AOTA THE AMERICAN OCCUPATIONAL THERAPY ASSOCIATION

OT PRACTICE

JANUARY 21, 2008

Camp Helping Hands

Addressing Hemiplegia in Children With Cerebral Palsy

PLUS

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AOTA & ASD 2008 Elections

CE ARTICLE

The Infants and Toddlers With Disabilities Program (Part C of IDEA)

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AC-199

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COVER PHOTOGRAPH: "Helping hands to the rescue" became the theme of Superhero theme day. Courtesy of "Camp Helping Hands" authors.

DEPARTMENTS

FEATURES

SPECIAL

SPECIAL

CE Article
The Infants and Toddlers With Disabilities Program (Part C of IDEA)
Earn .1 AOTA CEU (1 contact hour or NBCOT professional development unit) with this creative approach to independent learning.

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AOTA Updates

AOTA Advocacy Victory

After more than 2 years of advocacy, the American Occupational Therapy Association (AOTA) is happy to announce its success in eliminating an additional requirement for occupational therapy wheelchair evaluations under Medicare. Reimbursement and Regulatory Policy staff convinced the Centers for Medicare & Medicaid Services to eliminate a requirement that would have required an additional certification for occupational therapists performing wheelchair evaluations for higher-end power devices. For more information on the details of this victory, and what it means for practitioners, please visit www.aota.org. Click on the News section, then Advocacy Highlights.

Conference Update

AOTA's 88th Annual Conference & Expo in Long Beach, California, April 10 to 13, is packed with special events and highlights that attendees won't want to miss, including the Eleanor Clarke Slagle Lecture on Friday, April 11. This year's lecturer is Wendy J. Coster, PhD, OTR/L, FAOTA. Coster will discuss "Embrace Ambiguity: Facing the Challenges of Measurement."

For more information, visit www.aota.org/conference.

For the latest news affecting you and your profession, visit AOTA's Web site at www.aota.org.

AJOT Highlights

The January/February issue of the *American Journal of Occupational Therapy* (*AJOT*) features the articles "PDAs as Cognitive Aids for People With Multiple Sclerosis," "A Controlled Study of Services to Enhance Productive Participation Among People With HIV/AIDS," "Two Dimensions of Participation in Very Old Age and Their Relations to Home and Neighborhood Environments," and more. This issue also features an article from editor Mary Corcoran on "Journal Impact Factors and *AJOT*." AOTA members can access *AJOT* at www.aota.org.

AOTA Membership Works!

We are continually inspired when members let us know how they improved their reimbursement rate, client outcomes, community visibility, or even job satisfaction by using information from AOTA. To help celebrate OT Month, we want to share these stories with you. We will run as many answers to the question, "Why are you a member of AOTA?" as we have room for in the April 14, 2008, issue of *OT Practice.* If you would like to participate, please send a submission of no more than 250 words to otpractice@aota.org by February 4.

ACOTE Fall 2007 Accreditation Actions

The AOTA Accreditation Council for Occupational Therapy Education (ACOTE®) met November 30 to December 2, 2007, in Savannah, Georgia. Among the 125 program actions taken by ACOTE were accreditation actions to:

- grant continuing accreditation to 5 educational programs that had recent re-accreditation visits;
- grant initial accreditation to 3 new additional locations (satellite programs);
- grant initial accreditation to 1 new program level;
- grant initial accreditation to 3 new program formats; and
- change the status of 1 program from Accreditation to Accreditation—Inactive.

Continuing accreditation granted subsequent to a re-accreditation visit:

Augusta Technical College (OTA associate degree), Augusta, Georgia

Loma Linda University (OTA associate degree), Loma Linda, California (program currently on Inactive Status)

University of Missouri–Columbia (OT professional entry-level master's and combined baccalaureate/master's), Columbia, Missouri

University of Southern Indiana (OTA associate degree), Evansville, Indiana

University of Texas Health Science Center at San Antonio (OT professional entry-level master's and combined baccalaureate/master's), San Antonio, Texas

Additional locations granted initial accreditation:

Keiser University, Kendall Campus (OTA associate degree), Miami, Florida (additional location of Keiser University, Ft. Lauderdale, Florida)

Keiser University, Orlando Campus (OTA associate degree), Orlando, Florida (additional location of Keiser University, Ft. Lauderdale, Florida)

Keiser University, Pembroke Pines Campus (OTA associate degree), Pembroke Pines, Florida (additional location of Keiser University, Ft. Lauderdale, Florida)

Initial accreditation granted to new program level:

Southwest Virginia Community College (OTA associate degree), Richlands, Virginia

Initial accreditation granted to new program format:

Green River Community College (OTA associate degree), Auburn, Washington (evening/online format)

Santa Ana College (OTA associate degree), Santa Ana, California (evening/online format)

University of Texas Pan-American (OT professional entry-level master's), Edinburg, Texas (weekday format)

Program status changed from Accreditation to Accreditation—Inactive:

Medical College of Georgia at Columbus State University (OT professional entry-level master's), Columbus, Georgia (additional location of Medical College of Georgia, Augusta, Georgia)

As of December 17, 2007, the number of programs in the accreditation process totaled 282.

Total Programs	OT (145)	OTA (137)
Accredited Programs	144	129
Programs With Developing Program Status	0	2
Applicant Programs	1	6

Additional information regarding occupational therapy accreditation may be obtained from the ACOTE Accreditation section of the AOTA Web site (www.acoteonline.org) or from AOTA accreditation staff

AOTA BULLETIN BOARD

Imagine the Possibilities…

at **AOTA's 88th Annual Conference & Expo, Thursday, April 10 through Sunday, April 13.** Pre-Conference Institutes and Seminars on Wednesday, April 9. **Keynote speaker Warren Macdonald** will present his compelling story during the Welcome Ceremony on Thursday. Macdonald's legs were amputated during a freak rock fall while he was on a climbing expedition. Macdonald has continued to climb, and was the first double above-knee amputee to reach the summit of Mt. Kilimanjaro. You won't want to miss this memorable event. Complete details at www.aota.org/conference.

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Web-Based Extended Replays: Catch them before they're gone!

Through January 31: *Alzheimer's, Dementia, and Driving: The Transition From Driver to Passenger* (#PW11071-BB)

Through February 29: *Autism: Evidence for the AOTA Practice Guidelines* (#PW12071-BB)

Visit www.aota.org/aiseminars for complete details.

Celebrate Occupational Therapy Month In April!

It's not too early to start planning for Occupational Therapy Month! AOTA's got all the necessary materials to make every event—from community activities and campus celebrations to staff recognitions and facility open houses—a rousing success. Whether you're looking for T-shirts, mugs, pens and pads, or other key resources, AOTA has everything you need. Visit www.aota.org/OTMonth and start your planning today!

KEY RESOURCE FROM AOTA PRESS!

Enhancing Human Occupation Through Hippotherapy: A Guide for Occupational Therapy

Edited by Barbara T. Engel, MEd, OTR, and Joyce R. MacKinnon, PhD, OT(C), OTR

Hippotherapy—using a horse as a partner in treating a variety of disabilities—was developed in Germany and Austria as a physical therapy modality. This book covers a wide range of topics, including why this treatment tool is used, why it is effective, and how therapists can become involved in this dynamic, community-based approach. (Order #1106-BB, **AOTA Members: $55,** Nonmembers: $79)

Bulletin Board is created by **John Prudente,** AOTA Marketing Specialist.

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Societal Statements

Since 2006, the Representative Assembly (RA) Coordinating Council has been developing societal statements to inform the public about the profession's position on issues that affect the participation of individuals in society and to enhance awareness of occupational therapy. At the Fall 2007 RA Online meeting, two new societal statements were adopted ("Play" and "Youth Violence"). All of the statements are posted on the AOTA Web site, in the Press and Media, Issue Statements section.

SIS Elections

Elections are now going on for **Chairperson** of the **Physical Disabilities, Developmental Disabilities, Work Programs,** and **Sensory Integration Special Interest Sections.**

The election will end at midnight on January 31. As an AOTA member, you have voting rights in up to three Special Interest Sections that you selected as a member benefit. You can vote online by going to the AOTA Web site, www.aota.org and clicking on AOTA Elections—Vote Here! under AOTA News in the middle of the page. You will need to log on with your user name and password. Please read the candidates' position statements and let your vote be heard!

2008 CPT Changes

AOTA is very pleased that the American Medical Association (AMA) CPT Editorial Panel has approved a new cognitive testing code for 2008. This code was proposed by AOTA and other nonphysician professional associations to fill the void left 2 years ago by the deletion of code 96115.

The new code reads:

96125—Standardized cognitive performance testing (e.g., Ross Information Processing Assessment) per hour of a qualified health care professional's time, both face-to-face time administering tests to the patient and time interpreting these test results and preparing the report.

96125—An "active" code and payable by Medicare, assuming all coverage criteria are met.

Two additional codes added for 2008 that were supported by AOTA are described as follows:

99366—Medical team conference with interdisciplinary team of health care professionals, face to face with patient and/or family; 30 minutes or more, participation by nonphysician qualified health care professional

99368—Medical team conference with interdisciplinary team of healthcare professionals, patient and/or family not present; 30 minutes or more; participation by nonphysician qualified health care professional.

These codes are only reportable by one member of each profession who is "familiar with the patient, has performed an evaluation or treatment within the previous 60 days," and is actively participating in the team conference.

The Team Conference codes are considered "bundled" by Medicare and are not separately payable. Relative value units have been developed and may be used if the services are covered by other payers. The codes also would be useful in internal reporting of productivity.

Occupational therapists are specifically mentioned as professionals who perform this code in the AMA's publication *CPT*

Changes 2008—An Insider's View. Additional information on the use of these and other new and revised codes can be found in this book. (Call the AMA at 800-621-8335 and ask for product number OP512908)

Connections

Rebuilding Together

Louisiana State University Health Sciences Center Department of Occupational Therapy (LSUHSC-OT) has been promoting universal design in the redevelopment and rebuilding of New Orleans. The levee failures that destroyed 80% of the homes in New Orleans created an unprecedented opportunity to rebuild using more inclusive, accessible approaches. LSUHSC-OT has linked with Rebuilding Together—New Orleans to provide home assessments and modifications for homeowners who have physical disabilities, to enhance function and access. First-year students assessed the home of a person with multiple sclerosis, making recommendations to Rebuilding Together for accessibility modifications, including opening the floor plan for better wheelchair maneuverability, moving the bathroom to a larger room, adding an accessible tub, and installing a bidet. The PBS program *This Old House* filmed work done on the home in collaboration with the LSUHSC-OT volunteers. The program is scheduled to air on February 13.

Practitioners in the News

■ **Claudette Fette,** OTR, CRC, was appointed to the Texas Mental Health Planning and Advisory Council as a family member of a child/adolescent with mental health needs. The council advocates for Texans with mental health needs by monitoring services and advising the commissioner of the Texas Department of Health and Human Services, and provides oversight of the state's mental health services, including the state's mental health block grant plan.

■ **Alexander Lopez,** JD, OTR/L, developed the PAR FORE program for at-risk youth that was recently featured in the *New York Times*. It is a gang prevention and intervention program that uses therapeutic principles inherent in the occupation of golf to foster positive personal, social, and physical growth and development.

■ **Lucy Jane Miller,** PhD, OTR, and the Sensory Therapies and Research (STAR) center were mentioned at length in a December 10, 2007, *Time* magazine article discussing sensory integration disorders.

CE Article Clarification

Some information in the CE article "Overview of Manual Wheelchairs and What To Consider When Making Seating and Positioning Selections" (CEA 1007), which appeared in the October 22, 2007, issue of *OT Practice*, has been updated.

Since the time the article was submitted for publication, there have been coverage changes related to the rental of manual wheelchairs. Information regarding this change, as well as several other points of clarification, have been posted on the AOTA Web site at www.aota.org under Continuing Education, AOTA CE Articles, Available CE Articles/CEA1007.

