Shift in Community-Based Instruction

Deborah B. Schwind

- Communication devices charged** ✓
- Social story read** ✓
- Coat on** ✓
- Visual supports packed** ✓
- Sensory tools packed** ✓

The list of supplies needed for a weekly off-campus community-based instruction (CBI) activity never seems complete, because the community setting is not always predictable. CBI is an evidence-based practice that is part of a student's individualized education program (IEP). It allows for generalizing classroom skills in the community and provides experiential learning opportunities. It is a practice that helps develop the skills needed for life beyond school and can be used for students of all abilities. To be effective, it must be delivered with consistent instruction on a regular basis.

Off-campus CBI is a common practice. But in a self-contained classroom for children with autism, where I helped students in 3rd to 5th grade learn community safety and generalize classroom knowledge, such as money skills, our efforts at CBI were not working. Students were excited to get on the bus to go on the CBI activity, but they became upset when they realized they were not going home, even though social stories and videos were used to prepare them. The bus ride provided a great deal of sensory stimulation, both vestibular and auditory. On arrival at the community location, sensory thresholds were already met. Walking into the bright lights of a large store with unpredictable sights and sounds caused



sensory overload. Being in an unfamiliar setting escalated anxiety. When the instructional component of the outing began, there were visual or auditory instructions, along with the behaviors of peers, to process.

The same behavioral, communication, and sensory supports used in the classroom were implemented in the community. Behavior charts, communication systems, weighted backpacks, or compression vests were used based on individual needs, and heavy work was performed, such as pushing a grocery cart. These strategies worked for some, but not all. The cacophony of noises at the checkout counter was overwhelming—scanning groceries, filling bags, cashiers and students talking, students asking questions, students wanting to leave. This did not allow the students to process questions from the teacher or the cashier. Additionally, the cashiers spoke to the teacher, not the students. On arrival back to school, some students would act out and some shut down. The last part of the day became down time as a way to process this input. Instruction was difficult in the community and was not accomplished on return. The cost to instructional time once a week became more than we could justify.

Re-imagining CBI

As an occupational therapist, I knew I had to problem solve the difficulties we were having with our off-campus CBI program. These children needed consistency, familiar routines, familiar adults, a familiar environment, and predictability. Being in unpredictable, unfamiliar places without a routine caused anxiety. The team of stakeholders—administrators, teachers, related service providers, and parents—began collaborating and asking questions. Given the great importance of transition services for people with autism, who are far more likely to have trouble finding and retaining employment compared with the rest of the population (American Occupational Therapy Association, 2013; Cimera, Burgess, & Wiley, 2013), we decided that we wanted our students to perform tasks in a familiar environment so academic skills from the classroom could be generalized in meaningful, functional, and purposeful ways. Our solution? A school-based CBI.

By doing a school-based CBI, we could implement routines every day that would give our students learning opportunities



outside of the classroom for generalizing skills consistently. Instead of 1 day a week, they could do tasks every day. A predictable, familiar environment would cause less sensory overstimulation and sensory overload. Instructional time could be enhanced, not lost. The students would have more opportunities for social skills training and interactions with typical peers. In addition, if the students were successful, we could build a foundation of workplace behaviors and job skills.

By introducing jobs early—in this case, elementary school—a foundation of job interests and skills can be built, including a foundation of social skills and appropriate behaviors.

By setting the community-based instruction program within the school, the sights, sounds, and smells students encounter are familiar, minimizing sensory overload. This allows students to learn to deal with change in a familiar, non-threatening environment.

Figure 1. Jobs Performed in the School-Based, Community-Based Instruction Model for Students With Autism

- Stocking teachers' coffee station
- Working the Coffee Cart or lemonade stand
- Delivering backpacks containing food donated by a local church to qualified students
- Loading and unloading the backpacks
- Feeding the birds
- Assembling birdseed wreaths
- Watering the outdoor garden by unreeling and reeling the hose reel or filling the watering can
- Planting crops
- Harvesting crops
- Washing crops
- Working in the Farmers Market
- Stocking and sorting condiments in the cafeteria
- Sorting and stocking utensils in the cafeteria
- Stocking water bottles and juice boxes in the cafeteria
- Working in the school store
- Watering the indoor herb garden
- Painting and selling mugs
- Wiping down tables in the classroom
- Stacking and unstacking chairs in the classroom
- Hanging up clothes in the Lost and Found, including doing clothing closures
- Hanging up clothes by color coding
- Sorting items in the Lost and Found
- Assembling school nursing bags
- Assembling school supply bags
- Working the Ice Cream Cart in the cafeteria
- Scanning books from the library returns pile
- Sorting returned library books
- Popping and making popcorn bags
- Distributing food recovery bins
- Composting coffee grounds
- Composting teachers' lunch items
- Making dressings and vinegars
- Harvesting sunflower seeds



Daily Endeavors

"This goes with the red coats."

"We need more ketchup."

"Are we going to plant today?"

"Would you like some coffee?"

"This book goes here."

"Is this the right backpack?"

These are questions and statements that our students now make on a daily basis while they are doing their school-based CBI. (The jobs that are currently being done in our program are listed in Figure 1 on the left.) The school is a familiar, predictable environment with familiar people and familiar routines. The sights, sounds, and smells are familiar, minimizing unfamiliar sensory experiences. Although students learn to deal with change, this change is in a familiar, non-threatening environment. In addition, the jobs are performed in small increments of time, with multiple opportunities for repetition.

The jobs are introduced weekly by the occupational therapist through live modeling, demonstration, role playing, and video modeling, as well as by using adapted books that incorporate the vocabulary for a specific job. Conversation skills are practiced with visuals, with support from the speech-language pathologist. Adapted books are made for practice and reinforcement. The jobs are built into students' schedules, with natural breaks from classroom instruction while incorporating academics in a hands-on way. The jobs are placed on

students' visual schedules using a picture symbol and are performed in the school community after the job expectations are demonstrated and the students are able to perform the jobs in the classroom.

Curricular-themed units centering on a job have evolved so that they incorporate a range of topics. For example, one job is gardening, which includes the plant cycle, plant needs, water cycle, parts of a plant, nutrition, and healthy eating habits. The students write about their jobs (to learn and practice writing skills), make grocery lists for supplies, make recipe books, and create newsletters about the jobs.

