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# OT PRACTICE

**AOTA • THE AMERICAN OCCUPATIONAL THERAPY ASSOCIATION**

VOLUME 14 • ISSUE 7 • APRIL 20, 2009



**SPECIAL SECTION**

**Welcome to Houston!**
AOTA 2009 Annual Conference & Expo 26

## FEATURES





## DEPARTMENTS



**CE Article**

**Promoting Employment for People With Disabilities: Update on the Ticket to Work and Work Incentives Improvement Act**

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# NEWS

*Association updates...profession and industry news*

*AOTA Updates*

## Conference Update

It's not too late! You can still register onsite for the 2009 American Occupational Therapy Association's Annual Conference & Expo in Houston, April 23 to 26. If ever there was a time to take advantage of top-notch learning, it is **now!**

## New on OT Connections: SIS Article Review Forum

The Special Interest Sections (SISs) are sponsoring a new, interactive discussion and learning site on OT Connections. An article review forum is an electronic method to discuss a current research article. The electronic discussion will focus on understanding the research question, the research methods, the results and conclusion, and most importantly how the findings of the research can be directly related to practice and generalized to other clients. Each month, a different SIS will post a journal article and questions to facilitate discussion among participants. SIS forums are open to all AOTA members as a free benefit.

Beginning March 30, 2009, and continuing until April 30, 2009, join colleagues in an article review forum with a focus on **technology.** During this 4-week period, the chair of the TSIS and an article author, Tony Gentry, will pose questions and engage in electronic dialogue on the journal article, "PDA as Cognitive Aids for People With Multiple Sclerosis." Go to OT Connections at www.OTConnections.org, and login using your regular AOTA Web site login and password. Click on Forums, then SIS Forums, then Special Interest Section Article Review Forum in the list of SISs. Novice to experienced practitioners are welcome. All practitioners interested in technology, cognitive supports, and physical disabilities are encouraged to participate.

## 2010 AOTA Call for Papers

AOTA invites you to share your innovations and experiences by submitting a proposal to present at the 90th Annual Conference & Expo in Orlando, Florida, April 29 to May 2, 2010. Proposals can be submitted at any time from May 18, 2009, until midnight June 18, 2009, by logging onto the AOTA Web site at www.aota.org and clicking Call for Papers. Complete instructions are available online.

## AOTA and NAHB Collaboration

If you are honing your skills in the area of home modifications, AOTA's Annual Conference & Expo in Houston offers several great opportunities, including AOTA's Pre-Conference Institute "Home Modifications for an Aging Population" on April 22, from 12:00 p.m.–6:30 p.m., and an AOTA-National Association of Home Builders (NAHB) collaborative short course "Building Bridges: Enhancing Communication with Partners in Home Modifications" on April 23, from 12:30 p.m.–2:00 p.m. Or, take advantage of NAHB's Certified Aging in Place Specialist (CAPS) courses, hosted by the Greater Houston Builders Association, from April 26 to 28 (directly after AOTA's Annual Conference).

CAPS I and II courses will be held at the Greater Houston Builders Association, 9511 W. Sam Houston Parkway N., in Houston. The courses include "Marketing & Communications Strategies for Aging & Accessibility" (CAPS I) on April 27, from 9:00 a.m.–4:00 p.m., and "Design/Build Solutions for Aging and Accessibility" (CAPS II) on April 28, from 9:00 a.m.–4:00 p.m.

For more information on NAHB's CAPS designation go to www.nahb.org/caps. For registration information about the Houston GHBA, courses go to http://www.ghba.org/source/meetings/education.cfm or contact Peggy Means at 281-970-8970, ext. 161.

## Show Your Pride During OT Month!

April is OT Month, and there is still plenty of time to show your pride in being an occupational therapy practitioner. Help promote the profession by using great ideas and fun products from AOTA's 2009 Occupational Therapy Month Catalog at www.promoteot.com. AOTA members know better than anyone that occupational therapy helps people of all ages live life to its fullest. Take advantage of your knowledge, network, and 2009 OT Month resources to help educate others!

*Research Highlights*

## Occupational Therapy Autism Study

New research suggests that, because children with autism are unlikely to properly self-report their experiences, interviewing their parents may add important information to help families understand and better respond to the needs of their children, thereby easing challenges in daily routines.

This method—called the Critical Incident Technique—asks parents to determine situations where their child had a "good" sensory experience and situations where their child had a "bad" sensory experience, then provide their own perception of how these experiences felt to the child. According to the study, conducted by University of North Carolina at Chapel Hill researchers and published in the March/April issue of the *American Journal of Occupational Therapy*, the most common negative reactions for both typically developing children and children with autism are related to sound, and the most common pleasant experiences for both groups involve touch and movement. Children with autism were reported to have more "unusual" sensory experiences and negative food-related experiences than their typically developing peers.

"The ability of parents or other caregivers to adapt to their child's sensory processing problems can influence the number, type, or quality of shared experiences, both in a positive and negative way,

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Bulletin Board is written by **Jennifer Folden,** AOTA Marketing Specialist.

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and may facilitate or constrain engagement in daily family routines," said study co-author Grace T. Baranek, PhD, OTR/L, FAOTA, professor in the Division of Occupational Science at the University of North Carolina at Chapel Hill. "Qualitative studies like this one can add to our knowledge of both autism and the sensory processing issues associated with it."

Along with Baranek, other study authors were Virginia A. Dickie, PhD, OTR/L, FAOTA, associate professor and director of the Division of Occupational Science; Beth Schultz, MS, OTR/L, training coordinator for the Sensory Experiences Project; Linda R. Watson, EdD, associate professor in the Division of Speech and Hearing Sciences; and Cara S. McComish, MA, CCC-SLP, a PhD candidate in the Division of Speech and Hearing Sciences. AOTA members can access *AJOT* online at www.aota.org.

*Resources*

## Easter Seals Study Looking for Research Collaborators

In cooperation with the Autism Society of America, Easter Seals surveyed more than 2,500 parents of children with autism and typically developing children about daily life, relationships, independence, education, housing, employment, finances, and health care. The original data were mined for Easter Seals' purposes; however, there is potentially more information to be garnered that could help other professionals. The data currently reside in an SPSS file, and Easter Seals would welcome the opportunity to share it with interested researchers. Please contact Patricia Wright at pwright@easterseals.com for more information.

## Proposals for Alzheimer's Respite Program

The Brookdale National Group Respite Program awards seed grants to organizations working to develop and implement social model group respite programs. The goals of the program are to provide persons with Alzheimer's disease or a related dementia with opportunities to engage in meaningful social and recreational activities in a secure and supportive setting to maximize their cognitive and social abilities, and to provide relief and support to family members and other primary caregivers. Funding is available for up to 40 organizations working to develop new dementia-specific programs. Complete program guidelines are available at the Brookdale Foundation Web site at www.brookdalefoundation.org.

## Occupational Therapy and Psychiatric Rehabilitation

Occupational therapy practitioners are encouraged to review the special section on occupational therapy and psychiatric rehabilitation in the Winter 2009 *Psychiatric Rehabilitation Journal*. This special section was developed by an international editorial team of occupational therapists including Terry Krupa, PhD, OT; Catana Brown, PhD, OTR, FAOTA; Ellie Fossey, PhD, DipCOT, AccOT; and Deborah Pitts, MBA, OTR/L, CPRP. Contributing authors were invited by the editorial team and include occupational therapy researchers Bonnie Kirsh, PhD, OT, and Lynn Cockburn, OT(C), MSPH, MEd, from Canada;

Mona Eklund, Christel Leufstadius, and Ulrika Bejerholm from Sweden; Louise Farnworth from Australia; and Jaime P. Munoz, PhD, OTR, FAOTA, from the United States. The articles address occupational therapy's contribution to the field of psychiatric rehabilitation, including a perspective on functional assessment, occupational deprivation, and time use. This is the first time this journal has focused on a particular profession, and AOTA's Mental Health Special Interest Section Standing Committee is thankful to Pat Nemec and Kathleen Furlong-Norman, co-editors of the *Psychiatric Rehabilitation Journal*, for this unique opportunity. You can access the article abstracts at www.bu.edu/cpr/prj/.

## *Practitioners in the News*

■ **Terry de las Alas,** MS, OTR/L, was awarded the 2009 Outstanding Fieldwork Educator Award for Duquesne University. The award is student-nominated and given yearly to the fieldwork educator who actively demonstrates exceptional clinical skills, excellent team relationships, and superior interpersonal skills; motivates students to learn; and has a willingness to share resources and knowledge. Alas has supervised occupational therapy students for 6 years and currently works at The Children's Institute in Pittsburgh.

■ **Jessica Davis,** a second-year occupational therapy student at Alabama State University, along with **Nikki Raines,** MPA, OTR/L, and classmate **Jamie Hayden,** was on two broadcasts of "Time of Your Life" in November to promote CarFit events to the community. The group discussed CarFit and the implications of maintaining safe driving for the individuals themselves and others in the community, as well as the profession of occupational therapy.