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

Supporting VA Practitioners

Christina A. Metzler **Tim Nanof**

Occupational therapists and occupational therapy assistants who work in the Veterans Administration (VA) Health Care System have always been an important part of the OT community and AOTA. The rapidly growing need for their services and the complexities the VA is facing in treating wounded veterans from Iraq and Afghanistan really brings the issues of optimizing occupational therapy to the forefront. Those working in the VA are indeed living AOTA's Centennial Vision by moving forward with new approaches to low vision, traumatic brain injury (TBI), posttraumatic stress disorder (PSD), amputations, and technology. The VA has also been an incubator for many new ideas in occupational therapy practice and has been a key fieldwork site.

So, in support of our efforts to enable communities of occupational therapy to communicate through and with AOTA, we held a special telephone "Town Hall" meeting on November 29 for VA practitioners. It was a huge success, with more than 30 participants providing insight into and feedback from VA facilities across the country. It provided a forum for practitioners to share what they are doing and communicate with each other. But it also provided AOTA with the opportunity to learn more about the real-world experiences of these practitioners, who are now treating old and young veterans of our nation's armed forces.

Both AOTA Executive Director Fred Somers and AOTA President Penny Moyers participated in the call, and they were encouraged by the active participation of the VA occupational therapy practitioners and their ongoing interest in communicating with AOTA and each other. AOTA Chief Professional Affairs Officer Maureen Peterson discussed available resources for training and continuing education, as well as encouraged the use of AOTA's evidence-based resources. Members of the VA's rehabilitation leadership team also participated in the call and will be meeting with AOTA leaders soon.

AOTA has been working with key members in the House and Senate, such as Senator Daniel Akaka (D-HI), chairman of the Senate Veterans Affairs Committee and Representative Mike Michaud (D-ME), chairman of the Veterans Affairs Health Subcommittee. Key concerns on Capitol Hill regarding the VA continue to be the care of soldiers returning from Iraq and Afghanistan, specifically treatment for PSD and TBI.

AOTA's mission is to make sure leaders understand the critical role that occupational therapy can play in the VA and to promote attention to issues of concern to AOTA members working in the VA. During the Town Hall, participants talked about the special efforts being made in areas such as TBI. Occupational therapy practitioners are also involved in the VA's new "poly-trauma rehabilitation centers," which are sites around the county designed to meet the complex needs of veterans with very different combinations of injuries. These centers—located in Palo Alto, Tampa, Richmond, and Minneapolis—are supplemented by an additional network of 21 sites across the country established to provide long-term rehabilitation care for severely wounded veterans with multiple injuries or illnesses.

Low vision is also an area where the VA has been a leader in using occupational therapy. Participants described special projects and efforts at the Palo Alto VA around vision and driving, vision and behavior, and vision as a part of poly-trauma rehabilitation.

Mental health still has a strong foothold in the VA. Participants spoke about their work in collaboration with mental health practitioners and departments, but also of their important role to raise awareness of mental health issues in traditional rehabilitation.

What AOTA discovered is that there is a genuine need for VA OT practitioners to communicate with one another. For example, one OT researcher on the call told participants that they can develop research projects in their own areas and seek support from the VA, which funds a great deal of research (for information, check out http://www.hsrd.research.va.gov/). AOTA is also interested in working with the VA concerning recruitment, pay equity, fieldwork opportunities, and loan repayment. Hearing from members is a critical component of effective advocacy. AOTA needs to know what members are doing and what their concerns are, so we can provide assistance or convey the problem to the right person or entity, whether it is the Centers for Medicare & Medicaid Services, the VA, or members of Congress.

To continue this important two-way dialogue, AOTA is scheduling a second Town Hall conference call for VA practitioners. Check the AOTA Federal Affairs page at www.aota.org for details. ■

Christina A. Metzler is AOTA's chief public affairs officer.

Tim Nanof, MSW, is a legislative representative with AOTA's Federal Affairs Group.

Mentoring: Coming Full Circle

Molly V. Strzelecki

In 2007, the American Occupational Therapy Foundation (AOTF) and the American Occupational Therapy Association (AOTA) joined forces and created a new outlet to develop leadership within the profession. The co-sponsored AOTA/AOTF mentoring circle fellowships, helped along by Colorado-based The Mentoring Company, gave 18 participants the opportunity to expand and explore leadership in the profession as well as within their personal careers, turning to each other for advice and guidance in the process.

"We need to be actively developing leaders and leadership opportunities within the profession," says Ann Grady, PhD, OTR, FAOTA, a member of the AOTF Board of Directors, a trained facilitator with Mentoring Circles, and one of the catalysts in putting together the mentoring circle fellowships. "There is a lot of change taking place; a lot of the active leaders are reaching the retirement age, and we have a real void in terms of developing new leadership. [The mentoring circle fellowships] are an opportunity to do that."

"Leadership is everybody's practice, and leadership is something that can be learned though its practice."

One of the benefits of mentoring circles is that learning is broader and deeper through the storytelling process than if participants were simply to give advice about what a person should do.

Like many great ideas, the idea for the mentoring fellowships started with a simple proposal from Grady to AOTA, AOTF, and the National Board of Certification in Occupational Therapy outlining how the circles could contribute to leadership development. The pilot circle would include occupational therapy faculty members focusing on research and advancement. Additionally, pre- and postassessments for evaluation were built into the process, with the hope of eventually gaining qualitative research to measure the outcomes of these fellowships.

"It's a domino effect," says Ellie Gilfoyle, past president of AOTA, and currently a facilitator with The Mentoring Company, who was also involved in launching the collaboration. "The future of our profession is with our students, and the most important thing we can do is prepare faculty with the language, skills, and self-image of themselves as leaders so that they can be leadership role-models for students. Preparing occupational therapy professionals as leaders will ultimately help the profession."

Julie Manhard, president of The Mentoring Company, worked with the AOTA/AOTF mentoring circles and noted that this type of process meshed well with occupational therapy.

"As I got to know more occupational therapy practitioners [throughout the process], you could see a very similar set of values, both in The Mentoring Company and in the occupational therapy population," Manhard says. "There is a great desire to serve people, and to do that with integrity and with heart. That made for a good fit."

The pilot circle for the mentoring fellowships began in January 2007, with a kickoff meeting in Denver, and from the start the circles were a hit.

"I was surprised how quickly the group bonded," says Gilfoyle. "This group seemed to come together as a solid group much sooner than expected, and they became a group that felt safe and trusted each other. This trust enhanced the peer mentoring because each person could share their experiences and felt safe being vulnerable.

"The mentoring circle methodology and process provided people with an image of themselves as leaders and realizing the leader within," Gilfoyle continues.

"One of the things we noticed was the group used the mentoring circles as a way to inventory and assess their leadership practices and to hear what other people think about their leadership practice," notes Grady. "That became a key factor in our discussions because the practice inventory provides the language to talk about leadership. It names the practices and what they are. It created a culture of leadership that drew everybody in and motivated everyone to proceed with developing their leadership practice."

Manhard notes that one of the benefits of mentoring circles is that learning is broader and deeper through the storytelling process than if participants were simply to give advice about what a person should do. "The particular process of The Mentoring Company gives the participant context to the situation," she says. "[We discuss] people and places, history of the environment, strategies and statistics, and key learnings about leadership practices and behaviors, and applying these learnings

to real-time situations. It's a much different transfer of knowledge."

Subsequent meetings of the mentoring circle took place over the phone. By the final and closing meeting of the group in September—which, like the initial meeting, took place in person—it was clear that the circles had been a success, and members were already talking about ways to stay connected.

"Adults have many experiences from which we all can learn, and sharing experiences via stories about relevant events facilitates the application of leadership theories to leadership practice."

"I hope they take away an increase in their performance contribution, within both the Foundation and the Association, and in the occupational therapy setting," says Manhard. I want them to take away an increase in trusting their relationships and network of peers that help them become better leaders who are more effective at their work."

A second round of the mentoring circles launched this month, with new participants and new experiences. This session participants will be managers and directors of occupational therapy and occupational therapy assistant programs, rather than occupational therapy faculty doing research as was the case with the pilot group. However, the process for the circles will stay the same, with a focus on peer mentoring.

"The philosophy of mentoring circles is based on the power of peer mentoring and the power of storytelling," Gilfoyle says. "The circle process and methods are based on adult learning theory; adults have many experiences from which we all can learn, and sharing experiences via stories about relevant events facilitates the application of leadership theories to leadership practice."

"Through these circles we will begin to develop a network of people who have participated in the process and will be able to be in touch with each other and support each other in their leadership, creating a network of leaders," says Grady.

"Leadership is everybody's practice, and leadership is something that can be learned though its practice," she continues. "There are opportunities out there to practice leadership, make changes through leadership, and enhance one's own development through leadership, and that is something people get from these circles." ■

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

PRN in Physical Rehabilitation

Suzanne Holm

PRN occupational therapy practitioners in medical-model settings are often particularly challenged to use an occupation-based approach. The following demonstrates how one therapist used her limited time with a client to discover his valued activities, adjust his goals accordingly, and provide interventions for success.

"Steve" was a 31-year-old male who was employed as a construction framer. He was an unrestrained driver in a single-vehicle accident rollover and sustained a traumatic brain injury, iliac crest fracture, and right acetabular fracture. An MRI revealed bifrontal parenchymal hemorrhages, small bifrontal subdural hygromas, and diffuse axonal injury. He was admitted through the Emergency Department and stayed in the Neurointensive Care Unit for 10 days. He was transferred to the Acute Rehabilitation Department after 12 days on the Neurology floor, with a projected rehabilitation length of stay of 3 weeks. Steve's medical history included epilepsy and seizure disorder as a child, with no record of seizures since age 5, and a right femur fracture at age 24. His psychosocial history included alcohol abuse and illegal drug use, including THC and methamphetamine. At the time of the accident he was living alone in a one-bedroom mobile home and working full-time. He had three children, 3, 6, and 9 years of age, who lived with their mother and with whom he had minimal interaction. Steve's parents were actively involved in his care and discharge planning. His long-term goals were to return to his parents' home, learn to walk again, and eventually return to work.

Steve had been participating in occupational, physical, and speech therapy for 3.5 hours a day for less than 1 week on the Rehabilitation Unit when I saw him while providing treatment coverage for the primary occupational therapist. Using a task-oriented approach,[1,2] I explored Steve's situational role performance and occupational performance through the use of informal interview, evaluation of occupational performance tasks, and a nonstandardized visual screening during his treatment sessions. I also sought input from Steve's treating therapists and his family. Steve had fair sitting balance; intact equilibrium and righting response in sitting; right hemiparesis resulting in fair postural control with retro and right leaning in sitting (complicated by the non–weight bearing status of his right lower extremity); hypotonic right upper extremity with decreased proximal support and stability but fair distal coordination; and fair activity tolerance, with rest breaks required every 10 minutes. His visual-perceptual deficits included diplopia (double vision) and decreased right-sided attention. Cognitively he communicated his basic needs and followed two-step commands, but he demonstrated reduced temporal organization and adaptation (decreased initiation and attention to task). During his morning self-care routine from a wheelchair, Steve required minimal assist for upper- and lower-extremity dressing and toileting tasks, with verbal prompts to follow his weight-bearing precautions and to functionally incorporate his dominant right upper extremity.

Steve was reserved but actively participated in therapies. It was unclear at the time of this occupational therapy intervention if his prior drug use was affecting his recovery or his discharge plans. (Steve and his parents were receiving counseling services during his stay, and they were given additional resources at discharge.) Environmental support to increase Steve's independence included mobility devices (wheelchair, platform walker) and his parents' encouragement.

As part of the task-oriented approach, Steve was asked what he would like to do better as an informal self-assessment of role performance. He acknowledged a desire to read magazines and use his Game Boy electronic device. He reported that he could not perform these activities because of his double vision and his inability to maintain visual fixation and track. Therefore, he had not been engaging in familiar activities that he enjoyed. In his medical record a brief note from an ophthalmologist identified "CN VI palsy," but did not specified which eye was involved. Steve had an eye patch in his room, but he did not know when or how he should wear it. During his occupational therapy

At its 2007 spring meeting, AOTA's Representative Assembly (RA) passed a motion to begin a series of articles in *OT Practice* highlighting occupational therapists and occupational therapy assistants using engagement in occupation to support participation across the continuum of rehabilitation and disability. The RA Coordinating Council (RACC) will be working closely with AOTA's president to provide leadership and oversight with these articles.