For children with autism, opportunities to explore jobs through pretend play are very limited. When asking a typically developing child what they would like to do when they grow up, they may refer to a role they take on during pretend play, such as teacher or firefighter. Students with autism may have difficulty answering a question like this, as their repertoire of play is limited. This jobs program creates interests for different types of work and creates experiential opportunities for job exploration.

As students perform these jobs over the course of 3rd through 5th grade, the staff grade and modify the tasks by adding additional steps.

These school-based jobs are not just for the students with special needs; the entire school community benefits. This classroom is an integral part of the school



community. Staff members know all the students and converse with them because of the jobs. They become familiar with students' individual communication systems—verbal, picture symbols, or communication devices. Staff buy coffee from them at the Coffee Cart as well as vegetables and dressing in the Farmer's Market, ask them for ice cream from the Ice Cream Cart, and talk with them about books when they work in the library. The typical peers witness these interactions and model them. They see that our students in this classroom can do many things. They see their difficulties and develop empathy for them; more importantly, they see that our students in the self-contained classroom are very capable and contribute to our school community. The social impact of the school-based CBI program has created acceptance.

The skills learned in elementary school are taken to middle school on transition, and the occupational therapist is a bridge to collaborate with the middle school team. The skills learned in the elementary school can be shared with the middle school administrators so these skills can begin to be applied to larger community settings. Work successes can be expanded, and job complexity

can increase. Jobs can be applied to a larger community setting. Connections to employment options can be made, such as working in a clothing store while working in the school Lost and Found or working in a grocery store while stocking condiments in the school cafeteria.

Conclusion

Transition must be a continuum that begins early. Job success depends on job interests, work behaviors, independence with job skills, and foundational skills, the development of which should start in elementary school. If we wait to develop these work skills until students are 14 or 16 years of age, what opportunities have we missed? A foundation cannot be built when students are already adults. Rather, a foundation starts early—we do not have time to wait.

For More Information



Vimeo: OT at Cedar Lane Elementary School
<https://vimeo.com/161837834>



AOTA Online Course: Young Adults on the Autism Spectrum: Life After IDEA
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Best Practices for Occupational Therapy in Schools
 By G. F. Clark & B. Chandler, 2013. Bethesda, MD: AOTA Press. (\$89 for members, \$126 for nonmembers. To order, call toll free 877-404-AOTA [2682] or shop online at <http://store.aota.org>, and enter order #900344).

This school-based CBI program increases the participation of our students and addresses their occupational needs using evidence-based practice to guide decision making, collaboration, and practice interventions. It addresses the issue of lifelong participation through employment by building a foundation of work skills, including work behaviors, starting in elementary school. 🔄

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Occupational Therapy in Early Intervention

Supporting Families and Children Through Cultural Competency and Coaching

**Joan Augustyn
and Anna Wallisch**

A best practice principle in early intervention relates to remaining family centered, and pairing coaching and cultural competency helps guide practitioners when visiting culturally diverse homes.

As minority populations come close to accounting for the majority of people living in the United States (Rose, 2013; U.S. Census Bureau, 2010), the importance of occupational therapy practitioners in early intervention addressing the needs and desires of families of different cultures grows as well (Betancourt, Green, Carrillo, & Ananeh-Firempong, 2003). Although cultural competency in health care is already a prevalent idea, individuals do not always know how to apply cultural competency principles (Rose, 2013), and limited research exists concerning best ways to practice cultural competency in early intervention. However, there are a number of strategies occupational therapy practitioners may use to improve their practice with diverse populations, particularly the growing Latino population. Pairing the idea of cultural competency (i.e., going beyond cultural sensitivity and awareness by adapting one's practice skills) with the coaching model may help ensure that practitioners have the tools to address all their clients' needs.

Coaching

The coaching model uses conversations to encourage parents to reflect on and brainstorm about new strategies to reach their goals. Coaching aligns with the Individuals with Disabilities Education Improvement Act of 2004 Part C, and both help build the capacity of the family and promote child growth and development (American Occupational Therapy Association [AOTA], 2010). In particular, effective coaching embraces openness in a relationship with individuals who are different from oneself (Rush & Shelden, 2011), thus aligning with cultural competency. When the unique interaction among the child, environment, occupation, and performance are taken into consideration, interventions expand families' current knowledge and strategies (Graham, Rodger & Ziviani, 2009). When using reflective

Table 1: Innovative Practice Strategies

Practice Strategy	Ask Yourself	Framework Intervention
Ask permission before sharing information with a family. Make sure the presentation of that information is appropriate for the family and its values (Rush & Shelden, 2011).	What kind of information makes the most sense to this family? Visual, auditory, written, or hands-on? Did I ask the family members whether they are OK with my sharing some information?	Education
Review intended assessment(s) to see whether these align with the family's culture. Many assessments are designed based on Western cultural values (Reid & Chiu, 2011).	Does the assessment I want to use match what I want to analyze, as well as the cultural background of this family?	Advocacy
Make sure your relationship with the family comes first. This means allowing the family's ideas to guide the session (Barrera & Kramer, 2009).	How can I best create interactions that are respectful, reciprocal, and responsive?	Advocacy
Immerse yourself in the actual environment that the family performs and lives in (Rush & Shelden, 2011).	Where have I seen the child/family perform their everyday routines?	Occupations in natural context

conversations, new ideas are generated from the family's thought processes, thus providing ideas for culturally relevant strategies. Occupational performance coaching (OPC) provides a means for a family-centered interaction style, and it has been shown to improve outcomes for parenting competence that are sustained and generalized (Graham et al., 2009). Qualitative studies of OPC have indicated that parents perceive the parent-therapist relationship and analyzing and reflecting together as core components of increasing parent self-efficacy (Foster, Dunn, & Mische Lawson, 2012). Clearly, the coaching model provides one means to maintain culturally relevant strategies and an unbiased communication model, all of which embrace aspects of cultural competency.