■ **Gail Fisher,** MPA, OTR/L, clinical associate professor and associate department head in the Department of Occupational Therapy at the University of Illinois at Chicago, was appointed by the AOTPAC Board of Directors to represent AOTPAC's Region III. Fisher brings diverse political and advocacy experience to her position. She will serve a 3-year term that started January 1, 2009.

■ **Ingrid Kanics,** OTR/L, therapy director at Hattie Larlham in Mantua, Ohio, received the Inclusion Champion Award presented by the Mitsubishi Electric American Foundation (MEAF) at the Journey Toward Inclusion luncheon in San Diego. The award was established by MEAF to honor individuals who have made a measureable and sustainable impact on promoting the inclusion of youth with disabilities. Kanics was recognized for her inclusion advocacy within the Hattie Larlham organization and her efforts to develop programs and spread the word about inclusion to communities throughout the country. Kanics started working with Hattie Larlham when the organization hired her company to create the design for their new play center in 2003. This special facility assists in the development of cognitive, social, physical, and emotional skills of persons with mental retardation and/or developmental disabilities. It also provides educational and networking support to families and surrounding communities. Prior to joining Hattie Larlham as a full-time employee, Kanics worked at the Center for Creative Play as a consultant, where she assisted many communities and museums in creating universally accessible indoor play environments. ■

**Molly V. Strzelecki** is the associate editor of *OT Practice*.


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CAPITAL BRIEFING

# *Reimbursement and Regulatory Round-Up*

**Jennifer Bogenrief**

AOTA's Reimbursement and Regulatory Policy Department (RRPD) has been vigorously advocating for fair coverage and payment policies for occupational therapy (OT) practitioners and for inclusion of OT services in a variety of regulatory programs. The following are just a few of our recent successes.

## MEDICARE OUTPATIENT THERAPY CAP

In addition to the work of our Federal Affairs staff to introduce legislation to repeal the therapy cap, RRPD staff have been working closely with the Centers for Medicare & Medicaid Services (CMS) on two projects studying alternatives to the therapy cap. The Short Term Alternatives to Therapy Services (STATS) project seeks temporary fixes (through 2010) to alleviate the burden of the therapy cap on providers while controlling outpatient therapy utilization. The Developing Outpatient Therapy Payment Alternatives (DOTPA) project is long term (through 2013) and involves devising and testing an assessment tool to gather data about what types of patients require medically necessary therapy under the Part B benefit. AOTA has been actively advocating for OT through its expert member representatives to each of these projects. AOTA will continue to advocate for the recognition of OT practitioners' clinical judgment as an important part of identifying patient need and to monitor closely the potential use of data gathered to formulate a new therapy payment model.

## CHANGING MEDICARE'S IRF SYSTEM

AOTA is part of discussions about how to modify the Inpatient Rehabilitation Facility (IRF) classification system. The 75% rule was lowered to 60%, and now CMS's contractor, RTI International (RTI), is considering data and stakeholder input on recommendations for a modified IRF classification system. RRPD staff participated by attending the IRF Technical Expert Panel meeting in February, as well as submitting written comments ahead of the meeting. CMS/RTI will submit a report to Congress in June and continue to study the IRF system.

## AOTA GETS A VOTE ON QUALITY MEASURES

After nearly 2 years of advocacy with the American Medical Association's Physician Consortium for Performance Improvement (AMA-PCPI), AOTA recently attained a voting seat at the table in developing quality measures. As a non-voting member we were able to participate in workgroups, propose topics relevant to OT, and review and comment on all measures, but only physicians had the right to vote on measures. The right to vote is especially important for ensuring a greater number of OT measures for CMS's Physician Quality Reporting Initiative (PQRI). AOTA's primary representative is Trudy Mallinson, PhD, OTR/L, NZROT, and the alternate representative is Wendy Coster, PhD, OTR/L, FAOTA. AOTA's right to cast a vote through a representative at AMA-PCPI meetings will enhance our influence in measure development and provide a critical voice in future thinking about what qualifies as quality health care.

## KEY INPUT ON LOCAL MEDICARE POLICIES

In 2008, AOTA submitted comments on 13 individual draft local coverage determinations (LCDs) regarding a wide range of OT services and impacting 31 states. An LCD is a formal policy adopted by a Medicare contractor concerning whether a particular item or service is reasonable and necessary and should be covered in the contractor's jurisdiction. Contractors use LCDs to decide whether to pay claims submitted by Medicare providers. AOTA monitors LCDs and advocates in collaboration with state associations for appropriate payment polices.

## ORTHOTICS ADVOCACY

AOTA is doing significant work on orthotics issues. Some successes include accreditation and competitive bidding exemptions for OTs in private practice, and a surety bond exemption for OTs furnishing orthotics to their own patients. AOTA is working with a coalition of similarly affected provider organizations on many of these issues.

RRPD staff, along with staff from APTA and ASHT, met with CMS officials in February to discuss occupational and physical therapists' qualifications to furnish and fabricate orthotics and prosthetics (O&P) as part of an upcoming O&P rulemaking. AOTA provided background regarding OT licensure, scope of practice, professional standards, and education and training. CMS plans to publish a proposed rule by the end of 2009.

AOTA will continue to monitor the above issues, and more. Membership in AOTA and your state association provides the resources we need to advocate for fair coverage and payment for the full scope of OT services. ■

**Jennifer Bogenrief** is AOTA's senior regulatory analyst in the Reimbursement and Regulatory Policy Department.

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*1 - Alon G, et al. J Stroke and Cerebrovascular Dis. 2002;11:99-106. 2 - Alon G, et al. NeuroRehabilitation 2003;18(3):215-225. 3 - Ring H, et al. J Rehab Med. 2005; 37:32-36.*

# A Plan for Life

**Molly V. Strzelecki**

It's not every day that an occupational therapist gets called to the witness stand. And unless you're involved in advocacy for the profession, it's probably rare that you'll be asked to provide testimony in front of others. But for Nancy Mitchell, MA, OTR/L, ATP, CLCP, FIALCP, regular appearances with lawyers, judges, or insurance companies isn't really out of the ordinary.

"I have two jobs," Mitchell explains. "I work half-time as an occupational therapist, and the other half as a life care planner."

Mitchell started her life care planning business, Mitchell Disability Assessments & Life Care Planning, about 12 years ago after a physician contacted her with an attorney's request seeking an evaluation and report on a 4-year-old child with a disability. The physician asked Mitchell to paint a picture for him on what the disability would mean for the child as an adult.

"It was such a different way of thinking," Mitchell says. "And it was kind of fun for me, and stretched my thinking."

But what, exactly, *is* life care planning, you might ask. Mitchell uses the example of the late actor Christopher Reeve, pointing to the costs associated with his care after his paralyzing accident.

"What kind of wheelchair will he need? How much maintenance will it need? How much will that cost?" Mitchell says. "You're looking at an item, figuring out how frequently it needs to be replaced, what the cost of it is, even down to things like how many boxes of rubber gloves will the caregivers need? How many catheters? How many pieces of bath equipment? What bath pieces are most appropriate? You're looking at all of the things associated with the care. And it can be millions of dollars, depending on the person's disability." Mitchell's cases typically touch on one of the three main reasons life care planning is needed: (1) the plans are considered the damages part of a law suit, and are critical in determining the worth of a claim; (2) the plans are used by insurance companies for budgeting purposes when they are responsible for care; or (3) the plans are used in estate planning to set aside funds for an individual with a disability after their caretaker dies.

After that first case, the physician contacted Mitchell for a second case, which involved videotaped testimony. When she arrived to tape her testimony, a vocational counselor at the site queried Mitchell as to whether she'd ever thought about being a life care planner.

"'What's a life care planner?' I asked," Mitchell recalls. After some investigation she undertook the life care planning training—in her case, eight 2-day modules in various locations across the country—and got certified, then began marketing herself.

"Being a life care planner can be more lucrative than being an occupational therapist," Mitchell admits, "but you might not want to give up your day job for a number of reasons. Number one, it takes quite a long time to establish yourself in the practice and get enough business to sustain yourself. Secondly, it's important and helpful to be a practicing occupational therapist because it gives more credibility to your testimony—you're not just a 'hired gun' for the attorney or insurance company. There are occupational therapists who successfully life care plan full time, but I personally find that my continued occupational therapy work greatly enriches my business, and I've been told by attorneys that this is valuable."

When Mitchell began as a life care planner, she started out working solely in Minnesota, where she is also licensed as an occupational therapist. As her business grew, so too did the number of calls requesting her services in other states. While the life care planning certification is nationally recognized, her licensure in occupational therapy doesn't have the same reciprocity. Since starting, Mitchell has become licensed to practice occupational therapy in four additional states—North Dakota, South Dakota, Iowa, and Wisconsin—but doesn't know if she'll seek any more. It's not the process of obtaining the licenses Mitchell finds to be a barrier, though it does involve a lot of paperwork and providing of documentation from every state in which she is licensed; rather, it's keeping track of everything to make sure she's not in violation.