If you are interested in sharing your own "occupation in action" please send an e-mail to otpractice@aota.org for the guidelines.

intervention for activities of daily living I asked him to try wearing the eye patch, but he had difficulty tolerating it. He frequently tried to remove it completely, or he only partially covered his left eye. He could not tolerate wearing it over his right eye to facilitate intermittent monocular visual input.

I prioritized the need to clearly establish the extent of Steve's visual dysfunction and to explore alternatives to monocular eye patching due to the high incidence of visual dysfunction associated with traumatic brain injury[3,4] and his inability to perform valued occupations due to visual concerns. I administered a vision screen that included assessment of near and far acuity (binocular acuity was deferred, due to his diplopia), range of motion (mono and binocular), convergence, pursuits, saccadic eye movement, and peripheral field vision. Results indicated impairments in distant and near vision (distance was 20/32 in his right eye, and 20/50 in his left eye; near vision was 20/50 in his right eye, and 20/70 in his left eye), and a cranial nerve VI palsy in his right eye (limiting abduction and lateral range of motion). Steve also presented with a right homonymous hemianopsia. When asked during the screening, Steve responded affirmatively that "letters jump around on the page," "portions of a page are missing," and "things suddenly appear that I did not see approaching." He had difficulty following the confrontational peripheral visual-field testing instructions, so the line-bisection test was used to help identify deficits in the right visual fields.

In collaboration with Steve, we added the additional occupational therapy intervention goals of reading and using his Game Boy, using the following strategies to improve his visual-perceptual skills:

1. Steve will be independent with daily vision exercises and compensatory strategies during therapies.
2. Steve will use monocular vision strategies (e.g., the eye patch or transparent taped glasses) outside of therapy when reading or using his Game Boy.

These strategies would provide Steve with clearer direction and give him some control on what to work on to facilitate functional vision for his desired occupations. Occupational therapy staff provided additional information about Steve's visual status and gave recommendations to him, his parents, and the treating physical and speech therapists to support optimal participation in and outside of his therapies. I recommended that his therapists use verbal and tactile cues to increase Steve's ability to scan his environment visually and with head rotation, especially to the right, during mobility tasks; encourage him to wear his eye patch during tasks requiring visual attention; and increase the font size of written work (combined with isolating text) to minimize visual overload and increase his success with reading. I also recommended that Steve and his family consult a neuro-ophthalmologist who specializes in visual changes as the result of neurological impairments for a more thorough visual assessment and to monitor for progress or changes in his CN VI palsy/diplopia and his right homonymous hemianopsia. Results from Steve's visual screen and functional status were left for the primary treating occupational therapist with the recommendation to reassess his visual status as needed.

CONCLUSION

A particular challenge in my work is that I practice in both acute care and on a rehabilitation unit as relief (PRN) staff. Therefore, I may interact with a client only once or twice. However, in each session I attempt to clarify how occupational therapy ties into the client's goals and to help him or her create new goals if needed. I often recommend the focus of the next intervention session (based on client priorities or needs to address the goals) to help with the flow and plan of care and to provide a "picture in time" for the treating occupational therapist and other clinical caregivers.

All documentation occurs in an electronic health care record. Daily treatment notes are recorded in an Occupational Therapy Treatment Note that is outlined in an S.O.A.P. format, with drop-down menus for recording pain management, levels of assist, required equipment, education areas, and the treatment plan. Open-text boxes are used for documenting results of the skilled portion of therapy, the assessment, and the treatment plan. The visual screening results and recommendations are recorded in an Occupational Therapy Vision Screen Note. This documentation format increases the therapist's ability to locate specialized information efficiently.

Although I did not work with Steve again, his primary occupational therapist reported that approximately 6 months after his discharge from acute rehabilitation, he was living with his parents and had been cleared to bear weight through his right leg. His visual deficits had largely resolved. ■

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Suzanne Holm, MA, OTR, BCPR, is an inpatient acute care occupational therapist at Medical Center of the Rockies in Loveland, Colorado. She has more than 15 years' experience in adult physical rehabilitation in acute, inpatient, outpatient, day treatment, and community reentry settings. At the time of this case study she was a relief occupational therapist working at Poudre Valley Hospital in Fort Collins, Colorado.

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Camp Helping Hands

Addressing Hemiplegia in Children With Cerebral Palsy

SCOTT MATTHEWS
CRAIG KAUFMANN
LAURIE KNIS-MATTHEWS

It is estimated that 5 children in every 2,000 are born with cerebral palsy (CP), making it the most common cause of physical disability among children.[1,2] According to Rogers, "CP is characterized by nonprogressive abnormalities in the developing brain that create a cascade of neurologic, motor, and postural deficits in the developing child" (p. 176).[3] Of the various classifications, spastic cerebral palsy is the most common in children and accounts for 80% to 90% of diagnoses.[2] These children often have increased muscle tone, resulting in stiffness and a decreased range of motion.[2] Children with hemiplegia, a form of spastic CP, often have varying degrees of limited movement, coordination, and sensation on one side of the body, specifically within the affected arm.[4] In addition to the motor and sensory impairments, a child may exhibit behavioral issues that create difficulties in areas of occupation such as play, recreation, and self-care.[3]

According to Taub and Wolf, individuals diagnosed with upper-extremity dysfunction due to hemiplegia engage in a process called *learned nonuse*.[5] This process occurs when the person stops incorporating his or her affected limb into functional movement patterns. Rather, the person begins to compensate by using only the unaffected limb (and one hand) to perform tasks. Over time, the individual's attempts to incorporate the affected limb into functional movement become less effective.[5]

An evidence-based approach, constraint-induced movement therapy (CIMT), is increasingly being used to address the effects of learned nonuse by constraining use of the unaffected limb to increase functional use of the affected limb.[5] Research studies examining the effects of CIMT in children report functional improvements in the hemiplegic arm that last up to a year, and some claim that these gains are permanent.[5–8]

CAMP HELPING HANDS

Camp Helping Hands is a community-based program in Scotch Plains, New Jersey, providing services to children diagnosed with CP who are between 4 and 8 years old. Following the principles of CIMT, the therapists at Camp Helping Hands provide treatment for 6 hours a day during a 3-week period to facilitate constant use of the child's affected arm. During this time, the child wears a removable custom-made soft cast on the unaffected arm. The overall goal is for the child to increase the ability to bilaterally integrate both upper extremities while participating in meaningful occupations.

Camp Helping Hands is staffed by two occupational therapists, two Level II fieldwork students, four first-year occupational therapy students, and at least two pre–occupational therapy students who function as volunteers for a program of 10 children. Presently we do not have certified occupational therapy assistants (there are no OTA programs in New Jersey) participating in our program, but this would be a perfect fit.

Children eligible for the camp must have a diagnosis of upper-extremity dysfunction due to hemiplegia, such as CP, brachial plexus, or traumatic brain injury. The child must be able to move the affected wrist at least 20° of extension and the affected fingers at least 10° of extension. Children should be able to tolerate therapeutic activities among fellow campers. However, the staff will adapt to and accommodate the individual needs of each camper within a group format. Participation in the camp is ultimately determined by established achievable goals with the child, family, therapist, and physician. Parents typically pay out-of-pocket for these services based on sliding scale fees, so children from varied socioeconomic groups are able to attend.

There have been mixed results from families pursuing reimbursement from insurance companies. Some have been fully reimbursed, whereas others have been reimbursed only a small percentage of the cost.

Unlike in many traditional medical settings, the staff at Camp Helping Hands services children in a community-based activity—a learning center—rather than a hospital setting or therapy clinic. Activity learning centers are year-round indoor facilities that promote both structured and unstructured group play. Well-known chains of activity learning centers such as Gymboree and Little Gym typically serve children from 6 months to 5 years of age.

SUMMARY

Movement patterns resulting from cerebral palsy can be addressed while children have fun doing things they need and want to do.

"Helping hands to the rescue" became the theme of Superhero theme day.

PHOTOGRAPH COURTESY OF THE AUTHORS

Group play is promoted among the children at the camp to emphasize social interaction while addressing each child's unique goals. The group environment facilitates socialization, motivation, a sense of belonging, and peer feedback. For example, the children derive support and encouragement from each other and are often motivated to perform well when competing with one another during the therapeutically structured activities. This factor is particularly helpful for alleviating the frustration associated with participating in activities while wearing a cast on the unaffected arm for several hours each day. Children who are initially reluctant to wear the cast often change their minds while watching their peers having fun while doing so.

To facilitate the use of each child's affected arm, each day at camp centers around a specific theme (e.g., Olympic day, beach day, zoo day). All theme-related activities are designed to provide children with the opportunity to successfully use their affected arm in a fun, functional, and challenging manner. For example, on beach day the children are encouraged to use the affected arm while making sand art and a paper bag octopus, navigating an obstacle course, going fishing, playing beach volleyball, "surfing" (on a scooter board), building sand castles, and hunting for treasure. As the children initially participate in these activities, the staff often remind them to incorporate their affected hands by saying "use your helping hand," hence the name Camp Helping Hands.

OCCUPATIONAL THERAPY EVALUATIONS

A combination of evaluations—including the Jebsen Test of Hand Function,[9] AbilHand-Kids,[1] and the Canadian Occupational Performance Measure (COPM)[10]—were used to assess each child's ability to perform activities of daily living (ADL) with their affected arm. The Jebsen Test of Hand Function is a standardized assessment that evaluates hand function during ADL using seven timed subtests. These subtests are intended to present a broad assessment of hand function and include writing, turning pages, picking up small objects, feeding simulation, stacking checkers, picking up large light objects, and picking up large heavy objects. We did not use the first subtest, writing, in our assessment due to the inability of all the children to complete this task. To obtain standardized measurements and documentation of each child's performance in these areas, we administered this assessment once in the beginning of camp and again at the end of camp.

The AbilHand-Kids is a standardized measure of the manual ability of children diagnosed with CP. The assessment is a one-page questionnaire consisting of 21 activities such as "putting on a hat," "taking off a T-shirt," "washing the upper body," and so forth.[1] Parents were asked to rate how difficult the activities are for their

children on a scale of impossible, difficult, or easy. This assessment was also administered once at the beginning of camp and again at the end of camp.

CANADIAN OCCUPATIONAL PERFORMANCE MEASURE

The staff believed that it was important to use a client-centered approach when developing the treatment plans for each child. A Level II occupational therapy fieldwork student was responsible for administering the COPM to the parents of the children at the beginning and the end of camp. The information gathered from this assessment was used to develop each child's individualized treatment plan and make discharge recommendations.

The COPM emphasizes the relationship between the person, environment, and occupation in regard to occupational performance.[10] Administered as a semistructured interview, the COPM is "an individualized measure designed for use by occupational therapists to detect change in a client's self-perception of occupational performance over time" (p. 1).[10]

Occupational therapists conducted semistructured interviews with the parents to identify performance problems in areas of self-care, productivity, and leisure. The parents were asked to prioritize each item on a 1 to 10 scale, with 10 being most important. The therapist then asked the parents to rate their child's performance and satisfaction with performance on a scale of 1 to 10, with 1 being not able to do at all or not satisfied at all, and 10 being able to do extremely well or extremely satisfied. A performance and satisfaction score for each child was calculated by adding the ratings in each area and dividing by the number of problem areas identified. Used as an outcome measure, the COPM was administered to the parent or parents of each child at the beginning and end of camp to evaluate and measure any changes in their perception of their child's performance in the identified performance areas.

The findings from the COPM helped the staff to develop unique client-centered goals and interventions for each child while acknowledging the parents' perception as a key component in the intervention process. This collaboration created a trusting environment among the parents and staff from the beginning of the 3-week camp.