Cultural Competency

Cultural competency is individuals, or groups of professionals composing an agency or system, harmonizing their behaviors, attitudes, and policies to enable effective work in cross-cultural situations (Rose, 2013). Although *competency* is difficult to obtain, a large part of cultural competency relates to asking about cultural values, concerns, and beliefs. Practitioners may begin with cultural awareness (i.e., understanding families' beliefs and values) leading to cultural sensitivity (i.e., respecting families' beliefs and values). However, when practitioners move toward cultural

competence, they begin to take actions in their practice to meet the needs of families without judgment (Rose, 2013). Competency also means taking more systemic actions, such as providing quality interpreters as needed, and including staff who share a family's cultural background. Even within the same culture, each family will have their own culture of daily living. Practitioners need to take the time to explore and become aware of their own biases in order to ask questions about differences instead of assuming they know how families address certain aspects of daily life. Taking the time to reflect leads to establishing trust and individualized care. An early intervention occupational therapist who has awareness about cultural competence can be even more engaged in family-centered practice. Culturally competent practice is informing a family that you are unaware of their values, being willing to learn their beliefs, and asking prior to acting.

Occupational Therapy's Role

Occupational therapy practitioners provide a distinct perspective on the activities that are meaningful and occupy one's time. Practitioners in early intervention focus on child development and the occupations of playing, eating, social participation, and sleeping, thereby creating interventions to facilitate a child's occupational performance and remove contextual barriers (AOTA, 2014a). Through a culturally sensi-

tive lens, an occupational therapy practitioner considers and acts on factors related to a family's values, beliefs, spirituality, habits, rituals, and routines (AOTA, 2014b).

In addition to acting on factors related to the family, many practitioners face barriers when using interpreters to reduce language gaps. The coaching model emphasizes reflective, open-ended questions, where certain interpretations may alter the quality of the conversation. For instance, an occupational therapist might ask a family, "What do you plan to work on next week?" and following interpretation, the mother might respond with, "Yes, tell me what to do next week." Clearly, the meaning and reflective aspect of the question got lost during interpretation. One means to address barriers with interpreters is to explain the principles of coaching to them prior to sessions to assure adherence to the model (Rush & Shelden, 2008). Furthermore, through interpreters, practitioners have the opportunity to further expand their cultural knowledge. For example, during home visits, the interpreter may advise the practitioner to accept any offer of food or drink so as to not disrupt underlying cultural norms. In addition, some families may prefer to have a male or female therapist or interpreter. Without an interpreter's knowledge of culture, a practitioner may insult a family without intending to, thereby reducing the quality of the practitioner-family relationship. (See Table 1 for more on related practice strategies and their connection to the *Occupational Therapy Practice Framework, 3rd Edition* [Framework; AOTA, 2014b].)

Case Example: Viviana

The occupation of eating and feeding with children is a daily routine of great importance for all families. Mealtimes is a prime opportunity for attention to cultural considerations. For example, a Latina mother, Viviana, stated that she wanted to be more successful in feeding her underweight infant daughter. Through observing and asking Viviana questions about interaction style, typical environment, food preferences, oral-motor abilities, and feeding positions, the occupational therapist learned that Viviana liked to have her baby dressed in several layers of clothing. But the therapist discovered that the baby's skin felt hot, and she appeared fussy. The therapist also learned that Viviana typically fed her daughter while music was playing, with

Viviana sitting in the middle of the couch, using one arm to support her daughter in a slightly angled position. When Viviana would give a bottle to her daughter, the baby would turn her head sporadically, and when the baby did latch onto the nipple of the bottle, liquid seemed to spill out the sides of her mouth. What should the occupational therapist's plan have been? What factors would she need to consider?

The therapist:

- Asked Viviana what she thought an ideal feeding session would look like, with the plan to use her ideas when problem solving or asking about suggestions later in the session.
- Noted what was important and ideal to Viviana and displayed openness and active listening to let her know she was vested in supporting her priorities and values.
- Asked Viviana what she had tried to improve feeding. How had that worked? What did she think was interfering with her baby successfully feeding?
- Asked Viviana what she observed about her baby's body temperature during feeding.
- Asked Viviana whether the therapist could share information about how physiological aspects (such as temperature) related to successful feeding. What did she think she could do to reduce her infant's body temperature during feeding?
- Brainstormed with Viviana some alternatives that might physically support her as well as her baby during feeding.
- Asked permission from Viviana to share information about optimal feeding positions (i.e., a more upright angle for feeding a baby), and asked her how she could use the information within her own feeding routine.

When working with clients, practitioners may ask additional questions about the environment, such as, "What effect do you think the music has on you and your infant while she is feeding?" Other information sharing may involve oral-motor exercises (such as the mother mimicking kissing motions or touching the sides of the baby's mouth and cheeks) to help the baby's mouth be more "awake" and ready for feeding, as well as to promote closure of the mouth on the bottle to prevent spilling.

The occupational therapist also followed up with Viviana after she had time to implement some of the ideas they came up with. Then, after the follow-up, she periodically asked Viviana questions like, "What seems to be working?" "What do you think could go better next time?" and "How does this compare to your ideal feeding situation with your baby?"

Implications for Occupational Therapy

A best practice principle in early intervention relates to remaining family centered, and it is important to be aware of potential differences when visiting culturally diverse homes. The coaching interaction style provides one means to interact and build relationships with families, while allowing occupational therapy practitioners to remain respectful and adhere to the ideas, values, and beliefs of the family. Even though combining coaching conversations and cultural competency may seem simple, it takes time, practice, and reflection to recognize how one's own beliefs influence support for families in early intervention. ☺

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AOTA Podcasts: Chat in Spanish for Families: Pediatric OT
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Cultural Competency Tool Kits
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Multicultural Resources
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"No Hablo Inglés: Client-Centered Occupational Therapy Practice With Spanish-Speaking Clients"

By C. Reyes Smith, C. Hoyt Drazen, & S. Toth-Cohen. *OT Practice*, 19(22), 8–12. <https://goo.gl/MDCtiq>



Culture and Occupation (3rd Ed.)

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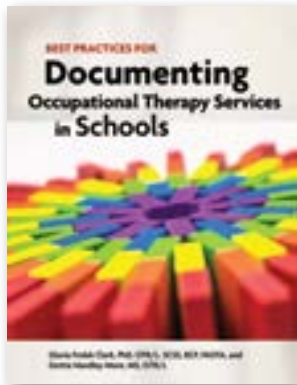
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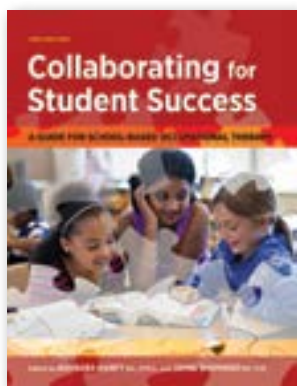
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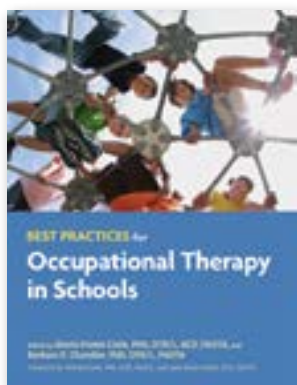
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this issue of **OT Practice**



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Edited by Kris Barnekow, PhD, OTR/L

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Celebrating

Patching a Quilt, Creating a School-Based

In recognition of OT Month 2017, *OT Practice* presents a sampling of educational and promotional efforts made by occupational therapy practitioners and students around the country over the past year.