"Keeping track of the licenses is a nightmare," she states. "I have a spreadsheet to keep track of them, but I still really worry that I won't look at it in time, and a license will lapse, plus it's expensive to maintain the licenses. Nurses have reciprocity where they can work across state lines, but occupational therapists don't have that. And the frustrating part is that there are so few occupational therapists who are life care planners in the country that I don't think anyone is really motivated to help us make this work."

Mitchell acknowledges that while she doesn't need to be a licensed

## Guidelines for Supervision, Roles, and Responsibilities During the Delivery of Occupational Therapy Services

Mary Jane Youngstrom

**Q: I am an occupational therapist with 3 years of experience and have just taken a new job in which I will be supervising an occupational therapy assistant. I have never supervised an OTA before and am wondering what type of supervision I should provide.**

**A:** The *Guidelines for Supervision, Roles and Responsibilities During the Delivery of Occupational Therapy Services* (AOTA, 2004) is an AOTA document that outlines general principles to guide the supervisory process and describes the roles and responsibilities of both the occupational therapist (OT) and the occupational therapy assistant (OTA) during the service delivery process.

This document describes supervision between an OT and OTA as a collaborative process, with each sharing in the responsibility. As the OT, you are responsible for the safety and effectiveness of all aspects of the OT service delivery process. Likewise, the OTA is responsible for seeking appropriate supervision to ensure safe and effective services. Together the two of you are responsible for collaborating to develop a plan for supervision. A supervisory plan should outline the frequency, methods, and content of supervisory exchanges.

Frequency, methods, and content vary by practice setting and are influenced by the following factors. A brief example of how the supervisory plan may be affected by each factor is described.

- Complexity of client needs (e.g., clients with more complex needs may require more direct supervisory observation).
- Number and diversity of clients (e.g., if a caseload becomes more diverse, the content of supervisory contacts will expand to cover discussion of treatment of different diagnoses or occupational needs).
- Skills of the OT and the OTA (e.g., an OT and OTA who are both more experienced and have worked together for a period of time may find that supervisory meetings can be less frequent while still ensuring safe and effective service delivery).
- Types of practice setting (e.g., a fast-paced practice setting with rapid client turnover may necessitate more frequent contact between the OT and OTA).
- Requirements of the practice setting (e.g., some settings may require weekly contact between the OT and OTA).
- Other regulatory requirements (e.g., state licensure laws and/or accrediting bodies may mandate that all supervisory contacts be recorded in a log).

Because each practice setting, each client caseload, and each OT and OTA are different, supervisory plans will vary and will change across time. It is important, however, to recognize that many state regulatory laws specify specific supervisory requirements, such as frequency of supervisory contact or the number of OTAs that may be supervised by one OT. These state rules and regulations take precedence over AOTA suggested guidelines. Be sure you are up to date on the rules and regulations about OTA supervision in your state.

### Reference

American Occupational Therapy Association. (2004). Guidelines for supervision, roles, and responsibilities during the delivery of occupational therapy services. *American Journal of Occupational Therapy, 58,* 663–667.

**Note:** COP revised this document and submitted it to the Representative Assembly for approval at the online meeting from March 30–April 10. The results arrived after this issue went to press, so please check AOTA's Web site for an update.

**Mary Jane Youngstrom,** MS, OTR/L, FAOTA, is a visiting professor at Rockhurt University's occupational therapy education program in Kansas City, Missouri, and see clients in outpatient and SNF settings. She was chair of the COP from 1998 to 2002 and is on the current COP.

**In Practice Perks,** Commission on Practice (COP) members provide regular summaries of different official documents. These documents can be found in the *American Journal of Occupational Therapy* and in *The Reference Manual of the Official Documents of The American Occupational Therapy Association, Inc.* More information about COP can be found on the AOTA Web site at www.aota.org. Click on Practitioners, then Practice Resources.

occupational therapist to work in another state as a life care planner, not being a therapist limits what she can do, meaning she can't bring her occupational therapist's skills to the table.

"I can't put my hands on the client, I can't do any testing, I don't do any functional activities," Mitchell says. But when working in a state where she is licensed as an occupational therapist, it's a completely different ballgame.

"I can really give my OT perspective of how a disability will affect a person's life," she says. "I have people do a lot of different functional activities like getting in and out of the bathtub, balancing a checkbook, taking them to the grocery store to see how they perform, and then talk about what assistance they might need.

"The most expensive part of a life care plan is typically when people need hired help," Mitchell continues. "When I can state that I had the client dress themselves, and yes, they can dress themselves but it takes them 45 minutes and they're exhausted when they're through, is that how they really want to spend their energy if it's so time consuming?"

Many pages of a life care plan fall under the expertise of an occupational therapist, Mitchell says, which makes it an ideal area for therapists.

"Occupational therapists are trained to look at the whole person, and to create a life care plan is to look at the global needs of the person and make recommendations," she says. For therapists interested in life care planning, Mitchell recommends talking to a life care planner to really understand the scope of the job, and having good occupational therapy experiences under your belt.

"I see a lot of people with spinal cord injury, brain injury, cerebral palsy, and the like," she notes. "You need to be detail-oriented, organized, and self-motivated, because you're working out of your home. You need to have good critical thinking skills. It's a lot to juggle and balance.

"But I love it," Mitchell says. "I've been an occupational therapist for 35 years, and for me to use my OT skills in a whole different way is exciting for me, and very cognitively stimulating. I feel very energized by this way of using the skills I've had for a long, long time." ■

**Molly V. Strzelecki** is the associate editor of *OT Practice.*

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## Seeing and Seizing Opportunity

# Change Agents

**JENNY WOMACK**
**TOMEICO FAISON**
**ELIZABETH HARTZOG**
**STACY SPRINGER**
**CHARLOTTE ROYSTER**

Do you see a need in your workplace and wish you had the time, skills, or resources to address it? Do you dream of reaching beyond your practice to meet needs in the broader community or on a systems level? Taking responsibility for realizing a solution to a pressing need can be daunting; we see people who do it, but convince ourselves that we don't have the time, talent, or connections to make it happen ourselves. This article tells the story of four clinicians, each of whom had these same thoughts, and yet used a combination of their education and personal passion to create change in their communities, their practices, and their world.

At the University of North Carolina at Chapel Hill (UNC-CH), a new curriculum based in occupational science and emphasizing clinical reasoning and occupation-centered practice was instituted in 1998. Among the seven themes that made up the foundation of the curriculum was the expectation that graduates would become scholars and change agents in systems. The ideal, but not the definition or expectation, of that outcome was clear. Are change agents those who become leaders in professional organizations? Department supervisors? Doctoral students? Or might there be a way to conceptualize the idea of working for positive change not by title, but by a willingness to see and act on opportunities?

In 2006–2007, the UNC-CH faculty conducted a survey of alumni from the first 6 years of this new curriculum (classes of 2000 through 2005) and their employers to determine whether the revised curriculum was meeting its objectives. Rather than asking if graduates saw themselves as scholars and change agents, we asked them to describe major accomplishments in practice and professional activities.

The four vignettes presented here are offered in the spirit of recognizing how commitment and leadership in any type of practice setting can positively affect clients, colleagues, and societal views of our profession. These alumni each indicated roles in which they had served as change agents and were asked to talk about that process and the advice they might give practitioners who wanted to take similar risks. Though featuring UNC Chapel Hill graduates, these are our stories as a profession—change agents at work, motivated to see beyond artificial boundaries and seize possibilities.

**Photo 1. Tomeico Faison helps a client read the Bible using a magnifier.**

### TOMEICO FAISON, CLASS OF 2001

**(See Photo 1)**

I graduated from UNC-CH in 2001 and wanted to immediately go into private practice. For some reason I had created an imaginary rule that I needed at least 5 years of experience before exploring entrepreneurship, so I postponed my dream and took a full-time job at a state psychiatric facility. During this time I often reflected on the project I completed during my community-based practice class in OT school. The project was a transitional retirement program for persons with developmental disabilities who worked in vocational workshops. I had taken it a step further by implementing it during my Level II fieldwork. During the course I had learned how to scan my environment for unmet needs and then develop a plan and project to meet those needs. When I went to the vocational workshop and started the transitional retirement program, the plan came to life.

PHOTOGRAPHS COURTESY OF THE AUTHORS

# at Work

## How to make a difference in any practice setting.

**Photo 2. Elizabeth Hartzog (second from left) and lead occupational therapists at her facility.**

Of course it was tweaked as needed, but the projected outcomes were met and the consumers and staff received a service that otherwise would not have been provided. Despite the success of this experience, my new practitioner fear constantly reminded me of the imaginary rule.

However, on July 21, 2002, rules did not seem to matter anymore. On this day my son was born 3 months premature, and a traditional work setting no longer fit my lifestyle. With my desire to remain in practice, be more available at home, and contribute financially to the household, I knew entrepreneurship was the only option. The skills I learned in the community-based course kicked in. From my research I knew there was still a need for services for persons with developmental disabilities in the community, and I had the tools to provide them.