Each parent identified three to four performance problems to be addressed through intervention. Some commonalities were noted among the parents' report of the occupational performance areas to be addressed (see Table 1 on p. 15). For example, all of the parents ranked dressing within the top five most important occupational performance issues to be addressed. Specifically, taking a shirt on and off was reported by four of the seven parents, and taking pants on and off was reported by three of the seven. Achievement toward this goal was addressed on a daily basis. Besides asking the children to put on and remove their coats, other dressing activities were incorporated into the camp as the children dressed up as their favorite superheroes or as a pirate. As their arm movements became more advanced, the children participated in races to dress themselves as quickly as possible. The children often cheered on their peers, which facilitated a positive environment. Children who required more assistance were encouraged to practice putting on their coats in a quieter and less stressful environment.

Research studies examining the effects of CIMT in children report functional improvements in the hemiplegic arm that last up to a year, and some claim that these gains are permanent.

Six of the seven parents wanted their children to stabilize the paper while completing homework assignments or coloring. Children performed arts-and-crafts activities such as coloring to facilitate the use of their affected arm as a functional assist. As previously noted, the staff often encouraged the children to "use your helping hand" during these activities to increase their awareness that their affected arm could be used to stabilize the paper.

The inability of the children to brush their teeth independently was another problem area reported by the parents. Parents were asked to bring in a toothbrush and toothpaste from home so their child could practice brushing his or her teeth after a snack or lunch.

It should be noted that for all activities and goals that required the use of two hands, the cast was removed and the task was practiced with two hands. The camp was designed for the children to participate in activities facilitating use of the hemiplegic arm with the cast on their unaffected arm for the first 7 days. Then the cast was removed for 1 hour per day for the next 6 days to allow the children to practice bilateral upper-extremity activities.

CASE EXAMPLE: TIM

Tim is a 5-year-old boy who lives with his parents in a middle- to upper-class suburban town. Tim was diagnosed with left spastic hemiparesis secondary to right closed-lip schizencephaly. At the start of Camp Helping Hands, an occupational therapist used the Jebsen Test of Hand Function to determine Tim's active range of motion (AROM), grip strength, and ability to perform ADL with his left upper extremity.

On initial assessment, Tim was determined to have full AROM in his left shoulder, elbow, and fingers and thumb; AROM within his wrist was determined to be at half range. Measured with a dynamometer, his grip strength was 3 pounds. According to the Jebsen Test, Tim's level of hemiplegic function was at a "functional assist" level, meaning he was able to perform isolated movements with his left upper extremity and to manipulate medium-sized objects. However, these movements were awkward and influenced by synergy patterns.[9]

Using the COPM, the occupational therapy student interviewed Tim's mother, Gina, on the first day of camp. Information obtained through the initial assessment and reassessment 3 weeks later is represented in Table 1.

Table 1. Pre- and Post-Data for Performance and Satisfaction of Goals as Identified by Parents for Their Child During a 3-Week Treatment Period

Child's Goals as Reported By Parent	Importance	Initial Performance	Final Performance	Initial Satisfaction	Final Satisfaction
Steven					
1. Taking long-sleeve shirt on and off.	10	3	5	1	5
2. Taking pants on and off.	10	1	5	1	5
3. Fastening seatbelt in car.	10	1	3	1	3
4. Opening a Ziplock bag during lunch.	10	3	7	1	8
Mary					
1. Going down stairs.	10	4	8	2	7
2. Playing with dolls.	9	2	6	1	5
3. Holding down paper while coloring.	9	4	7	4	5
4. Taking T-shirt on and off.	7	2	4	1	5
5. Holding down bowl while eating.	6	5	7	4	6
Tim					
1. Taking socks and shoes on and off.	10	2	7	2	7
2. Pouring juice without spilling.	10	5	7	5	7
3. Playing Legos.	10	5	7	5	7
4. Holding paper down while coloring.	10	5	7	5	7
5. Swimming.	10	3	7	3	7
Gus					
1. Brushing teeth.	9	5	6	5	5
2. Putting on T-shirt.	9	5	6	5	6
3. Using both hands to read a book.	9	6	6	6	6
4. Catching a ball.	8	3	3	3	3
Mark					
1. Taking pants on and off.	10	1	7	1	10
2. Brushing teeth.	10	3	5	5	8
3. Sitting safely in a chair while eating.	10	3	3	1	1
4. Socializing with peers.	10	4	6	2	10
5. Holding down paper while drawing.	10	2	3	5	3
Jill					
1. Taking pants on and off	10	1	1	1	1
2. Brushing teeth.	10	3	3	5	5
3. Riding a bicycle.	10	2	5	2	5
4. Increasing confidence to use both hands together.	10	2	5	1	6
5. Holding down paper while coloring.	8	4	5	5	5
Billy					
1. Taking T-shirt on and off.	10	1	8	1	8
2. Getting on and off an adult chair.	10	5	7	8	7
3. Holding down paper while coloring.	10	4	7	4	7
4. Climbing using both hands.	5	5	9	5	9

Gina identified problems with Tim's bilateral motor skills associated with the activities that were most important to him and the family: dressing, feeding, doing schoolwork, and playing. She explained that Tim's personal self-care activities such as dressing (donning and doffing socks and shoes on his left foot, which was his affected side) and feeding (pouring liquids and stabilizing bowls) were both difficult and time-consuming.

Initially, Tim required moderate assistance to put on his socks and shoes. He required maximum assistance to pour liquids into a cup, and moderate verbal cues to use both hands when stabilizing a bowl during feeding. Gina also noted that productivity skills associated with stabilizing paper during homework assignments and building Legos during play were challenging tasks for Tim. Lastly, she said that Tim enjoyed active recreation sports involving bilateral movements, such as paddling his arms while swimming, and swinging a bat, but he had a difficult time performing these activities. In addition, Gina shared that Tim's confidence and perceived sense of strength had been affected as a result of his constant struggle to perform the motor skills necessary to do the tasks she had listed.

On the first day of camp, Tim appeared to be a happy and friendly child. Although he was willing to engage in the camp activities, he was often reserved in social participation and engagement. However, over the 3-week period, Tim's level of self-confidence increased as he began incorporating his left arm during daily camp activities. Toward the end of the first week, he was arriving at camp very enthusiastic and motivated to start the day.

This was apparent as Tim soon began volunteering to help, and motivated the other children. For example,

during a craft activity on "superhero" theme day, the children painted superhero logos on the center of a white T-shirt. While completing his shirt, Tim ardently proclaimed "helping hands to the rescue" with a grin, while flexing the biceps of his affected arm. His superhero-like statement compelled other campers to also assume superhero-like stances while proudly repeating "helping hand to the rescue." This contagious phrase became the camp anthem, as children and staff regularly used it for motivational purposes. In addition, Tim demonstrated how to put his socks and shoes on, and even rallied other children to help him build the "tallest Lego tower" during group play. These areas of achievement were directly related to the goals Gina had determined during the COPM evaluation.

Toward the end of camp, Tim's left arm was again assessed by an occupational therapist to determine his AROM, grip strength, and ability to perform ADL, using the Jebsen Test of Hand Function. Findings indicated that AROM in his shoulder, elbow, and fingers and thumb remained full; the AROM of his wrist improved from ½ to ¾ range. His grip strength had improved as well, from 3 pounds to 6.3 pounds. In addition, Tim's level of hemiplegic function had improved from "functional assist" to "refined functional assist," meaning synergy patterns were now minimal, and he was able to use his affected upper extremity for all activities and fine motor tasks.

On the last day of camp, the occupational therapist discussed progress toward the goals identified through the COPM. Gina rated an improvement in performance and satisfaction for every occupational performance problem identified at the start of camp. For example, the average of her performance score ratings was 4 out of 10 after the initial COPM assessment. The average of her performance score ratings after the reassessment was 7, indicating a 30% improvement. Similarly, the average of her satisfaction score ratings was 4 (out of 10) after the initial COPM assessment. The average of her satisfaction score ratings after the reassessment was 7.2, indicating a 32% improvement over the course of the 3-week camp.

As the treatment for children continues to shift from the hospital setting into the community, more therapeutic programs must address the holistic needs of each child in the most natural environment.

Throughout the camp, Gina received daily updates on Tim's progress toward his goals. At the end of the camp experience, she received recommendations for therapeutic activities that Tim could perform at home to further facilitate functional gains. In addition, she was provided with a carryover recommendation note that described how her goals for Tim were addressed and what progress had been made. After the COPM reassessment administered at the end of camp, she expressed her overall impression of the camp as well as Tim's behavior:

> When we first started this program we didn't feel so hopeful; I mean… by rote, we've had him do so many types of therapy with similar results. I didn't want him to go to a hospital where he thinks of blood tests and sick people…this type of program is different to him… I wanted to make it fun for him. This type of intensive therapy makes so much sense to me. He's always worked on things like dressing and eating but now everything has definitely come together; he's gained confidence and is doing things he never thought he could do before. He's so proud of himself now and excited to show us the new things he can do.

CONCLUSION

As the treatment for children continues to shift from the hospital setting into the community, more therapeutic programs must address the holistic needs of each child in the most natural environment. Camp Helping Hands is an example of a program that combines the results of evidence-based practice with the therapeutic art of practice. Additional research studies are underway to explore the parents' experiences of having a child involved in a CIMT program and the carryover of skills learned into other settings, such as school and home. ■

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Scott Matthews, MS, OT, is the executive director of Intensive Therapeutics Services. These services were provided in Scotch Plains, New Jersey. Additional sites will be offered in Wayne, New Jersey.

At the time of this project, **Craig Kaufmann** was a master's degree student in the Department of Occupational Therapy at Kean University in Union, New Jersey, completing his Level II fieldwork at Intensive Therapeutics. He is currently employed as an occupational therapist with Intensive Therapeutics.

Laurie Knis-Matthews, PhD, is an associate professor and acting Occupational Therapy department chair at Kean University in Union, New Jersey.

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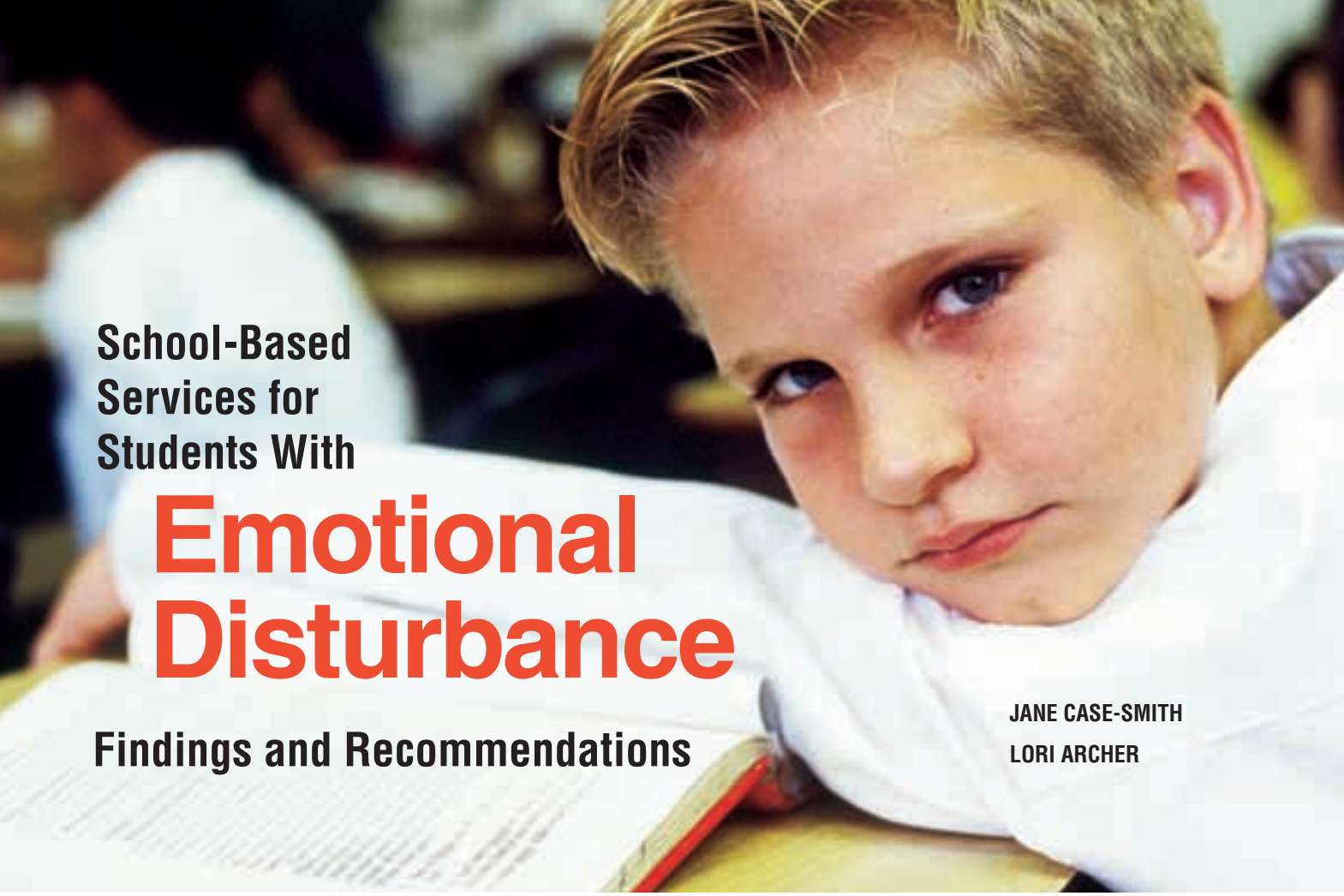

School-Based Services for Students With Emotional Disturbance

Findings and Recommendations

JANE CASE-SMITH
LORI ARCHER

PHOTOGFAPH © STOCKBYTE

SUMMARY

Emotional disturbance is often considered a barrier to providing occupational therapy services to students, when in fact it should be the focus of intervention.