Patching Together a Quilt to Celebrate Occupational Therapy Month

Jennifer Long

In occupational therapy, our work is similar to the assembly of a quilt. We work together piece by piece, and when all the pieces are sewn together to form the quilt, we can embrace our larger goal: independence and improved quality of life for our clients.

The occupational therapists at the Center for Lifelong Learning, in central New Jersey, had the same thought when they decided to create a quilt for OT Month last year. The Center for Lifelong Learning is a special education school for children ages 3 through 21 years with autism spectrum disorder and a variety of physical abilities.

For OT Month, we wanted to know what OT means to our students, so we distributed pieces of cloth to all 24 classrooms in our school with the assignment of having

the students draw or write “What OT means to you.” Our students got right to work, creating patches depicting items such as forks and knives, crayons and pencils, toothbrushes and combs, buttons and jackets, and all types of cooking utensils.

One teenage boy drew a picture of a plate of his favorite food with a fork and knife, because occupational therapy had taught him how to cut his food. Another student was very proud of himself for learning to tie his shoes, so he drew a picture of a shoe. Students also drew smiling faces and traced their hands. One of our students wrote, “OT makes us strong and independent.”

The therapists were ecstatic to see the individual pieces from each classroom,



each piece radiating its own personality. After collecting all the individual pieces of the quilt over several weeks, occupational therapist Annie Padmore, MSOT, OTR/L, assembled the quilt with her sewing machine and added special details, including a puzzle piece border for autism awareness.

It was important for us not only to create a quilt demonstrating what occupational therapy means to our school community, but also to highlight autism awareness, because a majority of our students have autism.

Additionally, the therapists added a sensory component to the quilt. They wanted the quilt to be tactilely as well as visually inviting, so they added texture material, such as real zippers, shoelaces, and a textured ball. The quilt, representing the presence of occupational therapy in our school and the lives of our students, has found a home on our school wall, proudly displayed for all to see. 🧵

Jennifer Long, OTR/L, is an occupational therapist in Sayreville, New Jersey.



Rose Parade OT Float

The Occupational Therapy Association of California (OTAC) helped spread the word about the value of occupational therapy around the world with a float entitled Celebrating a Century of Occupational Therapy at the Annual Rose Parade on January 2. Seen by more than 75 million TV viewers around the world, the float also generated a huge amount of sharing on social media sites. For more on OTAC's OT Centennial Float initiative, visit <https://goo.gl/W90GSf>.

OT Month

Celebration, and More

Get more ideas for celebrating year-round at www.aota.org/Conference-Events/OTMonth and share your celebrations with promotions@aota.org.



“Experience OT Day” Brings School Community Together

Leonora T. Bradley

At the beginning of the 2015–2016 school year, the public school district in Howell Township, New Jersey, underwent big changes after it internally restructured its 12 schools from a traditional grade model (Pre-K–5, 6–8) to a grade-banded model (Pre-K–2, 3–5, 6–8). Memorial Elementary School changed from being a middle school that serviced children in grades 6 to 8, to an elementary school servicing children in grades 3 to 5, inclusive of both the general education and special education programs. The special class programs for those with autism, cognitive impairment, multiple disabilities, and behavioral disorders for grades 3 to 5 were moved to Memorial Elementary, as were general education students from a variety of other schools across the district. Consequently, many regular education students and staff members were now in a building with special education programs that they had never been exposed to before. Naturally, new students and staff members were curious about the special class programs, the therapy room, and the related services personnel who were frequenting their classrooms on a regular basis. Staff and students were attempting to familiarize themselves with the variety of classrooms that now existed among them. Along with these changes came many staff changes that required administrators, teachers, and other personnel, to work together to foster a successful school environment, all while

adjusting to a new building, new staff, and new routines.

The school’s principal, Alysson Keelen, was looking for ways to encourage an inclusive and positive environment for all staff and students as part of the transition. The school’s occupational therapists, Jennifer Pacchiano and I (author Leonora Bradley), suggested that the Occupational Therapy Department hold an OT Month celebration in April that would allow staff and students to learn about the profession, and more specifically, its role in the school environment. We also had our own professional goals in mind, based on the American Occupational Therapy Association’s Centennial Vision of occupational therapy as a “powerful, widely recognized, science-driven, and evidence-based profession with a globally connected and diverse workforce meeting society’s occupational needs” (AOTA, 2007, p. 613). We wanted to target the professional staff of the school (teachers, assistants, administrators) as an avenue to promote the profession and its wide-reaching effects in terms of servicing people across the life span, with a focus on meaningful occupation for health, wellness, and participation in life.

In April 2016, with permission from the principal, the Occupational Therapy



Department decided to address two goals. The first was to educate the staff about occupational therapy. We wanted to foster an environment where staff members of the school could gain a sound foundational understanding of occupational therapy first and foremost as a health care profession, and then to understand how this profession fits into the world of public school education.

For this, we used the AOTA consumer-directed tip sheets (www.aota.org/tip-sheets) as information for staff. Each week, we emailed an introductory note and tip sheets to the entire school staff based on a different theme. Week 1 was “Health, Wellness, and Rehabilitation, week 2 was “Mental Health,” week 3 was “Aging,” and week 4 was “Children & Youth.”

We also made tip sheets available for free in the teacher lounges. During the month of April, the staff received lots of information on how occupational therapy can help with a range of topics, including breast cancer rehabilitation, chronic disease management, stroke rehabilitation, aging in place, posttraumatic stress disorder, backpack ergonomics, healthy play skills for children, and how to address sensory concerns for students at school.