Despite the strengths of my OT skills, I lacked formal business knowledge. I spent unexpected money and time seeking advice, searching the Web, and making phone calls about the legalities of business start-up. Then there were the times when I just felt alone. My friends and family were supportive, but I longed for networking and mentorship from experienced entrepreneurs. Unfortunately, many experienced entrepreneurs either felt threatened by potential competition or tried to reinforce the imaginary minimum experience rule. My faith in God and resilience prevailed, however. After 1 year of marketing and frequent rejections, I landed my first contract as a consultant for six local group homes with my new company—Therapeutic Solutions.

Today, Therapeutic Solutions has contracts with 33 group homes across North Carolina, and services have expanded to other settings, including psychiatric facilities and community-based agencies. We recently added low vision services because our clients demonstrated the need. Adding a new service prompted more change, in that I enrolled in the low vision distance education program at the University of Alabama-Birmingham to add to my knowledge and skills in this practice area. Our interventions in this realm are varied and client-centered. Examples include helping a consumer develop a signature, modifying a work station, completing a living skills assessment, recommending a splint, or teaching a person to use a magnifier for reading.

If our clients have unmet needs, what can we as occupational therapists, and as change agents, do? We can assess the environment, call on or expand our skill set and provide the service, or find someone who can. If our environment is not conducive to occupation-centered services, we can get involved politically to help change it. If we have always dreamed of providing an innovative community service, we step outside the box and do it. Occupational therapists not only can create changes in traditional settings, but as change agents we can improve our communities and society as a whole. Are you passionate and prosperous? If not, what needs to change?

### ELIZABETH HARTZOG, CLASS OF 2003

**(See Photo 2)**

I am currently the director of occupational therapy and therapeutic recreation at Carolinas Rehabilitation Main (CR-Main), an inpatient acute rehabilitation facility in Charlotte, North Carolina. CR-Main is an 80-bed, free-standing hospital affiliated with Carolinas Healthcare System, the third-largest health care system

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in the United States. I have worked at CR-Main for almost 5 years: 3 as a staff therapist with the brain injury program and 2 as director. I directly or indirectly supervise 20 full- and part-time occupational therapy practitioners, 4 certified therapeutic recreation specialists, 2 rehabilitation technicians, and an administrative assistant, as well as manage the student program for inpatient and outpatient departments. Other responsibilities include scheduling, budgeting, program development, compliance management, education and training, performance improvement, and advocacy.

In the months leading to my promotion, our hospital was undergoing both structural and cultural changes that created opportunities for innovative change. The hospital began placing direct care staff on internal committees, implemented a career ladder (which I credit for my rapid advancement), restructured rehabilitation management to include representation from all disciplines, and placed employee and customer satisfaction on the same level as financial goals.

As a staff therapist I was an informal leader in the department, largely due to my extroverted personality and self-confidence, both of which led me to look at current practices and question, "Why do we have to do things this way?" During my first year of practice, I questioned the supervisor/supervisee ratio within our department (which was approximately 1:18). I often brought this up in meetings with my direct supervisor as well as in employee forums over the next 2 years because we had learned in our administrative class at UNC-CH that a ratio of no more than 1:5 is ideal. After becoming the director, one of my first priorities was to change the ratio to a maximum of 1:5 by creating lead therapist positions, which allowed more effective management, education, and training. This ratio change has proven to be one of the most positive departmental improvements. By modeling the behaviors of change, I have contributed to a culture where all therapists, techs, and secretarial staff are empowered to question processes and initiate positive change. Staff-initiated performance improvement projects that have emerged are revised processes for student supervision and new employee orientation, and school transition checklists for pediatric clients returning to school.

As a staff therapist I was asked to be on several hospital committees, which provided me with opportunities to meet managers, assistant vice presidents, and vice presidents. My favorite was the performance improvement committees, where I was able to offer constructive criticism of current processes and offer suggestions that would benefit direct providers of care. Recently I heard a speaker on improving quality in health care say that after you learn the performance improvement process, you start looking at everything in your world differently. I knew exactly what he meant. A fresh perspective, combined with a lack of experience in fighting the inertia that prevents change, allowed me to believe I could change the world. Now I have refined my communication skills, learned what I can and cannot control, and realize that questioning can be a valued skill. My advice for new practitioners who want to be change agents is to take risks, ask questions, and aim high. The worst that can happen is someone can say no…and then you can always ask, "Why not?"

**Photo 3. Stacy Springer (left) observes a client in Ecuador as he completes his first independent transfer with the sliding board he cut and sanded.**

## STACY SPRINGER, CLASS OF 2004

**(See Photo 3)**

While completing a community-based program as a student, I also had an opportunity to serve as a leadership trainee with a university center serving children and adults with developmental disabilities. Under the direction of the OT section head, I helped implement a pilot occupational therapy program for adults of retirement age with developmental disabilities in a community-based residential setting, a project I continued part-time during Level II fieldwork while also spending time at another child development institute. In both settings I was challenged to develop innovative solutions to client needs, such as designing accessible and inviting outdoor play spaces with an interdisciplinary team.

After graduation I accepted a position as the assistive technology coordinator for a school district. I had some doubt as to whether I would be perceived as an occupational therapist without explicitly being identified in that role. Nevertheless, I felt confident that I had the skills necessary to practice from an evidence-based and client-centered perspective, fostering in others the belief that they hold the power to change their lives.

*continued on page 17*

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Just over a year later I came across a call for applications to participate in the Community Inclusion for Technology International (CITTI) Project, a nonprofit organization that builds the capacity of communities in developing countries to use assistive technology for people with disabilities. This was exactly what I wanted to do—go beyond working with the individual, and to do more with families, communities, and countries. I was accepted as one of the 9 professionals among a total of 17 individuals who participated in the CITTI Project to Ecuador 2006.

Our project team traveled to various disability organizations and special education schools to support their use of assistive technology. The CITTI Project does not bring materials and resources, nor does it support an expert model approach. The project's goal is to collaborate with the communities and use materials found and purchased locally that are culturally relevant, sustainable, and replicable. Our goal was to use low-tech supports so the people of the community could continue to carry out the interventions and adaptations after we left. We collaborated with organizations, communities, and families to determine their needs and then supported the identified solutions. As a result, we built a wheelchair ramp for a special education school; conducted home visits for children based on identified needs in the areas of bathing, dressing, and eating; and created a variety of low-tech supports for school participation such as adapted writing tools, slant boards, and communication boards. In addition, a small group of interns stayed an additional week to create tools for some of the independent living facilities, including a step-by-step analysis for creating such tools.

I was asked to return for the CITTI Project Ecuador 2007 as a core team leader, tasked with developing a manual: *A Visual Guide of Adaptations for People With Disabilities*. The goal of the guide is to support individuals with disabilities by documenting how to create replicable, economic, sustainable adaptations using materials indigenous to their community. The guide, made possible through a grant, is written in Spanish with English translations; however, it relies primarily on photos to cross many language and literacy barriers.

The CITTI Project 2007 was a true culmination of previous planning and trips. Not only did we digitally document all the low-tech tools that were created during the project, but we also completed intense trainings that included collaborative make-and-take sessions at two special education schools and one independent living center. *A Visual Guide of Adaptations for People with Disabilities, Volume 1: Adaptations in the Home* was published for the Ecuador Project 2008, where it was distributed free of charge to the organizations, schools, and communities from previous projects. It is also available for download on the CITTI Project Web site (www.cittiproject.org/). Future planning indicates that this will be one chapter in many more to come.

During this project I felt not only like an occupational therapist, but also like an assistive technology specialist, teacher, student, and most importantly, humanitarian. The CITTI Project is the ultimate example of a group of people coming together from across the nation, from various disciplines and backgrounds, with one goal—to empower communities to be their own agents of change.

## CHARLOTTE ROYSTER, CLASS OF 2005

During my educational program, I knew I wanted to do something different than traditional occupational therapy. After graduating, I had the opportunity to contract with a continuing care retirement community (CCRC) for 10 hours a week, providing all Medicare billable services. Combining my undergraduate degree in business with my occupational therapy education, I started a company: Quality of Life Rehab Solutions. Within 3 months, I had built a caseload of 40 hours a week, and within 10 months I had created two full-time occupational therapy positions at this CCRC.

In addition to showing staff at the CCRC the value of occupational therapy in a traditional third-party payment system, I also created programs to enhance the quality of life in the community. For example, along with the help of a fieldwork student, I created a transition program to promote independence and satisfaction as a resident moves through different levels of care. Many times a person is discharged from rehabilitation or a hospital setting without practicing the skills at home. The transition program allows the resident to practice the skills with the occupational therapist in his or her home, and to spend time at home alone while still receiving skilled care. As the resident increases the amount of time at home, the occupational therapist determines the client's main barriers to returning home full-time and creates a plan to resolve those barriers. The program also allows the client to gain confidence and self-efficacy regarding task performance and ability to live at home.