Emotional and behavioral problems can negatively affect children's participation in school and have become an important issue for school-based professionals. In the 2001–2002 school year, almost 500,000 children diagnosed with emotional disturbance received special education services.[1] Children with emotional disturbance often struggle with interpersonal relationships, exhibit inappropriate behavior, and express feelings of general pervasive unhappiness or depression.[2] Emotional problems can also manifest as physical symptoms or fears associated with certain persons or school situations.[2] Students with emotional disturbances may have difficulty attending to their school work, interacting with their peers or teachers, or exhibiting appropriate classroom behavior.[2] Characteristics sometimes observed in children with emotional disturbance include hyperactivity, aggression or self-injurious behavior, withdrawal, immaturity (inappropriate crying, temper tantrums, poor coping skills), and learning difficulties.[3] Given the effects of emotional problems on children's participation in school, these problems should be a focus of occupational therapy services.

Occupational therapy practitioners provide services to a broad range of children within the entire spectrum of eligibility categories.[4] Although the roles of occupational therapy practitioners in the school appear to be increasing, research by Barnes and colleagues indicates that practitioners rarely contribute to developing and implementing programs for children with emotional disturbances.[5] Given the importance of social participation, it is somewhat surprising that occupational therapists do not often provide services to children whose primary problems are social competence and social-emotional functioning.[5]

SURVEY

In 2005–2006, we completed a survey research project to (a) examine the roles of occupational therapists with students with social–emotional problems, (b) describe therapists' intervention goals and strategies, and (c) identify barriers to providing services to these children. We sent the written survey to 1,000 occupational therapists who were members of the American Occupational Therapy Association School System Special Interest Section.

A total of 555 surveys were returned, representing school-based occupational therapists in all 50 states (the sample was geographically stratified, and the return represented the sample). Most respondents (n = 310) worked with elementary-age students. Respondents also served students in

Table 1. Barriers to Providing Services to Students With Emotional Disturbance

Theme	Description	Potential Solutions
The occupational therapy role with students with emotional disturbance is not recognized or valued.	Team members do not understand the scope of occupational therapy practice. Intervention for children with emotional disturbance is generally the purview of psychologists and counselors. These professionals seem to take ownership of emotional disturbance in the IEP. Some respondents noted that these other professionals were better trained to address emotional disturbance.	Provide in-services on the role of occupational therapy with students with emotional disturbance. The multidisciplinary evaluation meetings offer another opportunity to describe this role. Your services are best explained in the context of a student's goals and how occupational therapy can support those that include social participation.
Occupational therapists use sensory integration as the primary approach for students with emotional disturbance.	Respondents noted obstacles to using sensory integration, such as not having enough space for interventions, and teachers not following through with recommendations. Other team members did not understand the sensory integration approach.	Interventions recommended to be carried out by other professionals must be practical and easy to implement. For example, sensory integration interventions should be implemented in the student's classroom, during gym or on the playground using easily accessible materials. These interventions also need to be linked to specific goals and outcomes (e.g., "if you allow him to spend a few minutes in the latex tunnel between classes, he will be calmer and more organized"). Take the time to connect the intervention with the goal and ensure that the goal you have in mind is valued by the teacher and other members of the IEP team. Goals will be valued when they support the student's ability to access, participate in, and progress within the curriculum. They should include continuous progress monitoring, data collection, and evidence-based practice.
Occupational therapists focus on sensory and motor skills, not behavior issues.	The respondents reported that they primarily worked with children on sensory, motor, and visual-perceptual skills, focusing on fine motor, hand handwriting, and/or sensory integration. Many indicated that they served children with emotional disturbance only if the children were referred to them for sensory or handwriting problems.	This focus does not reflect the *Occupational Therapy Practice Framework: Domain and Process*[11] or the *Scope of Practice (2004)*.[12] Social participation and behavior are part of our domain, and interventions to promote social interaction and participation are part of our skill set. Don't be afraid to step out of the sensorimotor box!
Caseloads are too high.	Many respondents indicated that their caseloads were already too high, and they did not want to begin providing services to another diagnostic group. Therefore, they did not seek these referrals.	Caseloads are high; however, it is important that therapists keep in mind where the critical needs are. Reporting caseloads as a barrier suggests that children with emotional disturbance are not a priority. The national data suggest that these children are underserved and need occupational therapy as much as or more than other students. With high caseloads, priorities need to be established—is the student with emotional disturbance less important than other students?

preschool (n = 112), middle school (n = 117), and high school (n = 83), and many provided services to more than one age group. The average number of years in practice was 15.7. Students with emotional disturbances represented 8.2% of the occupational therapists' caseloads. Only 9 respondents (< 2%) had more than 50% of students with emotional disturbances on their caseload, which was similar to the findings of Barnes and colleagues, who found that 10.9% of occupational therapists' caseloads were students with emotional disturbances. Our survey extended Barnes and colleagues' findings by identifying the types of school-based services that occupational therapy practitioners provide to students with emotional disturbance and identifying the barriers to services for this diagnostic group. The following is a summary of the results of our survey, with recommendations as to how occupational therapy practitioners can overcome some of the stated barriers.

COMMON GOALS AND APPROACHES FOR STUDENTS WITH EMOTIONAL DISTURBANCE

The survey results indicated that only two items on the individualized education program (IEP) of students with emotional disturbance were frequently addressed by occupational therapists: (1) improving the child's

Table 1. (Continued)

Theme	Description	Potential Solutions
Parents and home environments can be barriers.	Some respondents believed that parents and the children's home environments were barriers because parents did not follow through with suggestions. Some respondents reported that when parents were not involved or were not consistent with the child's medications or program, the efforts of school personnel were undone.	In some cases the family is contributing to the child's emotional problems. When this occurs, a cohesive team approach is needed with social work, and possibly psychology, involved. Community supports should be sought. It is important to have team discussions as to how to deal with difficult families, and therapists need to have their own supports when challenging situations occur. The family may require additional emotional support as well.
Occupational therapists lack the skills to address children with emotional disturbance.	A number of respondents believed that they were not skilled in providing services to children with emotional disturbance, and continuing education in this area was not available to them. Consistent with these reports, some respondents believed that these students were too difficult to work with. They could not achieve occupational therapy goals with students' disruptive behaviors.	The first step in gaining more proficiency in an area of practice is recognizing that one needs increased competency. Solutions to this barrier rest first with universities' educational programs, where more information about evaluation and intervention for children with emotional disturbances is needed. In our experience, most of the continuing education on interventions for emotional disturbance is taught by psychologists, educators, and social workers. Occupational therapists need to take advantage of these educational opportunities to enhance their competence and integrate the information into their repertoire of skills. One strategy to help do this is to attend a conference on emotional disturbance with other members of the school team. Practice new approaches with the other team members to reinforce learning.
Students receiving occupational therapy services are scheduled into short periods of time that are insufficient to accommodate the intense needs of children with emotional disturbance.	The respondents indicated that they did not have time to provide appropriate services to this group because of high caseloads. They perceived that children with emotional disturbance need longer and more frequent services. They noted that by the time the therapist got a child's behaviors under control, the 30-minute session was over. They perceived a need to help these children on a more intense time schedule and to be available in times of crisis. Because they traveled from school to school and had small blocks of time for each student, they believed that occupational therapy services were or would be ineffective.	Scheduling and service delivery models in school practice need to be examined, and change needs to be considered. Research of interventions for students with emotional disturbance has shown that to be effective, intervention needs to be provided on an intensive schedule.[13] When needed for certain students with emotional disturbance, occupational therapy practitioners should have an extended period of time (e.g., 2 to 3 hours per week) to work intensively on specific skills. School-based teams need to be more flexible in how services are provided and scheduled. Although this concept has been discussed for many years,[14] systems remain rigid. We need to change the system to allow for more effective practices that grant students the intervention intensity required to enhance performance.
Children with emotional disturbance are not identified in the educational system or are misdiagnosed.	Some of the respondents' school districts had not identified many, or even any, children with this condition. Some respondents reported that the schools did not identify emotional disturbance because this condition does not cause academic failure and is not seen as a problem relevant to the child's educational goals. The respondents reported that children with emotional disturbance were not well identified and were often hidden by another diagnostic label.	This barrier implies that the school system is not well prepared to provide full inclusion to students with emotional disturbance. There also seems to be a lack of recognition that certain students have emotional problems requiring intervention. Occupational therapists have skills in identifying emotional problems and making appropriate referrals. Early intervention for emotional disturbances can make a huge difference in outcomes. Because occupational therapy practitioners spend one-on-one time with students, they may be the first to identify an emotional problem and should involve other professionals to prevent serious social–emotional–behavioral problems as the child progresses through school.

attention to task, and (2) improving the child's motor skills. The respondents commented that they often received referrals for students with emotional disturbance only when the students exhibited concurrent attention, sensory, or motor issues. Other occupational therapy goals, which were identified as frequently addressed by the respondents, linked more closely to behaviors associated with emotional disturbance. The goals that were

FOR MORE INFORMATION

Children With Behavioral and Psychosocial Needs: Occupational Therapy Practice Guidelines
By L. Jackson & M. Arbesman, 2005. Bethesda, MD: AOTA Press. ($39 for members, $55 for nonmembers. To order, call toll free 877-404-AOTA or shop online at www.aota.org. Order #1198C-MI)

Every Child Wants To Play: Simple and Effective Strategies for Teaching Social Skills
(30-min. DVD & companion workbook)
By A. Baltazar Mori & D. Bonfield Piantanida, 2007. Framingham, MA: Therapro. ($80 for members, $113.50 for nonmembers. To order, call toll free 877-404-AOTA or shop online at www.aota.org. Order #1414-MI)

Is it Sensory or Is it Behavior? (Manual and Cards)
By B. A. Paris & C. Murray-Slutsky, 2005. San Antonio, TX: Psychological Corp. ($53 for members, $75.25 for nonmembers. To order, call toll free 877-404-AOTA or shop online at www.aota.org. Order #1337-MI)

AOTA Online Course: ***Occupational Therapy in School-Based Practice: Contemporary Issues and Trends—Creating Positive Learning Environments Addressing Behavior, Social Participation, and Psychological Issues in School-Based Practice—Elective Session 6***
By G. Frolek Clark. Bethesda, MD: American Occupational Therapy Association. (Earn .1 AOTA CEU [1 NBCOT PDU/1 contact hour]. $22.50 for members, $32 for nonmembers. To order, call toll free 877-404-AOTA or shop online at www.aota.org. Order #OLSB6-MI)

Practical Considerations for School-Based Occupational Therapists
By L. Pape & K. Ryba, 2004. Bethesda, MD: AOTA Press. ($39 for members, $55 for nonmembers. To order, call toll free 877-404-AOTA or shop online at www.aota.org. Order #1233-MI)

addressed "more than sometimes" included improving organizational skills (children with emotional disorder often have disorganized thinking), increasing behavioral control, improving the child's focus on work, improving social interaction, and reducing inappropriate behaviors. (These items were taken from the School Function Assessment Cognitive/Behavioral Scale.[6]) About 84% of the respondents used sensory integration interventions as a primary approach. Several noted that they only served students with emotional disturbance who also demonstrated sensory integration disorders. Most respondents associated emotional problems with concurrent sensory processing disorders. Almost a third (29%) indicated that they applied the Alert Program.[7] Although sensory integration intervention was the primary approach used, the respondents reported barriers to using this approach in the schools. These barriers included insufficient space for sensory integration equipment, limited teacher and parent follow-through with sensory diets, and limited team buy-in to using the sensory integration approach.