Although the weekly emails to staff were beneficial and well-received, the high point of the month was the “Experience OT Day” that the department held during the third week of April. The day consisted of 15-minute group tours of the occupational therapy room by all classes and teachers, who signed up for a tour based on their schedules. The turnout was phenomenal, which showed the great interest in and curiosity about occupational therapy, from both staff and students.

The 15-minute tour incorporated a variety of hands-on experiences and information. On entering the room, the classes were shown a 2-minute video introducing occupational therapy, and describing how it promotes health, wellness, and independence for people of all abilities and all ages across settings.

After the video, the students participated in some school-based occupational therapy activities that educated them about topics such as sensory integration, how physical movement can affect learning, gross and fine motor skills development, and how such things affect one’s functioning throughout the school day. Set up in the occupational therapy room and reset for each group that came through, the stations included bouncing on large therapy balls and mini trampolines for proprioceptive and vestibular input, as well as coloring on the floor in prone position using different types of writing implements for grasp. A vertical surface station provided space for all students to experience a different position for writing and wrist extension when they signed

Creating an OT-Themed Holiday Tree

During the 2016 holiday season, the University of Tennessee Health Center (UTHSC) Master of Occupational therapy (MOT) Student Occupational Therapy Association (SOTA) chapter designed and created an occupational therapy-themed holiday tree. The tree was on display during the month of December at the Memphis Pink Palace’s Enchanted Forest Festival of Trees, sponsored by Le Bonheur Children’s Hospital. Using therapy equipment from the UTHSC MOT department, the students adorned the tree with gait belts, Therabands, pediatric splints, adaptive silverware, walkers, and even a skeleton (dressed in an ugly Christmas sweater, of course). The students created ornaments explaining what occupational therapy means to them and included labels on all of the adaptive equipment so that the public could learn more about the various adaptive tools. The students received great feedback from the Le Bonheur team responsible for the event, and they plan to carry on the tradition of promoting the occupational therapy profession and the UTHSC MOT program next year at the event!

Anne Zachry, PhD, OTR/L, is chair and assistant professor of the Department of Occupational Therapy at the University of Tennessee Health Science Center, in Memphis.

their names on a supersized “OT Month 2016” poster. Students used utensils and tongs on a lightboard activity with colorful water beads as a challenge for visual-motor integration, tactile sensory input, and upper extremity control. Each station had specific directions to follow so students could experience each activity in different ways, focusing on the use of their muscles, eyes, and attention while moving into different body positions.

Both general education and special education students were motivated, engaged, and participated with great joy and social interaction as they got to “experience OT” for themselves. This experience helped students to see each other and themselves in a new way in their new school community, while fostering understanding, tolerance, and compassion.

Lastly, an educational packet was created by the therapists and given to each student to take home. It included the definition of occupational therapy, and information on the background knowledge and education required to become an occupational therapist. Another handout specific to school-based occupational therapy was included that defined what occupational therapy practitioners do in the school



environment to enhance engagement and participation for all students. The last part of the packet was an occupational therapy coloring sheet that students could take back to class and use on their own time while reflecting on their experience.

“Experience OT Day” served as a platform for students and staff to experience a little bit of what occupational therapy practitioners do in the schools and how the profession positively impacts the educational experience of students of all abilities. More broadly, it also contributed to efforts to foster a positive and inclusive school community at Memorial Elementary School, showing how good things can be accomplished when occupational therapy practitioners, administrators, and teaching staff work together. 🍷

Reference

American Occupational Therapy Association. (2007). AOTA’s Centennial Vision and executive summary. *American Journal of Occupational Therapy*, 61, 613–614. <http://dx.doi.org/10.5014/ajot.61.6.613>

Leonora T. Bradley, MS, OTR, is an occupational therapist in the Howell Township Public School district in New Jersey. In addition to providing direct therapy to her students, she collaborates with teachers and administrators as part of a multidisciplinary approach to support student goals in the educational environment.

Assistive Technology for a Novice School-Based Occupational Therapist

Salvador Bondoc
Valerie Strange

Q

I am an occupational therapist new to the school-based setting. I receive frequent requests to provide assistive technology

(AT) evaluation to support students experiencing difficulties with reading and writing. With the wide array of technology options available, how do I go about choosing the best options to meet each student's individual needs? How do I ensure that what I am doing is within the scope of occupational therapy?

A

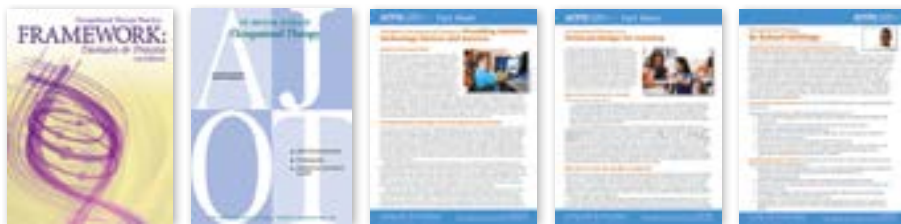
With the plethora of available technologies to support a student's attainment of educationally relevant goals, the choice of which

technology to use can be overwhelming for an occupational therapist who is a novice at working in a school-based setting. It may be tempting to go straight to a vendor or find the latest version of the technology that is being requested by the consulting or referral source. However, occupational therapy practitioners should be systematic and client-centered with their approach and apply proper professional reasoning when considering students' individual needs. As a new therapist in the school setting, it is important to consider using a set of guidelines for decision making that also incorporates the school team, particularly those professionals with different perspectives, knowledge, and contexts to support the decision-making process. In this regard, two important documents that may guide occupational therapists with their process are the *Occupational Therapy Practice Framework, Domain and Process, 3rd edition (Framework)*; American Occupational Therapy Association [AOTA], 2014) and the *AOTA Statement Assistive Technology and Occupational Performance* (AOTA, 2016). In particular, the latter highlights the role and process of occupational therapy in the ethical and competent provision of services using AT.

Using the *Assistive Technology and Occupational Performance* statement along with the *Framework* as a guide, the occupational therapist should begin by evaluating the student's occupational performance, skills, and capabilities (what can the student do?) as they pertain to the educationally relevant concerns (what is the student expected to do?). In addition, the appropriate team members, often led by occupational therapy practitioners,



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...it is important to remain engaged in a collaborative process to stay abreast of ongoing AT developments.

must determine the tasks, contexts, and environments that support performance and present barriers to participation. Through clinical reasoning and the use of a guiding framework, the occupational therapist may determine whether technology supports are needed. Once the therapist completes the “whole picture,” collaboration may continue with the team of professionals in providing AT. In this stage of the evaluation process, it is critical to outline the problem(s); identify goals; and suggest strategies, supports, and/or services to reach these goals. For example, do the suggested supports and/or services increase independence, increase access to curriculum, and/or increase participation within the educational context?