While building these positions I also began advocating for occupational therapy to become a part of the Life Enrichment department (known in many CCRCs as the Activities department). The CCRC staff quickly understood how an occupational therapist was able to help restructure activity groups so that the participants were engaged in all aspects of planning

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and management, leading to a more meaningful experience. The CCRC valued this expertise and agreed to have occupational therapy consult with the Life Enrichment staff to enhance programming. As a result, I work with long-term-care residents in areas of gardening, cooking, intergenerational opportunities, and outings.

If there is a population with unmet needs, you must find a way to prove how your services and expertise are valuable to that population. Though my program development and consultation activities did not come under the umbrella of reimbursable services, they were nevertheless important to the community where I worked. After demonstrating their importance to administration and staff, I was able to advocate for 20% of my position to be budgeted through facility programming funds.

There have been challenges along the way. Starting your own business leaves you vulnerable to criticism and working for yourself requires a large investment of personal time, but it is ultimately incredibly rewarding. If you believe in what you are doing and the change that can be enacted, you will find that your passion—as well as the invaluable input from your clients—will make your work truly worthwhile.

## CONCLUSION

Advocacy, innovation, persistence, confidence, and passion are the major themes repeated throughout the narratives of these four occupational therapists. Their stories represent significant personal and professional accomplishments, and also help to define the core characteristics of a change agent. Change agents envision, question, appraise, collaborate, and consult. They take a deep breath and step beyond the "imaginary rule," as Tomeico Faison called the artificial boundary we impose on ourselves. In their examples of risk taking and seizing opportunities, these occupational therapists give all of us permission to do the same. In each of our settings, with our unique roles, personal attributes, and professional skills, we all can be agents of change. ■

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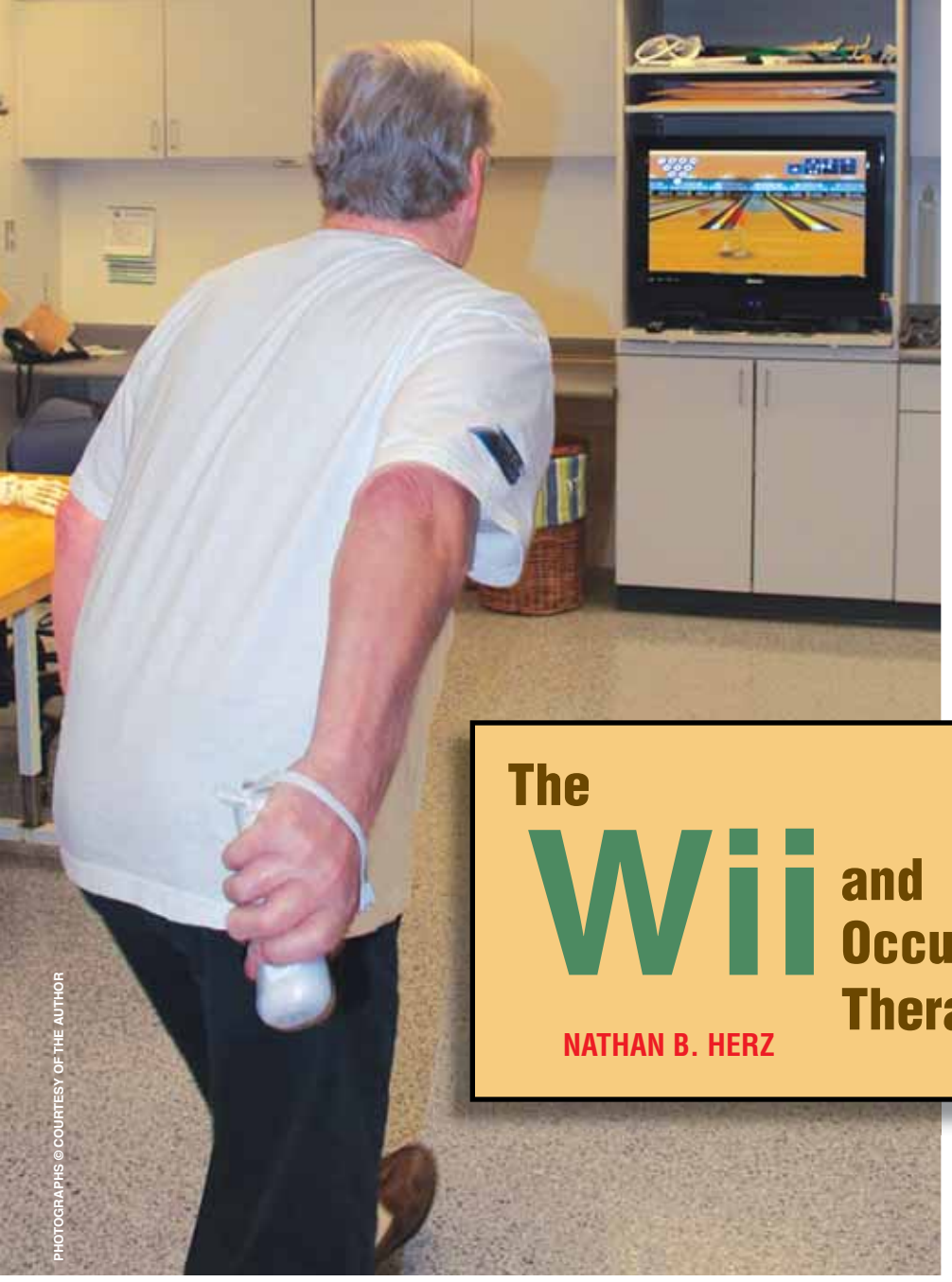

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# The Wii and Occupational Therapy

NATHAN B. HERZ

The 2006 introduction of the Nintendo Wii gaming system has led to a new era in gaming technology and participant interaction. With its wireless, motion-sensitive remote controllers, built-in Wi-Fi capability, and virtual environment, the Nintendo Wii allows users to participate in activities by using the physical movement and cognitive skills associated with doing them in "real life." What makes the Wii of particular interest to occupational therapy practitioners is the ability to facilitate client participation in activities that they want or need to do, while controlling the physical environment in which this takes place. All of the Wii games are associated with either leisure activities (e.g., bowling, golf) or activities of daily living (ADL) (e.g., cooking, driving). Each Wii activity requires the performance patterns and skills associated with the activity in real life, yet can be modified for each client's current level.

## NINTENDO Wii DESCRIPTION

The Nintendo Wii is a gaming system, so all of the activities are referred to as games and are presented in a gaming format, using measurable outcomes for successful participation (e.g., doing something within the allotted time, completing specific steps, scoring points). The games that are included with the base system are sports-related—tennis, bowling, boxing, golf, and baseball—although many other types of games associated with a wide variety of activities (e.g., fishing, cooking, brain teasers, driving) may be purchased. All of the games require physical movements, cognitive/perceptual skills, balance, and endurance to be successful and are played as if one is actually completing them on a court, field, course, ring, alley, kitchen, or other appropriate environment.

Each Wii game allows one or two players, and some allow up to four. For example, two individuals can comfortably play baseball and boxing, because two teams are playing or two individuals are boxing, respectively. The tennis, bowling, and golf games allow four individuals to participate at once. The games themselves emulate the specifics associated with each activity: tennis re-creates a doubles match; baseball adds additional fielders; bowling uses a ten-pin, ten-frame game; golf is played on a 3-hole or 9-hole course; and boxing offers a three-round match.

The Wii sensors plug into the unit, so the screen character's hands go wherever the player's hands go. The Wii remote is a single unit that can be used unilaterally (e.g., holding a "racket" for playing tennis) or bilaterally (e.g., batting a baseball). The nunchuk plugs into the original sensor, allowing the participant to use both arms separately (e.g., boxing) and adding more control options. The Wii can be used through a television and/or a projection unit, making the applications easy. As of this writing, there is also a 7-inch screen (costing about $59) that can make the system portable.

The Wii allows participants to create an avatar called a Mii by selecting hair, eyes, nose, mouth, body type, and coloring similar to their own. Users can

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transfer the Mii from game to game and track their level of progress. A Mii can be further personalized by assigning a nickname, gender, and birthday.

## USING THE Wii IN OCCUPATIONAL THERAPY

The Wii is not only fun for most people (which can create motivation and participation), but the games address issues such as attention, following directions, problem solving, visual-perceptual skills, listening, and functional movement and exercise, all of which include integrating multiple human systems. The integration of human systems refers to the sensorimotor, cognitive/perceptual, and psychosocial components that must work together to meet activity demands. For example, any activity requires a combination of balance, motion, strength, and cognition.