Many of the respondents (61%) also used behavioral approaches. It appeared, based on survey comments, that behavioral programs were designed and established by other professionals on the team (e.g., psychologists, counselors, social workers) then were carried out by all members of the team. A team approach in which all members are using consistent strategies is congruent with best practice.

Approximately a third (34%) of the respondents used social skills training. A number of tools are available to support social skills training, including Social Stories[8]; games to help children express their feelings; and group tasks such as cooking, using construction toys, or creating art projects. Social Stories was the only strategy listed that addressed only social skills.

BARRIERS TO PROVIDING SERVICES FOR STUDENTS WITH EMOTIONAL DISTURBANCE

Although the primary goals for children with emotional disturbance are often to improve behavior or eliminate disruptive behaviors to facilitate learning,[9] a number of respondents (n = 41) did not identify changing behaviors as the goal, but identified disruptive behaviors as a barrier to their occupational therapy intervention program. These respondents may not recognize that the behavior itself should be the focus of intervention and may not embrace behavioral change as an important outcome of their services.

Almost two thirds of the respondents believed that they were not well prepared to work with children with emotional disturbance. Although all occupational therapy educational programs have content on mental health practice, often the focus is on adults with mental illness. A number of respondents reported that continuing education on interventions for social–emotional problems among children was not available in their area. In our experience, most professional training in social–emotional learning and positive behavioral support is taught in conferences led by psychologists, educators, or social workers.

In Table 1 on page 18 we have summarized the primary barriers to providing services to students with emotional disturbance as reported by the respondents to our survey. We recorded all of the written comments into a single document, organized them by topic, identified and labeled the themes, and developed potential solutions to strengthen the role of occupational therapy in this practice area. The themes are presented in order, from cited most often to cited less frequently. All the themes in the table were reported by at least 20 respondents.

RECOMMENDATIONS

Based on our survey results, we make the following recommendations to improve school-based occupational therapy practice with students with emotional disturbances.

1. Educate the team about the role of occupational therapy with students with emotional disturbance. Explain how occupational therapy services can support these students' social and behavioral goals. With the enactment of No Child Left Behind[10] and its emphasis on academics, social–emotional goals may not be a high priority for school administrators; however, social–emotional ability is pivotal to a child's learning process and academic achievement. Encourage team members to place a higher priority on children's social–emotional competence as fundamental to learning. Occupational therapy practitioners are in a position to recommend that IEPs include social–behavioral goals.

2. When selecting sensory integration strategies for students with emotional disturbance, clearly link the strategies to the IEP and specific team-decided outcomes. Demonstrate explicitly how the sensory integration strategy supports particular goals. Think about the practicality of the strategy and design sensory activities that are easy to implement in the classroom and are linked to everyday

habits and routines. In addition to sensory integration activities, implement strategies that specifically address social–emotional performance, such as social skills groups or occupational therapy projects that engage students in interaction.

3. Step outside the sensorimotor box. Identify the occupational therapy role in promoting social participation and appropriate social behaviors. Practitioners who use sensory integration as an intervention tend to focus on helping children achieve optimal arousal and attention, which is a first step in engaging them and eliciting their participation in classroom activities. Organize small-group construction tasks, implement group cooking and baking activities, make posters that illustrate examples of social engagement, organize community outings to a restaurant, facilitate group service projects for nursing home residents, and engage small groups of students in playful social interaction.

4. Make sure you have regular communication with the family. When working with a child with emotional disturbance, communication with the parents or guardians is critical. If needed, suggest team meetings outside the context of the IEP to coordinate team and family efforts. The beliefs and goals of the family and child should be embedded in the IEP.

5. Seek continuing education about emotional disturbance offered by interdisciplinary instructors. Use clinical reasoning to integrate information from other disciplines into your occupational therapy interventions.

6. Help to design more flexible and creative scheduling in the school system. System change is needed to allow for intensive blocks of intervention services. A student's IEP needs to allow for flexibility in scheduling so therapists can move among the roles of consulting and providing services.

7. Assist in identifying children with emotional disturbance. Often, social–emotional problems are not identified until significant problems arise in adolescence. The educational impact of emotional disturbance, like many other conditions, can be minimized or significantly reduced if early intervention is provided. ■

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Jane Case Smith, EdD, OTR/L, FAOTA, is a professor and the director of Occupational Therapy, School of Allied Medical Professions, at The Ohio State University.

Lori Archer, MS, OTR/L, is a school-based occupational therapist and the related services coordinator at Forest Rose School, Fairfield County Board of MRDD, in Lancaster, Ohio.

Conducting Fieldwork Interviews

Donna Costa

Shelly Pavese, OTR, asks: "I am the clinical coordinator for the occupational therapists at our hospital. I have a question regarding your experience with accepting students. Do you utilize a phone interview prior to accepting a student for their clinical? If you do, would you be inclined to share your questions with me? We are trying to develop a system that is uniform for accepting students."

This is a good question, but there is one bigger question to ask first: What is the purpose of a student interview prior to starting fieldwork? The answer to this will help determine what questions to ask during the pre-fieldwork interview. Bernard and Goodyear suggested that the purpose of the interview is twofold: "it becomes a first-level orientation for the student to the agency and its expectations, and it allows the site supervisor the opportunity to gain relevant data about the student on which to make a decision" (p. 195).[1] Fieldwork educators need to reflect on what they want the outcome of the interview to be—is it to get to know students, evaluate how much they know, prepare them for the expectations of the fieldwork site, introduce them to the staff, evaluate their personality to match them with a suitable supervisor, or some other reason?

I have heard some students tell me that their fieldwork interview was more stressful than a job interview because they were asked many questions to test their knowledge base. They left the interview feeling demoralized, and feared that they did not get the fieldwork placement. This type of interview is counterproductive, in my opinion. Some fieldwork sites use the interview to screen students, but this is a questionable practice; if screening is the reason for the interview, then there should be clearly defined criteria against which the student will be evaluated. A student who is not accepted should be given feedback—preferably directly—about the reason. Otherwise, the interview becomes a failure experience for the student. In addition, the reasons for nonacceptance must not violate federal or state laws; in other words, just as employees cannot be discriminated against for age, race, gender, religion, disability, and so forth, neither can students.

The pre-fieldwork interview should be an opportunity for students to see the fieldwork site where they will be spending 8 to 12 weeks in an immersion experience. It helps them to understand the expectations of the fieldwork site staff, meet their future fieldwork educator, and go away with an understanding of the "culture" of the facility (i.e., the clients, their conditions, the pace, the environment, the staff, the dress code, the hours, and what to do about lunch). The format I use is to give students a tour of the site, introduce them to staff and other students, and discuss the expectations and an overview of their assignments. I review their medical information and personal data sheets, discuss their Level I fieldwork experiences, and briefly review what assessments and treatment interventions they've learned in school. The collaborative supervision model is explained to students with an assurance that this works very well. If I have other students currently at the site, then I leave the potential students with them so they have an opportunity to talk without my being present. Students are offered the opportunity to ask questions, and at this point their questions are fairly concrete—what should I wear, what should I do about lunch, what hours will I be working? I also tell students to expect a minimum of 1 hour a night of reading, doing written assignments, and planning. A large number of students are surprised by this, thinking that they will be able to get all of their work done during the day. Particularly in the beginning this is not the case, and so it is helpful for them to hear the expectations up front.

Face-to-face interviews are not always possible, and so I sometimes use telephone interviews. Again, it is important to have a similar structure for the phone interview. Perhaps the fieldwork facility has a Web site that students can be referred to so they can see photos of the site and learn about its philosophy. The other items mentioned above can be handled similarly in a phone interview. I find that providing information up front gives the student a chance to acclimate to the interview, become more relaxed, and then become more comfortable with asking questions.

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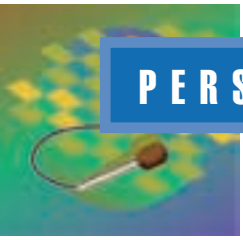
Have a Question?

Send your questions regarding fieldwork to *OT Practice* to have them considered for a future topic of "Fieldwork Issues." Please include your credentials, and indicate whether we can use your name. Send questions to otpractice@aota.org.

Donna M. Costa, DHS, OTR/L, is the chairperson of and a clinical associate professor in the Occupational Therapy Program at Stony Brook University, HSC School of Health Technology and Management, in New York. She is the author of *Clinical Supervision in Occupational Therapy: A Guide for Fieldwork and Practice*, which was published by AOTA Press.



PERSPECTIVES

OT Saved My Life

Surviving Domestic Violence

Terry Olivas-De La O

"Why do you want to become an occupational therapist? You don't need to go to college, just be with me!" was all I heard after being pushed down 12 flights of stairs and then dragged by my hair to my abuser's car. This was only the beginning of a year that began more than 20 years ago. Now I feel comfortable sharing why I did not finish my OTR degree, how proud I am to be a COTA, and how strongly I am committed to occupational therapy practitioners participating in every way with domestic violence services. As practitioners, researchers, educators, and students, we need to support those of us within our profession and whom we serve daily to understand how domestic violence affects so many who are hiding in undue shame and who are trying to find their occupation of living.

On that cold winter night more than 20 years ago, as I was being pulled from my apartment in my pajamas by an angry boyfriend and then left on a corner known as "hooker alley" in this area of California, I honestly believed that if I lived I would do everything in my power to become an OT, because this was my dream. When he returned to pick me up and bring me home, broken of body, heart, and soul, I felt I had nowhere to turn for help. The police had only warned him the last time he did this to me because they could not see my bruises. This time, when he was out of earshot, I called a classmate to come and get me; thank God for Linda, Bryan, and Roland, who were partially responsible for saving my life that night. Much later, I realized that I was also responsible, by asking them for help.

At that time there were few safe houses or hotlines (and I wasn't aware of any in my area). Many people, including law enforcement officials, blamed the victims or didn't see a need to provide special assistance. The domestic violence laws now in effect did not exist, so my abuser did not have to spend time in jail, even after I finally pressed charges. Without any options, I lived in fear with my friends for more than 3 months, hiding and praying not to be found. I had to make some difficult life changes. I dropped out of the OT program for 3 months and started work in a chemical plant, even when my dream since I was 11 years old had been to be an OT. How easily influenced I had been by "Joe." Each time I broke up with him he promised to be "better." Abusers make promises to their victims every day, and sadly we believe them for reasons only we understand. Somehow, I kept finding myself back into his and my deep, dark, secret cycle.