The occupational therapist has a distinct role in matching the student’s abilities and needs with potential supports that enhance participation across contexts. The Fact Sheet *The Role of Occupational Therapy in Providing Assistive Technology Devices and Services* (AOTA, 2015) provides general information about defining technology and occupational therapy’s role, as well as case vignettes related to a variety of AT types that address clients’ barriers to participation.

For a therapist who is new to providing occupational therapy services using AT, intra- and interprofessional collaboration is essential to ensure that the process of evaluation incorporates analysis of activities and environments with multiple perspectives provided before determining the right person–technology fit. Furthermore, part of the collaborative process is ensuring that the AT tool is

user friendly not only to the student user, but also to the educational team who shares the responsibility of AT implementation and carryover. Additionally, it is imperative to problem solve features of the technology and evaluate the effectiveness of the selected tool(s). Ultimately, it is the occupational therapist’s responsibility to monitor and assess the outcome of AT intervention and modify the intervention as needed.

As emphasized in *Assistive Technology and Occupational Performance* (AOTA, 2016), the provision of AT in the context of occupational therapy practice is client centered. That is, clients and their occupational needs (not the technology itself) are the primary consideration. Because of the evolving nature of technology, there is no single-best AT option for a given need. What was useful and cutting edge yesterday may be obsolete and inefficient tomorrow. Thus, it is important to remain engaged in a collaborative process to stay abreast of ongoing AT developments.

The For More Information sidebar above provides some resources for practitioners who are novices in applying AT in school settings. Practitioners can also learn more by networking with members of the Technology and Early Intervention & School Special Interest Sections on OT Connections, at www.otconnections.org. 📍

The Practice Perks Column is developed by AOTA’s Commission on Practice to disseminate information about AOTA official documents and other resources that are important and timely to the profession.

For More Information



Consumer Tips for Evaluating Assistive Technology Products

www.greatschools.org/gk/articles/evaluating-consumer-at-products/



Fact Sheet: *Occupational Therapy and Universal Design for Learning*

<https://goo.gl/AwDYQE>



Fact Sheet: *Occupational Therapy in School Settings*

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Also in Baltimore, June 25–26, 2017. Sponsor a training at your location. For dates & locations see calendar/registration on www.aotss.com. Abilities OT Services at www.AOTSS.com and www.irlenvlcmd.com. Internet learning options. Email info@aotss.com. Call 410-358-7269.

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APP May 20–21

Low Vision Rehabilitation: Treatment of the Older Adult with Vision Loss. Faculty: Mary Warren MS, OTR/L, SCLV, FAOTA. Practical workshop teaches participants how to evaluate and develop interventions for adults with vision loss from age-related eye diseases. Developing low vision programs, and documentation for insurance reimbursement included. Appropriate for all OT/OTAs working with older adults. Contact: www.visabilities.com or (888) 752-4364 or Fax (205) 823-6657

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APP July 26–29

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Promoting Medication Adherence: An Occupational Therapy Approach to Evaluation and Intervention by Jaclyn Schwartz, PhD, OTR/L. This on-line continuing education course examines the core concepts of medication management for adults in physical and psychosocial rehabilitation settings. Earn .3 CEUs (3.75 NBCOT PDUs/3

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Every Day Ethics: Core Knowledge for OT Practitioners and Educators, 3rd edition, by Deborah Yarett Slater, MS, OT/L, FAOTA. This important course provides a foundation in basic ethics information that gives context and assistance with application to daily practice for students, clinicians, educators, researchers, and those in other occupational therapy-related roles. Seven overarching learning objectives address critical information for occupational therapy personnel, including recognition of the role of ethics as part of our professional responsibility. Content also addresses what is actually meant by ethics, with a discussion on key ethical theories and principles that assist in analyzing and resolving situations that present ethical challenges. Earn .3 AOTA CEU (3.75 NBCOT PDUs/3 contact hours). Order #OL4953, Members: \$35, Nonmembers \$65, <http://store.aota.org> 0317

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Pediatric Constraint Induce Movement Therapy: Modules 1 and 2 by Andrew Persch, PhD, OTR/L, BCP. This continuing education program will provide you with information necessary to help you get started completing a PCIMT program with your pediatric clients. This course defines PCIMT, provide an overview of the evidence that informs practice and describes assessments and components of documentation of service delivery. Total credit earned (both courses must be completed) .3 CEUs (3.75 PDUs/3 Contact Hours). Order #OL4932, Members: \$59, Nonmembers: \$99, <http://store.aota.org> 0217

Online Course

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

CE Article

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

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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 PDUs/7 contact hours). Order #OL4983, AOTA Members \$79.00, Nonmembers \$200.00, <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



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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 PDUs/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 PDUs/2 contact hours). Order #OL4977, AOTA Members: \$34.95, Nonmembers: \$44.95, <http://store.aota.org> 1216

Online Course

Introduction to Evaluation and Treatment of Children with Eating and Feeding Disorders by Donna Reigstad, MS, OTR. This beginner to advanced beginner course is for pediatric therapists interested in developing the foundational

skills to provide comprehensive evaluation and treatment within an interdisciplinary setting. Participants in this course will develop an understanding of normal and abnormal aspects of oral motor skills and swallowing, and examine the developmental, psychosocial and cultural factors affecting children's eating and feeding skills. Earn .5 AOTA CEU (5 NBCOT PDUs/5 contact hours). Order #OL4980, AOTA Members: \$75.00, Nonmembers: \$120.00. <http://store.aota.org> 1016

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SIS Quarterly Practice Connections #3 - Measurement/Assessment. Earn CE credit with the *SIS Quarterly Practice Connections!* In this course, which draws from the content of *SIS Quarterly Practice Connections #3 - Measurement/Assessment*, you will learn to describe benefits of using assessments and various forms of measurement in occupational therapy practice; identify specific assessment tools that are used in occupational therapy for various populations and practice settings; and explain how OTs can use assessment results to develop holistic, occupation-based intervention plans. Earn .1 CEU (NBCOT PDU's 1.25/1 contact hour). Order #CESISC03, Members: \$20.99, Nonmembers: \$24.99. <http://store.aota.org> 1016