The major advantage of the Wii for many occupational therapy practitioners is that we can use it to create a virtual environment that we personalize for each client to address occupational performance deficits. For example, when working with individuals with Parkinson's disease, I found games that re-created what each client wanted and needed to do, then used those games to work on developing needed skills. Even very specific interests can be addressed; for instance, I used the program "Trauma Center: New Blood" for a client who was a veterinarian. The system allowed him to refine and practice his fine motor skills during "surgery" and to gain the motion associated with that aspect of his job in an environment that was as close as possible to the real thing. Another example is the "Cooking Mama: Cook Off" game, in which the user follows a recipe and cracks an egg, stirs, mixes, slices, and fills pots. Part of the cook-off includes making the movements necessary to coat pans with butter and even flip food on a grill. The remote and nunchuk have the ability to associate speed, movement, and force (based on the accelerometer found in each) to the activity being completed. For example, when "breaking an egg," the user has to use the right amount of force to crack the shell and put the egg into a bowl. If the force is not hard enough the egg does not crack, and if it is too hard the egg ends up on the countertop. Using the Wii for this kind of activity allows the client to practice indefinitely in an environment that is very close to reality, without any waste or embarrassment.

**A client uses a sensor in each hand for boxing.**

Participants do not necessarily need to play against someone—they can play against the computer. As the person improves, the computer makes the games more difficult (in the same way that occupational therapy practitioners implement the "just right challenge"). In some cases the computer will allow unexpected challenges or allow a new activity to open after a certain level in playing is achieved, which can increase the user's motivation.

### Physical Disabilities

The Wii allows us to remediate, adapt, modify, restore, and grade activities and skills for a valued activity in a graded, nonthreatening way. An example of this was seen with a participant in my "Efficacy Study of OT" in people with Parkinson's disease, who could not walk without her husband's assistance. At the end of 8 weeks, as a result of her participation, she had gained the ability to dance with her husband. I was able to grade the activities by having her sit while playing the Wii sports games to build strength and endurance. She then progressed to standing with a support, and finally she was able to stand for the games independently. The advantage of the Wii was that the virtual environment allowed me to use a variety of sports games to keep it interesting, and to grade them to match her abilities to keep it safe. By participating in these sports games her gait and balance improved, which helped her dance again. A similar result occurred with an individual who was in a nursing home and loved bowling. It was not practical to take him to a bowling alley, so he started in-bed bowling with the Wii. Eventually he stood up to play, creating the movements that were necessary for him to bowl—standing, walking, and throwing the ball. His therapy goal had been to sit up and do table-top activities, but bowling was so motivating that he exceeded this goal.

Demands for eye–hand coordination, form constancy, figure–ground relationships, sequenced movement (motor planning), timing, and depth perception add to the ability of the Wii system to address improvement in functional movement, endurance, cognition/perception issues, and balance. For example, we used the Wii sports programs to help improve the reaction time of a client with a traumatic brain injury, a goal that was achieved and verified by testing reaction time on a driving simulator. Because the Wii can create so many virtual environments, and is usually inherently motivating, it provides practitioners with many more options for focused attention than are easily created in the clinic or facility.

Practitioners can also use the Wii Fit, which uses a pressure plate that synchronizes with the base unit and allows the user to engage in a fitness program through activities such as strengthening, yoga, aerobics, and balance. Many of these activities can be used as adjunctive or preparatory for achieving occupational therapy goals such as dressing independently (by improving balance

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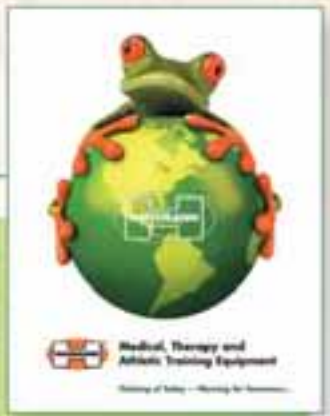


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and strength). Other activities include ski jumping, skiing, soccer, and even doing the hula hoop. A client at risk for falling in the shower (and thus not engaging in this important daily activity) may be motivated to build strength and endurance by using the hula hoop, then be willing to participate in therapy sessions that take place in the shower.

Many of the Wii Fit activities can be graded and used in a variety of positions. I have used the balance activities for clients with neurological impairments by having them sit on the Wii Fit board to promote trunk stability. Being seated while receiving the visual cues associated with the activities we are working on achieving, such as bed mobility, can help participants adjust to the proper alignment for balance and build up to participating when standing, practicing in a safe environment without risk of injury.

During my recent research, approximately 60% of the participants decided to buy a Wii system for themselves. Although having a fun and motivating system is a bonus during occupational therapy sessions, clients who buy a Wii system to use at home must be educated on how to use it safely and understand that there are no guarantees that an injury will not occur, including injury from overuse.

## Wellness

In addition to allowing users to participate in a fitness program to address physical disabilities, the Wii Fit also keeps track of weight, body fat, exercise time, and progress. When I demonstrate the Wii Fit I have different people try the Mii I created for myself, and when they stand on the plate it will say, "My, you have changed your weight since the last time you played—have you been doing something different?" By recognizing changes in the user, the Wii can help motivate or get people back on track.

The Wii system also calculate a user's Wii fitness age, by gauging performance in balance, speed, and stamina. The test itself can only be taken once a day per Mii. Fitness age results are graphed over 1, 2, or 3 months, with daily results posted on the Wii Message Board. I began at Wii age 60 (I was only 46) and worked my way down to 29. I had to practice, but my improvement was motivating and made me want to be successful by challenging myself further.

As therapists, we need to relate this type of progress to occupational therapy goals and outcomes. Progress must be translated and carried over to other contexts, as well as to other types of activities.

## Pediatrics

The Wii also has many different games for pediatric clients. "Big Brain Academy" addresses sequencing, form constancy, spatial relations, colors, and other cognitive/perceptual skills. This game is divided into five areas: identify, visualize, compute, analyze, and memorize. There are three activities for each area, and they can be made easy, medium, or hard. The Wii Play offers nine other games for children. For example, with Find Mii, participants are challenged to find similar or different Miis (people) in crowds, in the dark, and in other environments. The Pose Mii asks users to put their Mii in the same position as others, which can address body image and proprioception. Each of

these games has a cognitive/perceptual aspect that addresses identifying skills, sequencing skills, and spatial relation issues. The pediatric games can also be used for adult clients with cognitive disabilities.

### Psychosocial Practice

The Wii can be used across the lifespan. The variety of games not only creates different aspects of participation, but can also address specific diagnoses and deficits, including mental health conditions like depression or anxiety. Using Wii in a mental health setting allows users to participate in interesting, motivating activities within the safety of the facility. The Wii can support psychosocial goals by allowing people who thought they could not compete in specific sports or games to interact with others while participating through adaptations. The interaction itself, coupled with participating in the games, can alleviate loneliness, isolation, anger, and a decrease in self-worth or self-esteem. For example, some facilities have established "bowling night," where residents use the Wii bowling game in a weekly competition, providing a fun competition while enhancing social skills.

Unlike video games, the Wii is generally interesting to people of all ages and abilities. This encourages grandparents to play games with their grandchildren, and parents to play games with their children. Elderly individuals who may not be able to participate in the activities outside or in the real environment can do these virtual activities inside, and with modification (e.g., a grandparent can pitch a baseball to a grandchild while sitting down inside, and the activity is still fun for both of them).

## DISADVANTAGES

As with any rehabilitation tool, there are disadvantages and contraindications associated with the Wii. A participant can be injured while playing the sports games or have an increase in fatigue or pain from overuse. One individual I know bought a Wii to assist his mother with the later stages of rotator cuff rehabilitation. One night he came home to find that his mother had an increase in shoulder pain. Concerned, he asked if she had been outside lifting things or trimming the bushes, since that was a favorite activity of hers. She stated, "No, I just played the Wii for a few hours."

To be safe, the environment needs to be arranged to accommodate the type of games being played. For example, the sports games require room to swing the baseball bat and throw the ball, swing the tennis racquet, swing the golf club, and throw punches in the boxing ring. One client was so into the boxing that she moved forward 10 feet and ended up punching the screen the Wii was projected on. Many of the other games require less space and can be done sitting or standing. Various games contain warnings about seizures, eye strain, repetitive movements, and

motion sickness. (The motion sickness warning is valid; the movement got to me when I played the cow riding race in Wii Play). Another disadvantage is that the Wii was not designed to be used for persons with physical or mental disabilities, so practitioners need to be alert for negative feedback and its effect on their clients. For example, when one loses in a game, a large "You Lose" comes on the screen and the Mii character hangs its head. For some players, this could lead to a decrease in motivation and abilities, and an increase in depression; however, the "You Lose" aspect is so overt that most players make a joke out of not winning.

## APPROXIMATE COSTS

One needs the Wii base system ($249) to use the Wii Fit ($89). The base system comes with the five sport games, one handheld remote, and one nunchuk, as well as everything necessary to support the system's connection to a television or computer.

**FOR MORE INFORMATION**

**www.nintendo.com/wii**

Additional games range from $19.95 to $49.95. Two people playing can pass the remote and nunchuk back and forth, or you can purchase another remote ($39) and nunchuk ($19). If you choose to buy a second remote and nunchuk, I recommend purchasing the Wii Play ($49) combination of a remote and games, with a separate nunchuk, for a total of $58.