During this time I shared my "problem" with a professor to ensure that I would be able to continue in the program after my leave of absence. There was no domestic violence assistance in either the OT program or the university, and she simply encouraged me to continue in school. She could not understand my fear, and she and others asked me, "How could you let yourself get beat up?" (May I say here, it is my hope that none of my fellow occupational therapy colleagues say this to anyone at any time. Domestic abuse survivors already have enough guilt. We need you to offer assistance; do not give up on us, no matter how frustrated you are—we hear you, we just don't see any options.) Finally I had to share with my parents that I was "not making it in school." I felt so ashamed that I could not give them the real reason. My concerned mom came to the university to speak with the dean of occupational therapy to see what we could be done to help me accomplish my dream, because she was not giving up. The dean's only comment was, "perhaps OT

Domestic Violence Statistics

- Abused women are six to eight times more likely to use health care services than are nonabused women.[2]
- Thirty-seven percent of abused women first disclosed the abuse to their health care provider, which began their healing.[3]
- The cost of domestic violence exceeds $4.1 billon per year in direct medical and mental health care services.[4]
- Injuries resulting from intimate partner violence can force victims to take time off from work and lose wages, resulting in stress and even depression.[5]
- Rates of depression, suicide attempts, and substance abuse are higher in mothers who are domestic violence victims.[5]

How OT Practitioners Can Help Survivors

- Be part of a safe house or group home to address communication, occupations, and self-empowerment. If necessary, start as a volunteer and find out how to become part of the staff or the board.
- Work with the site's domestic violence counselor, social worker, and psychologist on goal setting for clients. Be the client's advocate on all levels.
- Demonstrate occupational therapy's understanding of participation and occupational performance for self-empowerment of work, education, social participation, leisure, and all activities of daily living.
- Assist the survivor to address life skills for herself and her family (e.g., cooking together with her children, reading) and encourage participation by all those who live with her.
- Encourage survivors to get not just a "job," but to further their education to become self-sufficient.
- Reinforce leisure skills. Encourage survivors to take time outside of therapy to do fun things that are inexpensive but fulfilling: journaling, taking walks, doing embroidery, painting—help them find a passion!
- Help influence public policy and ensure that there is funding for occupational therapy to be an active part of domestic violence recovery.
- Donate items for safe homes: new undergarments, self-care items, and your time.

is not for Terry, maybe she should transfer to LACC [Los Angeles Community College] and become a COTA." I wondered, can't the dean tell there is something deeply wrong? Why was I prepared to help patients as an OT, but I couldn't help myself when I was in personal turmoil? How could this be changed, and more importantly, how could I change?

Unbeknownst to me, Joe had found out where I was working and got a job there. One day I found that my car's engine had been tampered with. When I went back to the building to find a ride, I encountered him in the hallway. He twisted my arm so hard that I later developed yet another bruise. Fortunately a co-worker saw him, and I was called into the manager's office. She believed me and put him on suspension, which was all she could legally do at the time. However, as is common in abuse cases, her disciplinary action ultimately put me in more danger.

Two days later Joe was waiting for me outside my "safe haven." (I later learned from a police follow-up that he had been following me for months.) He said I was "going to pay" because I had humiliated him at work. I ran into the house, but he got inside too, yelling "you will never be anything in your life!" I thought I was alone when he pinned me against the refrigerator and began choking me, but a close friend and roommate rushed to my aid. As she hit him in the back with a bat, I escaped. That night, I made plans with my parents to return home, although I didn't share that I had been abused by Joe, and instead put up a brave front. My brother and a friend arrived the next day with a trailer, and with many mixed feelings I returned home to be with my family and seek another career.

Two years before being accepted into the occupational therapy program, I had survived a horrific car accident and was told by the specialists that I could never be an OT due to my back injury. At that time, I was not about to quit because of an injury. Now, I again had to decide what my future would be.

A year later, I found a rewarding path as an occupational therapy assistant. With the guidance of two outstanding OT professors at LACC, Karen Tabeck and Ellie Hilger, I was able to reignite my passion for this profession by learning the new skills and tools that I still use as a COTA.

In 2006, President George W. Bush signed the 2005 reauthorization of the Violence Against Women Act of 1994.[1] A close friend read that Joe beat up another young woman so badly she almost died, and because of this law he ended up in prison.

I believe we can make a difference in domestic violence through educating, volunteering, and making occupational therapy a priority in the recovery of each person involved, through the process of prevention, intervention, and recovery.

I strongly endorse occupational therapy being part of every domestic violence center, board, commission, and organization. Survivors such as myself deserve the expertise and services of occupational therapy practitioners. I have the honor not only of assisting other survivors of domestic violence as a volunteer, but also of dedicating my company and organization to the important work that is needed on behalf of all those whom we advocate for and serve every day.

My quest to be an occupational therapy practitioner saved my life by motivating me to continue my educational and professional journey. It inspired me to have strong occupational structure and to create justice for myself and others. I have also been honored to share my experience with other Latina young women. Recently, a former 13-year-old domestic violence client shared with me that she did not take her life after having heard my story and learning about "OT tools." She is looking forward to attending college one day.

In closing, I would like to thank all occupational therapy assistant and occupational therapy colleagues who strive to work in the field of domestic violence to make a difference on behalf of all women, men, and children who need our services each and every day.

Hugs from the heart. ■

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Terry Olivas-De La O, COTA/C, is the chief executive officer and founder of Family Success by Design, Inc., in Monrovia, California; the editor of AOTA's *Home & Community Health Special Interest Section Quarterly*; and a former AOTA Board member.

FOCUS ON

School System Special Interest Section

Barbara Chandler

Doors open. Doors close. We decide, by our actions, which doors we walk through and what we do on the other side.

Occupational therapy practice under the Individuals with Disabilities Education Act (IDEA)[1] continues to evolve as early intervention, preschool, and school services change with each reauthorization and with ongoing research about what is most effective in these systems of service delivery. The School System Special Interest Section (SSSIS) exists to support occupational therapy practitioners working in early intervention (EI), preschools, and schools. A SIS arises out of member needs and is a collection of individuals with a common interest. At its most obvious, an SIS provides networking opportunities and information via Conference programming, *Quarterly* newsletters, and listservs. The Standing Committee and other SIS members are called on as resources for AOTA staff, and provide expert advice on legislation, regulations, initiatives, and state and local perspectives. There are tremendous opportunities in EI, preschools, and schools, and occupational therapy practitioners bring a unique and needed perspective. Unless we want others defining what occupational therapy is and can or cannot do, it is up to us collectively as an SIS and as individual members to advocate for (verb) and be an advocate for (noun) occupational therapy in these practice settings. Your membership in AOTA is the first step in this advocacy.

The Standing Committee identified three focus areas for the 2006–09 term: psychosocial and emotional development (06–07), early intervention (07–08), and feeding and eating (08–09). The more formal activities of the Standing Committee are centered on these topics. However, many other important topics of interest require initiative and action at the state and local levels.

For example, practitioners need to be cognizant of and advocate for appropriate credentialing of EI providers. We should be leading the way in EI related to embedding intervention in everyday routines, providing services in the natural environment, and facilitating social–emotional development. The new EI listserv (co-sponsored by the School System, Developmental Disabilities, and Sensory Integration SISs) is an example of the sharing of ideas and actions that is necessary to fulfill our potential in this practice area. The National Early Childhood Technical Assistance Center (www.nectac.org) is an excellent resource for information as well as for opportunities to participate in Communities of Practice.

Preschool services are receiving increasing attention following the most recent reauthorization of IDEA. The flexibility allowed by IDEA for how states serve children age 3 to 5 years of age requires practitioners to know the service provision parameters (intent, focus, setting, etc.) to most effectively contribute to positive outcomes. This transitional period is a crucial time in a child's life. Occupational therapists' knowledge of development and the many ways to foster learning outside of didactic means is a critical contribution—greatly needed—to preschool services. (For information on the implementation of IDEA, go to www.ideapartnerships.org. Anyone can participate in these communities of practice.)

One of the most profound changes in school services is the increasing focus on collaborative practice, or having everyone working on the same page toward the same goal. Occupational therapy's emphasis on task analysis and problem solving is a natural link to initiatives such as Response to Intervention (RtI) and Positive Behavioral Supports (PBS). These, as well as Functional Behavioral Analysis and Behavioral Intervention Plans, are opportunities to use the full scope of occupational therapy practice within the schools. There is also increased attention on the outcomes of services, particularly transition services and school mental health services. SIS members are participating on national initiatives on RtI, school behavioral health, and transition. AOTA has publications and information available about these activities on the Web site at www.aota.org.

To more accurately reflect the mission and work of the SSSIS, during AOTA's 2008 Annual Conference & Expo, the Representative Assembly will consider a motion to change the name to the Early Intervention and School SIS.

I may be writing this column, but the School System SIS is you. Be an advocate and advocate for full, appropriate, and effective occupational therapy services in EI, preschools, and schools. There is plenty to do, so get busy! Keep the doors open and be ready to walk through. ■

Reference

1. Individuals With Disabilities Education Improvement Act of 2004. Pub. L. 108-446.

Barbara E. Chandler, MOT, OTR/L, FAOTA, is chairperson of the School System Special Interest Section.

Official 2008 AOTA General Election

Began Online January 14

Remember, the voting site opened at 12:01 a.m. EST on January 14, 2008, and closes at midnight EST on February 20, 2008.

For the fourth year in a row, the general election for Association positions are being conducted through February 20, 2008. The slate of candidates is:

Board Director (Vote for Two)

- Patricia Crist
- Melanie Ellexson
- Paula Kramer
- Michael J. Steinhauer
- Wendy Welch-Gillen

OTA Alternate Representative to the Representative Assembly (RA)

- Robert Imel
- Michele Luther-Krug

World Federation of Occupational Therapists (WFOT) Delegate

- Anne Dickerson
- Mary Evert

WFOT 2nd Alternate Delegate

- Linda Kelly
- Signian McGeary

Assembly of Student Delegates Steering Committee

Each year, AOTA student members have the opportunity to cast a vote for the persons they think should hold the offices of Chairperson, OT Vice-Chairperson, OTA Vice-Chairperson, Secretary, and Communications & Advocacy Chairperson of the Assembly of Student Delegates (ASD) Steering Committee. The Student Representatives to the Commission on Education (COE) and the Representative Assembly of ASD are positions that serve a 2-year term.

Only student members of AOTA are eligible to vote in ASD elections. The election is currently underway on AOTA's Web site. To vote online, follow the instructions for voting in the AOTA General Election, below.

2008 Election Candidates

Chairperson
- Tracy Camacho
- Meghan Doherty
- Kara Speidel
- Yutangali Sud

Communications & Advocacy Chairperson
- Sarah Callura
- Shannon Lindsay
- Summer Shepstone
- Michelle Swalboski
- Gretchen Ward
- Brooke Ward

OTA Vice-Chairperson
- AnnaLiza Lewerk

OT Vice-Chairperson
- Karen Dobyns
- Amanda Juarbe
- Erin Hanna
- Jennifer Herold
- Michelle Lee
- Logan Stickney
- Ashley Taylor

Secretary
- Amy L. King
- Heidi Krausz
- Michelle Simon
- Danica Steinle

Student Representative to the Commission on Education (COE)
- Diana Ray
- Abbey Sipp

Student Representative to the Representative Assembly (RA)
- Christina Fraizer
- Jennifer Gardner
- Catherine Hoyt
- Rachel Rama
- Ashley Dunn Thompson

Learn about the candidates by going to the AOTA Web site at www.aota.org. Click on Leadership & Governance to read their biographies and position statements. To contact a candidate directly with questions, just click on his or her e-mail address. The biographies and position statements are also available on the ballot itself. You can print out a sample ballot and mark your candidate choices before officially voting online.

To access the ballot, go to the AOTA Web site home page and click on **AOTA Elections—Vote Here!** Because the ballot is contained in a Members-only area, you will be asked for your member login name and password. After these are entered, you will be transferred to an introduction page in the voting system. Those of you visiting the AOTA Web site for the first time will need to click on Create a Login Name and Password in the Member Login section to get started.

After you are in the site, just follow the directions. To help you with your voting decisions, the biographies, position statements, and pictures can be accessed by clicking on the icon next to each candidate's name on the ballot. After you have made up your mind, click on the box next to the candidate's name in the ballot section. The voting is completely confidential and secure, and you will be asked to verify your choices before your vote is cast. Because the online ballot ties into AOTA's database, no signature or member number is required and you can use any computer with Internet access. One nice feature is that you are allowed to enter the system as many times as you would like to review candidate information before you cast your vote. However, after you have cast your vote, you will not be able to log back into the system and change your vote in any way.