Online Course

A Contemporary Occupational Performance Approach to Pediatric Self-Regulation Part I: Theoretical Framework and Evaluation Considerations by Meredith Gronski, OTD, OTR/L and Theresa Henry, MSOT, OTR/L. This course will present an evidence-based theoretical foundation for authentic practice with children and youth who struggle with emotional and behavioral regulation. This course will offer a comprehensive framework for evaluation from an occupational performance perspective, focusing on assessment tool selection and developing a comprehensive, yet targeted measurement model. Earn .1 AOTA CEU (1.25 NBCOT PDU/1 contact hour). Order #OL4930, AOTA Members: \$24.99, Nonmembers: \$34.99. <http://store.aota.org> 0716

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A Contemporary Occupational Performance Approach to Pediatric Self-Regulation Part II: Self-Regulation Intervention Framework and Strategies by Meredith Gronski, OTD, OTR/L and Theresa Henry, MSOT, OTR/L. This course will present the most effective treatment strategies from a comprehensive foundation of evidence-based practices, all within the context of the PEOP (Person/Environment/Occupational Performance) framework, from Part 1 of this 2- part course. The primary focus of this course will be on client-centered, environmentally-relevant interventions that lead to productive occupational performance across the developmental continuum from early childhood to adolescence. Earn .1 AOTA CEU (1.25 NBCOT PDU/1 contact

hour). Order #OL4931, AOTA Members: \$24.99, Nonmembers: \$34.99. <http://store.aota.org> 0716

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Applying the OT Practice Guidelines for Adults With Neurodegenerative Diseases by Katharine Preissner, EdD, OTR/L. Evidence-based practice is integral to successful client outcomes. This course is intended to assist occupational therapy practitioners in providing evidence-based assessment and interventions to adults with neurodegenerative diseases (NDDs). The course facilitates the use of the practice guidelines by presenting the information in a multimedia format and walking the learner through case studies that illustrate important concepts in the guidelines. Four interactive case studies are presented that address the following NDDs: Multiple Sclerosis (MS), Parkinson's Disease (PD), Amyotrophic Lateral Sclerosis (ALS), and Transverse Myelitis (TM). Earn .15 CEU (NBCOT 1.88 PDUs/1.5 contact hours). Order # OL4896, AOTA Members: \$34.95, Nonmembers: \$49.95. <http://store.aota.org> 0216

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Occupational Therapy: Across the Parkinson's Disease Continuum Series - designed and created in collaboration with the Parkinson's Disease Foundation. These online courses are designed by expert occupational therapy practitioners in the field of Parkinson's to help their colleagues to ensure best practice care for people living with the disease. These courses will provide practical, evidence-based knowledge across the continuum of Parkinson's care to help occupational therapists evaluate and treat individuals in all settings — including in home care, community rehabilitation and long-term care practice settings. Earn .2 AOTA CEUs (2.5 NBCOT PDUs, 2.0 contact hours). Members/Nonmembers: \$19.95. **Module 1:** Overview of Parkinson's Disease (Order #OL4960); **Module 2:** Assessment in Parkinson's Disease Intervention (Order #OL4961); **Module 3:** Occupational Therapy Intervention for Parkinson's Disease (Order #OL4962); **Module 4:** Parkinson's Disease: Emerging Research, Resources, & Beyond (Order #OL4963). <http://store.aota.org> 0216

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Faculty



Assistant Professor, Midwestern University

The **Midwestern University Occupational Therapy Program** in Downers Grove, IL has immediate opportunities to join an established occupational therapy program. The program is currently in the Candidacy phase of the transition process from

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Interested applicants should apply online at www.midwestern.edu. Application packets should include a letter of interest, CV, and the names and contact information of 3 professional references. Additional questions may be directed to Mark Kovic, OTD, OTR/L, FAOTA, Chair, OT Program Search Committee, Occupational Therapy Program at mkovic@midwestern.edu.

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Faculty



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Qualifications: Master's degree in a relevant field and four to five years of relevant experience; eligible individuals must meet the required criteria for adjunct/part-time faculty status.

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Faculty



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The Department of Occupational Therapy at East Carolina University is seeking applications for a 12-month, tenure-track faculty position at the rank of Assistant or Associate Professor for a Master of Science program with a 10-year ACOTE re-accreditation.

A cohort of 26 students is admitted each fall and demonstrates high levels of participation at national conferences to disseminate student research. The first-time pass rates for NBCOT certification exam have ranged from 96-100% over the years. The Department has five dedicated labs with ample equipment and supplies which are all technology-enhanced. The Department is among nine departments in the College of Allied Health Sciences that is attached to the medical library. The College is within the Division of Health Sciences, along with nursing, medicine, and dentistry. It is also adjacent to a 900-bed, level-1 trauma center which offers multiple opportunities for partnership. East Carolina University, with 29,000 students, is located in Greenville, North Carolina (population of 89,000). It is 90 miles from the beautiful Crystal Coast and the Research Triangle and is within driving distance of the District of Columbia, Myrtle Beach/Hilton Head, and the Smoky Mountains. Faculty workloads support a balance of teaching, research, and service. Faculty member responsibilities include teaching, mentoring and advising graduate students in research including projects and/or theses, engaging in scholarly research and funding, and service at the university, community, and professional levels. Start date will be July 1, 2017 or later.

Minimum Qualifications:

- Occupational therapist with an earned post-professional doctorate in occupational therapy or a related field (PhD, ScD, EdD, DHSc, DSc, OTD, DrOT)
- Three years of clinical and/or teaching experience in occupational therapy
- Eligible for licensure as an occupational therapist in the state of North Carolina

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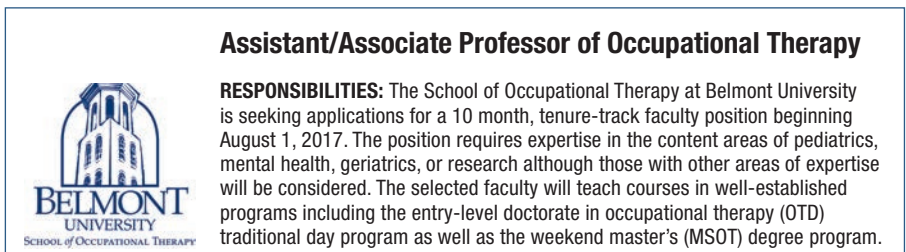
- Demonstrated post-doctoral research experience
- Doctorate degrees listed under AOTA post-professional OT Programs
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Special Instructions to Applicants: East Carolina University requires applicants to submit a candidate profile online in order to be considered for the position. In addition, please submit online the required applicant documents: Curriculum Vitae, Letter of Interest, List of Three References (noting contact information). For additional inquiries, contact Dr. Young Kim, Chair of Search Committee, at kimyo15@ecu.edu.