For facilities with space issues, the Wii is an investment whose outcomes easily justify the cost (e.g., using the cooking program as opposed to building a kitchen area). Rural facilities and smaller long-term-care facilities can benefit from the Wii in the same way.

## SUMMARY

The Wii and Wii Fit have many applications for a variety of activities to address functional movement, cognition and perception, endurance, gait, and balance issues that are associated with many illnesses and injuries. The Wii facilitates occupational performance by allowing clients to choose what is meaningful for them. Integrating of functional movement with the participant's interaction in the various games helps lead to physical, cognitive, psychological, and social improvements. Using the Wii as an occupational therapy intervention helps our clients "live life to its fullest." ■

**Nathan B. Herz,** OTD, MBA, OTR/L, is an assistant professor at the Medical College of Georgia. Since 2006 his primary focus has been in the area of physical disabilities and the use of the Wii system. He has lectured nationally on the use of the Wii in physical disabilities and regionally on the Wii and rehabilitation across the lifespan. He has been in the field of occupational therapy for more than 25 years and received his doctorate in occupational therapy in 2004 from Creighton University.


# AOTA 2009 ANNUAL CONFERENCE & EXPO—Welcome to Houston!

## Presidential Spotlight

**By Penelope A. Moyers Cleveland, EdD, OTR/L, BCMH, FAOTA**

I am looking forward to launching my third and final year as your AOTA President. It will be invigorating for me to work closely with the President-Elect, Dr. Florence Clark, who will exit the office of AOTA Vice-President on July 1 and then will prepare for her presidency, which will begin in 2010. It is my goal to create a seamless transfer of leadership over this next year to ensure advancement toward the Centennial Vision. In my Presidential address, I am sharing with you my thoughts about how to continue our progress in light of pressures from the external environment. In expressing my ideas, I use an analogy of "creating a web without a true spider." There are two useful concepts illustrated, one being that we must link science, education, and practice in order to help people live life to its fullest. The second idea is that we are all responsible for creating these linkages because of dynamic changes in knowledge within every area of practice. For instance, practitioners need evidence to support their clinical reasoning and need ongoing education to contribute to their continuing competence. Educators need to connect practice and science to prepare future practitioners, academicians, and scientists. Scientists rely on practitioners to determine the relevant practice questions, and on educators to develop ways to transfer science into practice.

So, how do we each become a spider spinning these webs linking practice, education, and research in a way that connects with the webs created by others? I believe each occupational therapy practitioner must construct these linkages on the personal, organizational, and professional levels. Linking science, education, and practice at the personal level means reaching beyond what you perceive as your limits in order to pursue knowledge management and knowledge creation. This requires surrounding yourself with a learning community of professionals, scientists, students, and educators who are interested in tackling the complex issues of our practice. In order to practice authentic occupational therapy that pushes the boundaries of arbitrary policy, we also need to create these linkages at the organizational level, thereby facilitating positive change in the systems in which we work. The professional level means working through AOTA and our state associations to make sure we are bringing what we learn through science, education, and practice to bear on advocating for health care and educational reform that considers the importance of our services in changing people's lives.

I plan to describe how AOTA has made significant progress in developing the resources needed for each of us to craft these linkages at all three levels. Thus the resulting larger web as we work together spreads out exponentially, fashioning an infinite network of energy in pursuit of our goals. There will be some surprises in my address, as you know I like to use drama to illustrate our potential power in achieving great impact in helping people live life to its fullest. Come and see whether you won't view yourself and your capacity in an entirely new way, where you will want to Be the Spider!

**The Presidential Address,** "Creating a Web of Energy Without a True Spider," will take place on Friday, April 24, from 11:15 a.m.–12:00 p.m. in the Convention Center Exhibit Hall C, and is included with Conference registration.

## Welcome Ceremony and Keynote Address

Wondering how to proactively respond to the growing global connectiveness? In his Keynote Address, "Beating the Odds: Preparing a Diverse Workforce in the Sciences and Allied Health," University of Maryland–Baltimore County President Freeman A. Hrabowski III will share insights from his 3 decades of studying this issue. Hrabowski's work has focused on minority student achievement, particularly the underrepresentation of minority students in science and engineering. A major outcome of his research has been the creation of the Meyerhoff Scholarship Program for high-achieving minority students in science and engineering. This program has produced nearly 560 graduates, including 125 who have earned PhDs.

**The Welcome Ceremony** and Keynote Address will take place on Thursday, April 23, from 4:00 p.m.–5:30 p.m. in the Convention Center, Exhibit Hall C. Included with Conference Registration.

## New SIS Conference Events for 2009!

AOTA Special Interest Section (SIS) events have multiplied this year with the addition of new interactive opportunities to meet with SIS leaders and members.

### Open Networking

On Friday, April 23, and Saturday, April 24, the SIS Open Networking meetings are an invitation for all Conference attendees to meet informally with members of the SIS Standing Committees and candidly discuss issues of interest in specific practice areas. These will be conveniently held in the Expo area. See the program guide for the full schedule.

### Three Fitness Events

In the interest of promoting good health and much needed

# April 23–26, 2009

relaxation, the SISs are sponsoring three fitness events this year.

- The 3rd annual **SIS Fun Run and Walk** will be held on Friday morning around Discovery Green across from the Convention Center. The course is .5 miles, and participants can go around as many times as they like. Free T-shirts to the first 300 participants—first come, first served, so get there early, and don't forget to bring your own water bottle!

  **6:45 a.m.–7:30 a.m.;** meet in front of the Convention Center. Included with registration.

- On Saturday morning, **"Group Groove"** will let you experience a combination of club, urban, and Latin dance styles as you smile your way through a 45 minute fitness dance class.

  **6:45 a.m.–7:30 a.m.,** Hilton Americas Ballroom of the Americas F. Included with registration.

- And on Sunday, **"Core Conditioning"** will offer Pilates-inspired floorwork designed to strengthen your core muscles groups for a lean yet powerful body!

  **6:45 a.m.–7:30 a.m.** Hilton Americas 343 AB. Included with registration.

(*Note:* AOTA recognizes that many Conference attendees enjoy participating in fitness-related events to promote health and wellness, and we are pleased to offer them. However, participation is at the attendee's own risk and individuals should only participate at a level consistent with their general physical health and abilities.)

## Roundtable Discussions

One of the most popular events of Conference is always the SIS Roundtable Discussions. New this year, each SIS is hosting **two roundtables:** One is a structured topic with a moderator, and one is an unstructured discussion geared to your questions and concerns, allowing participants to identify topics they want to discuss on the spot. All roundtables will be held on Friday, April 24. **Tickets are required to attend these sessions** and will be available in the Member Resource Center in the Expo, during the Grand Opening on Thursday evening only (they will not be available on Friday morning). Tickets are limited to ensure close interaction, and are distributed on a first-come, first-served basis, so don't delay!

The SIS Roundtables will take place on Friday, April 24, from 12:30 p.m.–1:15 p.m. in the Hilton Americas 335 ABC. Included with Conference registration, but you must have a ticket.

## Tech Day

And don't miss Tech Day, a new hands-on, interactive exploration of high- and low-technology products to enhance client participation in occupations across the lifespan. The two morning sessions will address technology applications for children and youth, and the afternoon sessions will target adults of all ages. Sample topics include voice recognition, Microsoft Access features, the Wii, and switches for environmental control.

**Morning Tech Day** sessions will be held from 8:00 a.m.–9:30 a.m., and from 10:00 a.m.–11:30 a.m. Afternoon sessions will be held from 1:15 p.m.–2:45 p.m., and from 3:15 p.m.–4:45 p.m. in the Hilton Americas, Ballroom of the Americas E. Included with registration.

*continued on page 28*

## Annual Awards and Recognitions Ceremony

Join friends, family, and colleagues to recognize and pay tribute to those whose achievements have enriched the field of occupational therapy. This important ceremony provides a wonderful opportunity for each of us to reconnect with our profession and reflect not only on the accomplishments of others, but our own capacity for achievement. After the ceremony, join the award recipients for the Annual Awards and Recognition Reception. **This year's award recipients are listed on page 29.**

**The Annual Awards and Recognitions Ceremony** will be held on Saturday, April 25, from 5:15 p.m.–6:15 p.m. in the Convention Center Exhibit Hall C. It is included in Conference registration and open to the public. **The Annual Awards and Recognition Reception** will be held from 7:30 p.m.–8:30 p.m. in the Hilton Americas Ballroom of the Americas D. $35 per person includes desserts and cash bar.

## AOTPAC Night: OT Karaoke Idol

Wind down and have some fun while supporting a great cause. The American Occupational Therapy Political Action Committee (AOTPAC) is adding a friendly OT Karaoke competition to AOTPAC night, which is always the Conference hot spot for music and dancing. Even if you aren't a singer you won't want to miss this competition—especially when you see the guest judges!