Application Types Accepted: Candidate Profile (EHRA only). Applications will be considered until position is filled. Please submit an online ECU application for vacancy # 975006 to ECU Human Resources at www.jobs.ecu.edu.

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Faculty



Assistant/Associate Professor of Occupational Therapy

RESPONSIBILITIES: The School of Occupational Therapy at Belmont University is seeking applications for a 10 month, tenure-track faculty position beginning August 1, 2017. The position requires expertise in the content areas of pediatrics, mental health, geriatrics, or research although those with other areas of expertise will be considered. The selected faculty will teach courses in well-established programs including the entry-level doctorate in occupational therapy (OTD) traditional day program as well as the weekend master's (MSOT) degree program.

QUALIFICATIONS: A minimum of five years of clinical experience in occupational therapy or other health-related fields is required. Two years of full-time graduate teaching experience or its equivalent is preferred; one year experience or its equivalent is required. Experience with mentoring student research and a history of peer-reviewed publications is also preferred. An earned doctorate (PhD, EdD, OTD) is required. Post-professional degree is preferred. Candidates must be licensed, or eligible for licensure, in TN and have current NBCOT certification.

THE UNIVERSITY: Belmont University is located in Nashville, Tennessee. Belmont is a student-centered Christian university focusing on academic excellence that seeks to attract an active, culturally and academically diverse faculty of the highest caliber skilled in the scholarship of teaching, discovery, application, and integration of faith. Belmont is listed #2 among most innovative schools and #6 among best regional schools in U.S. News and World Report's annual rankings of America's Best Colleges in the South. Belmont brings together the best of liberal arts and professional education in a Christian community of learning and service.

APPLICATION: Additional information about the position and the online application can be found at <https://jobs.belmont.edu>. An electronic version of a Cover Letter, Curriculum Vitae, Teaching Philosophy, and a Response to Belmont's Mission, Vision, and Values statement articulating how the candidate's knowledge, experience, and beliefs have prepared him/her to contribute to a Christian community of learning and service must be attached in order to complete the online application. Review of applications will begin immediately and continue until the position is filled. The selected candidate will be required to complete a background check satisfactory to the University. Questions concerning this position should be directed to Elena Wong Espiritu, OTD, OTR/L, BCPR, Faculty Search Chair, at elena.espiritu@belmont.edu.

Belmont University is an equal opportunity employer committed to fostering a diverse learning community of committed Christians from all racial and ethnic backgrounds.



OT–OTA Relationships

My First Professional Mentor

Aimee Sidhu

In 2000, I began my career as a school-based occupational therapist for a small, rural school district with about 1,000 students, between 35 and 50 of whom I wound up working with each year. As an entry-level therapist (in fact, the only occupational therapist), with no present mentor or guide within my practice setting, I quickly found myself “drowning.” After struggling on my own for a while, I realized that I needed to surround myself with other practitioners who could help guide and inform my career, in order to increase my effectiveness as a clinician. I did this in two ways: first, I initiated a county-wide pediatric clinicians group for occupational therapists and physical therapists, and second, I took part-time work at the local skilled nursing facility (SNF). That was where I met Arlene.

Arlene, wearing a white lab coat and scrubs, was walking with a clipboard down the long Med A wing of the SNF, pointing out to me the different client rooms and common areas and the general set up of the facility. As we rounded the corner at the Nurse’s Station, she quickly flipped through a number of client charts and rapidly gathered up-to-date information about the clients in our workload that day. I was being initiated into the world of occupational therapy in a SNF, and my expert guide was an occupational therapy assistant.

My experience to that point with occupational therapy assistants was slim, in that I had not had any field-

“...I realized that I needed to surround myself with other practitioners who could help guide and inform my career...”

work experiences with them, and there had only been one in my occupational therapy class.

Yet this has been one of the most rewarding professional relationships of my career—not for its longevity (we worked together for only about 2 years) or lifelong friendship, but for the challenge and vision it spurred in me. Arlene truly taught me everything I needed to know about being an occupational therapy practitioner in a SNF. More importantly, she taught me everything I needed to know about being in an intraprofessional supervisory relationship.

Our intraprofessional relationship was built on implicit trust. This concept is found throughout the literature (e.g., Ayres, Watkeys, & Carthy, 2014; White & Winstanley, 2014). I trusted that she knew the things that I didn’t—what the supervisory regulations were, how to calculate a Resource Utilization Group score, how to document in the relatively new electronic medical record and the paper chart, how to measure active and passive elbow range of motion, how to

(accurately!) measure blood pressure, how not to get “conned” into doing too much for the client, and how to make friends with all the important but sometimes overlooked colleagues (e.g., nursing assistants, restorative aides, janitors, cooks). Arlene understood the occupational therapy scope of practice, both professional and legal, thus allowing her to teach me about and appropriately delineate my role and responsibilities within the SNF setting.

More than 10 years later, all these many lessons learned are etched in my visual memory because they were my “firsts” in intraprofessional relationships and “firsts” in specific client care situations. My first mentor did much to help me achieve effective clinical care for clients, establish my own growth and development in the field of occupational therapy, and begin to understand how the intraprofessional relationship works within the profession. 📧

References

- Ayres, J., Watkeys, F., & Carthy, J. (2014). Quality and effectiveness of clinical supervision: Evaluation of an occupational therapy service. *British Journal of Occupational Therapy*, 77, 447–450.
- White, E., & Winstanley, J. (2014). Clinical supervision and the helping professions: An interpretation of history. *The Clinical Supervisor*, 33(1), 3–25.

Aimee Sidhu, MA, OTR/L, is an instructor and the academic fieldwork coordinator at Bates Technical College’s Occupational Therapy Assistant Program, in Tacoma, Washington. She is currently an occupational therapy doctoral student at Mount Mary University, in Milwaukee, Wisconsin.

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