**AOTPAC Night** will be held on Saturday, April 25, from 8:00 p.m.–11:00 p.m. in the Hilton Americas Grand Ballroom AB. $40 for OTs and OTAs, and $25 for students. Includes munchies and a cash bar.



## Centennial Vision Session

As 2010 approaches, this session highlights five successful practitioners from diverse backgrounds who are bringing the Centennial Vision to life. These clinicians, educators, and researchers have developed innovative practice approaches, such as using golf to prevent youth from joining gangs, designing accessible playgrounds, and creating a hip hop dance troupe. Don't miss their stories of ground-breaking ways that occupational therapy can help meet society's diverse, dynamic needs.

**The Centennial Vision Session** (SC 401) will be held on Sunday, April 26, from 9:00 a.m.–10:30 a.m. in the Convention Center 370 ABC. Included in Conference registration.

## The 2009 Expo

The world's largest occupational therapy Expo is not to be missed! The Exhibit Hall is your opportunity to explore products, services, job opportunities, and ideas. Unlimited admission is included with your Conference registration. You probably won't be able to see everything during one visit; unopposed times allow you to return when there is no other programming. Check out the Exhibit Hall Pocket Guide provided in your tote bag for exhibitor lists, booth locations, and a schedule of the Exhibitor-Sponsored Seminars, for which contact hours will be awarded. If you are unable to attend education sessions at Conference, you can enjoy the benefits of the Expo by purchasing a 1-day Exhibit Hall pass at a discounted price. Passes are sold on-site during Conference Registration hours.

**The Expo** will be in Convention Center Exhibit Halls DE.

### Expo Hours

**Thursday, April 23**
Grand Opening and Welcome Reception
5:30 p.m.–9:00 p.m. (unopposed)

**Friday, April 24**
11:00 a.m.–6:00 p.m.
(12:00 p.m.–1:30 p.m. unopposed)

**Saturday, April 25**
9:30 a.m.–2:00 p.m.
(11:00 a.m.–1:30 p.m. unopposed)

### AOTA Member Resource Center

Stop by the Member Resource Center in the Expo for the highlights of AOTA's initiatives, accomplishments, and membership benefits. Meet Association leaders and staff, and learn about the programs that will help you in your career. Free tickets for the SIS Roundtable Discussions, which will occur on Friday afternoon, will be distributed here during the Grand Opening on Thursday evening. These tickets go fast, so come early to avoid disappointment. Have a few extra minutes? Check your e-mail at the complimentary CyberCafé.

### AOTA Marketplace

Come to the AOTA Marketplace in the Expo for all the professional resources you need in one location! Browse through bookshelves full of AOTA Press selections, including new releases and previews of what's to come. Visit our new Assessment Center to preview and order resources for practice. The CE Center gives you a hands-on opportunity to explore AOTA's vast range of professional development products to enhance your career, and the promotional products give you the tools to educate others about OT.

## Registration

If you didn't preregister for Conference, you are welcome to do so on-site. The registration area will be located in the Exhibit Hall Lobby (Level Two) of the George R. Brown Convention Center. Registration will be open during the following days and times:

**Wednesday, April 22**
10:00 a.m.–7:00 p.m.
**Thursday, April 23**
7:00 a.m.–8:30 p.m.
**Friday, April 24**
7:00 a.m.–6:00 p.m.
**Saturday, April 25**
7:00 a.m.–6:00 p.m.
**Sunday, April 26**
7:00 a.m.–11:00 a.m.

AOTA® The American Occupational Therapy Association, Inc.

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### 2009 AOTA/AOTF PRESIDENTS' COMMENDATION AWARD

M. Carolyn Baum, PhD, OTR/L, FAOTA

## 2009 AOTA Award and Recognitions Recipients

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Thomas F. Fisher, PhD, OTR, CCM, FAOTA

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Sarah Burton, MS, OTR/L
Margaret Kaplan, PhD, OTR
Jane Painter, EdD, OTR/L

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Sue Berger, MS, OTR/L, BCG
Shirley A. Blanchard, PhD, OTR/L, ABDA
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Diane L. Smith, PhD, OTR/L
Wendy B. Stav, PhD, OTR/L, SCDCM
Scott D. Tomcheck, PhD, OTR/L

### CORDELIA MYERS WRITER'S AWARD

Marian Arbesman, PhD, OTR/L

### JEANNETTE BAIR WRITER'S AWARD

Jean McKinley-Vargas, MS, OTR/L
Katherine Thomas, BS, MS

## 2009 AOTF Award Recipients

### ACADEMY OF RESEARCH

Nancy A. Baker, ScD, OTR/L
Leeanne M. Carey, BAppSC(OT), PhD

### A. JEAN AYRES AWARD

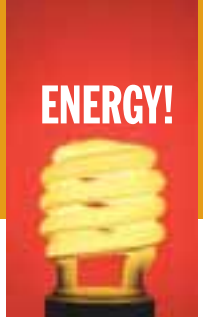
Shelly Lane, PhD, OTR/L
Susanne Smith Roley, MS, OTR/L, FAOTA

### VIRGINIA SCARDINA AWARD OF EXCELLENCE

Teresa May-Benson, ScD, OTR/L

### AOTF MERITORIOUS SERVICE AWARD

Phyllis Bauer Madachy

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- Valley Medical Center

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- Chatham University
  **Booth 117**

EVIDENCE PERKS

# *Evidence-Based Practice Resources*
## Children and Youth

**Marian Arbesman** **Deborah Lieberman**

The American Occupational Therapy Association's (AOTA's) Centennial Vision provides a clear path for occupational therapists and occupational therapy assistants working with individuals from birth to young adulthood and their families by stressing excellence in service that is informed by evidence. The Centennial Vision also encourages all occupational therapy practitioners to be aware of innovative and emerging areas of practice.

Having easy access to evidence-based practice resources may be a challenge for those working with children and youth outside the medical model. Pediatric practice sites may lack access to the medical libraries available in hospital-based settings. In addition, practitioners working in pediatrics may visit multiple sites on a given day, limiting the time available for searching the Internet. Also, evidence-based practice (EBP) resources need to accommodate the varied and wide range of clinical conditions and limitations in occupational performance, which pediatric occupational therapy practitioners encounter on a daily basis. Recent updates to AOTA's EBP Resource Directory, available in the Evidence-Based Practice and Research section of the AOTA Web site (www.aota.org) should make the process of finding and accessing relevant Internet resources that much easier. To access the EBP Resource Directory, click on Practitioners or Educators-Researchers, and then on Evidence-Based Practice and Research. The Children and Youth EBP Resources can be found in the Selected EBP Resources section of the EBP Resource Directory. You will need to log in as an AOTA member to access this information.

A particularly useful resource in this section for practitioners looking to quickly develop a basic understanding of EBP should check out *Evidence-Based Practice [EBP]—What Does It Really Mean for Early Education and Intervention?* This PowerPoint, created by Virginia Buysse, PhD, at the FPG Child Development Institute at UNC–Chapel Hill, has many ideas for application of evidence to practice, policy and research.

Other resources included in this section of the Resource Directory include general practice guidelines that are available for download. The practice guidelines available on the National Guideline Clearinghouse, for example, include autism, developmental delay, cerebral palsy, and traumatic brain injury. The New Zealand Guidelines Group Web site also has a practice guideline on autism. Other Web sites focus on a specific disability or treatment area, with specific application to occupational therapy. CanChild Centre for Childhood Disability Research, based at McMaster University, has evidence on a variety of topics in the Keeping Currents section. One example is *An Update on Constraint Therapy in Children With Hemiplegia.* Other examples of Web sites relevant to occupational therapy are Tots 'n Tech Research (which has information on assistive technology); Evidence Based Review of Moderate to Severe Acquired Brain Injury (ABIEBR); and Center on the Emotional and Social Foundations for Early Learning (CSEFEL). Web briefs available for download from CSEFEL include *Helping Children Understand Routines and Classroom Schedules,* and *Using Environmental Strategies To Promote Positive Social Interactions.* In addition, the National Secondary Transition Technical Assistance Center, and Specialized Intervention for Children and Transition-Age Youth With Severe Emotional Disabilities focus on issues related to transitions.

Web sites recently added to AOTA's EBP Resource Directory provide evidence-based resources for innovative existing and emerging areas of practice. For example, information on injury prevention that includes bicycle and car seat safety and violence prevention can be found at the National Center for Injury Prevention and Control, Children's Safety Network, the Harborview Injury Prevention and Research Center, and the National Center for Mental Health Promotion and Youth Violence Promotion from SAMHSA. The Community Guide and Healthy Youth from the Centers for Disease Control and Prevention (CDC) provide evidence-based resources on childhood obesity.

Regardless of whether you work in an existing or emerging area of pediatrics, the EBP Resource Directory Web sites listed above easily provide useful and valuable information to inform, guide, and foster the provision of occupational therapy services from an evidence-based perspective. Reading the information from these sites and determining how to incorporate the findings into your clinical expertise is a welcome challenge that can be embraced by all responsible practitioners working with children and youth. ■

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