You will receive a voter confirmation receipt that can be printed out in case you have a question later. For voting issues or problems, do not hesitate to call 800-729-2682, extension 2025, or e-mail nomcom@aota.org. Please include your member name and number, a brief description of the problem, and your contact information. The voting site opened at 12:01 a.m. EST on **January 14, 2008,** and will close at **midnight EST** on **February 20, 2008**.

Thank you very much for exercising your right to vote in this very important election, and for your membership in AOTA!

Paper Ballots

If you prefer a paper ballot, call 800-729-2682, extension 2025, and we will be happy to mail the ballot to you. After you have voted, send the paper ballot to AOTA 2008 General Elections, PO Box 65284, Washington, DC 20035-5284. All ballots must be **received** on or before **February 20, 2008**, to be counted. Ballots received after this date will not be counted. Also, remember to cast your vote either online or through the paper ballot method, but not both.

NOTE: Paper ballots are **not** available for the Assembly of Student Delegates (ASD) Steering Committee election (above).

CALENDAR

To advertise your upcoming event, contact the OT Practice advertising department at ***800-877-1383, 301-652-6611****, or* ***otpracads@aota.org****. Listings are $95 each for 1–10 lines, $150 for 11–15 lines, per event. Multiple listings may be eligible for discount. Please call for details. Listings in the Calendar section do not signify AOTA endorsement of content, unless otherwise specified.*

Look for the AOTA CE logo on continuing education promotional materials. The AOTA CE logo indicates the organization has met the AOTA APP requirements and offers continuing education that meets quality standards..

AOTA Events

AOTA continuing education courses are preapproved or recognized by many state occupational therapy licensure boards or regulatory bodies. For specific information on your state requirements refer to your state regulations or contact your state regulatory body. For details about AOTA courses, visit www.aota.org. To order AOTA courses, call 877-404-AOTA or shop online at www.aota.org (Books & Products). Group discounts are available on all SPCCs, online courses, and AudioInsight™ Seminars—call for details.

Long Beach, CA **Apr. 10–13**

AOTA's 88th Annual Conference & Expo. *Imagine the Possibilities.* Pre-Conference Institutes and Seminars on Thursday, April 9. 500 timely, relevant sessions in 25 primary topic areas; hundreds of exhibitors at the Expo; non-stop networking! Plan to register **by February 13** to save with the Early Registration discount. Mark your calendar now and visit www.aota.org/conference for details.

AOTA AudioInsight™ Seminar **Feb. 6**

Occupational Therapy and Transition Services. Live Audio Conference, 12:00 p.m.–1:00 p.m. ET presented by Kristin S. Conaboy, OTR/L, Susan M. Nochajski, PhD, OTR/L, Sandra Schefkind, MS, OTR/L, Judith Schoonover, MEd, OTR/L, ATP. Occupational therapy practitioners have specialized knowledge and skills that can promote academic success and social participation as students transition through the educational system and prepare for meaningful employment, higher education, and the acquisition of critical life skills. This 1-hour AudioInsight™ Seminar will present an overview of the importance of addressing transition needs as part of a student's IEP and the key role of the occupational therapy practitioner as a potential collaborative member of the transition team. The Dr. Seuss book *Oh, the Places You'll Go!* provides a simple but effective tool that underscores building on a student's strengths and goals when developing a transition plan in order to support student success. Earn .1 AOTA CEU (1 NBCOT PDU/1 contact hour). Order #P2081-CR. $30 AOTA Members, $42.50 Nonmembers. For complete details or to register for the Live Audio Conference **(by February 4)** or Web-Based Extended Replay: www.aota.org/aiseminars or 877-404-AOTA.

AOTA AudioInsight™ Seminar **Until Jan. 31**

Alzheimer's, Dementia, and Driving: The Transition From Driver to Passenger. Web-Based Extended Replay—access the Audio Conference as often as you wish on your computer **through January 31.** Presented by Maureen Mohyde and Lisa A. D'Ambrosio, PhD. Earn .15 AOTA CEUs (1.5 NBCOT PDUs/1.5 contact hours). This seminar focuses on the issues and difficulties that caregivers of those with Alzheimer's and other dementias face with issues of driving. The changes that occur in the brain due to Alzheimer's and how these changes affect driving behaviors are reviewed. The faculty discuss strategies for how caregivers can determine when driving is problem and how they can seek additional resources and build support for themselves as they address issues around driving. They then describe strategies for planning meaningful conversations and what caregivers can do if all other strategies fail. This seminar draws on the educational materials developed by The Hartford, *At the Crossroads: The Support Group Kit on Alzheimer's Disease, Dementia, and Driving.* Order #PW11071-CR. $45 AOTA Members, $64 Nonmembers. Save 10% with group registration; call 877-404-AOTA. Complete details at www.aota.org.

AOTA AudioInsight™ Seminar **Until Feb. 29**

Autism: Evidence for the AOTA Practice Guidelines. Web-Based Extended Replay—access the Audio Conference as often as you wish on your computer **through February 29.** Presented by Jane Case-Smith, EdD, OTR/L, FAOTA, BCP. Earn .15 AOTA CEUs (1.5 NBCOT PDUs/1.5 contact hours). This course will briefly identify the primary issues in children with autism spectrum disorder (ASD) that limit their daily occupations and participation in school, home, and the community settings. Based on an extensive review of the research literature, the evidence-based interventions provided by occupational therapy practitioners for children with ASD will be identified and described. The interventions and their effects will be explained using the following categories: (1) sensory integration or sensory based; (2) relationship based, interactive; (3) developmental, skill based; (4) parent focused or parent mediated; and (5) behavioral. The research evidence and interpretation of the findings will be discussed. Intervention methods and strategies that have been found to be effective across studies will be identified and interpreted for occupational therapy practitioners. Implications of these studies for practice with children with ASD will be summarized. Order #PW12071-CR. $45 AOTA Members, $64 Nonmembers. Save 10% with group registration; call 877-404-AOTA. Complete details at www.aota.org.

Ongoing

Internet/Home Study **Ongoing**

Become an Accessibility Consultant. Incorporate home safety, environmental modifications, assistive technology, and ADA consulting in your present career, or begin a private practice. Extensive manual included. Instructor: Shoshana Shamberg, OTR/L, MS. Cost: 2-Day $350–$400; COMBO+Internet $625–$675; Internet-Home Study $300–$400. **Next 2-Day: New Orleans, LA, Feb. 24–25 and Baltimore, MD, Apr. 6–7, 2008.** Earn CEUs OT/OTA/PT/PTA; college credits; AOTA Approved Provider. Member NBCOT PP Registry. Contact Abilities OT Services, 410-358-7269. Brochure/free info: www.aotss.com; e-mail: info@aotss.com

AOTA CE on CD™ **Ongoing**

The New IDEA Regulations: What Do They Mean to Your School-Based and EI Practice? With the 2004 reauthorization of IDEA and the new Part B regulations, released in August 2006, occupational therapy practitioners in school-based and early intervention practice need to understand what they mean, how they impact your work, and what new opportunities may result. The information contained on this CD is from the special edition AudioInsight™ Seminar originally presented on October 18, 2006. An excellent opportunity to update your knowledge on IDEA. Earn .2 AOTA CEUs (2 NBCOT PDUs/2 contact hours). Order #4825-CR, $68 AOTA Members, $97 Nonmembers.

AOTA CE on CD™ **Ongoing**

Response to Intervention: A Role for Occupational Therapy Practitioners. Response to Intervention (RtI) is a process for educational decision-making promoted by the U.S. Department of Education. High-quality instruction and interventions are matched to the student's needs, and progress is monitored frequently. Occupational therapy practitioners need to understand how federal statute and data-based decision-making have changed how we address the needs of students. This CE on CD™ will address the evolving role of occupational therapists and occupational therapy assistants who work with students in grades K–12. The information contained on this CD is from the AudioInsight™ Seminar originally presented on March 7, 2007. Earn .2 AOTA CEUs (2 NBCOT PDUs/2 contact hours). Order #4826-CR, $68 AOTA Members, $97 Nonmembers.

AOTA CE on CD™ **Ongoing**

Everyday Ethics: Core Knowledge for Occupational Therapy Practitioners and Educators. Developed by the AOTA Ethics Commission, the CD will help practitioners and educators identify and analyze ethical dilemmas, provide a framework for making ethical decisions, identify the different agencies involved in regulating the profession of occupational therapy and their roles, and identify a process for filing and handling complaints related to ethical violations. The AOTA Press publication *Reference Guide to the Occupational Therapy Code of Ethics, 2006 Edition* is a required text for successfully completing this course. Earn .3 AOTA CEUs (3 NBCOT PDUs/3 contact hours). Order #4827-CR, $73 AOTA Members, $103.50 Nonmembers.

AOTA Conference Session Webcast **Ongoing**

Do Trees Really Talk? Using Sensory Experiences in the Early Education Classroom. Perfect for occupational therapy practitioners who strive to create a positive early education classroom environment that facilitates successful learning. Learn strategies for recognizing teacher responsibility and consulting with school personnel for optimum understanding and cooperation, and broaden the scope of sensorimotor experiences in the early education classroom setting. The information contained on this Webcast is from AOTA's 87th Annual Conference in St. Louis. Earn .15 AOTA CEUs (1.5 NBCOT PDUs/1.5 contact hours). Order #CSC310-CR, $45 AOTA Members, $64 Nonmembers.

AOTA Conference Session Webcast **Ongoing**

Ergonomics in the Classroom: An Overview of Ergonomics for School-Aged Children. Ideal for occupational therapy professionals looking for research-based principles and strategies that reduce musculoskeletal strain and enhance occupational performance in classrooms. The information contained on this Webcast is from AOTA's 87th Annual Conference in St. Louis. Earn .25 AOTA CEUs (2.5 NBCOT PDUs/2.5 contact hours). Order #CWS208-CR, $66 AOTA Members, $94 Nonmembers.

AOTA Conference Session Webcast **Ongoing**

Improvised Splinting: Enabling Patients in Instrumental Activities of Daily Living and Leisure Activities with Creative Fabrication. Learn key strategies and concepts for creative hand therapy splinting with a focus on purposeful activities and occupations. Find out why the initial interview is important in discerning the appropriate occupation-based treatment, and identify reasons why the biomechanical frame of reference has such a grip on hand therapy. The information contained on this Webcast is from AOTA's 87th Annual Conference in St. Louis. Earn .15 AOTA CEUs (1.5 NBCOT PDUs/1.5 contact hours). Order #CSC226-CR, $45 AOTA Members, $64 Nonmembers.

AOTA Conference Session Webcast **Ongoing**

Innovative Approaches in the Upper-Extremity Rehabilitation After Stroke. Perfect for occupational therapy professionals looking for innovative and emerging technologies to use in treating those with a neurological impairment caused by stroke. Get new ideas and the related research evidence to support treatment. The information contained on this Webcast is from AOTA's 87th Annual Conference in St. Louis. Earn .3 AOTA CEUs (3 NBCOT PDUs/3 contact hours). Order #CWS105-CR, $79 AOTA Members, $112 Nonmembers.

CALENDAR

AOTA Conference Session Webcast **Ongoing**

Integrating Evidence From Neuroscience and Family Systems To Foster Childhood Occupations. Learn more about how the current research on brain development and function applies to pediatric occupational therapy practice. Presented through case-based discussions on ethical reasoning and common dilemmas faced by pediatric occupational therapy practitioners, this Webcast identifies and explains the key components of family-systems theory and how the parent–child roles support growth in both child and parent. The information contained on this Webcast is from AOTA's 87th Annual Conference in St. Louis. Earn .2 AOTA CEUs (2 NBCOT PDUs/2 contact hours). Order #CWS304-CR, $53 AOTA Members, $76 Nonmembers.

AOTA Conference Session Webcast **Ongoing**

Non-Driver Rehabilitation Specialists: Community Mobility Across the Life Span. Ideal for occupational therapy professionals looking for more information and resources that span across practice areas. Emphasizes the role occupational therapy plays in community mobility, and offers a variety of resources in your state, including reporting laws for medical personnel, state driving requirements, wheelchairs and accessible vehicles for clients in acute and rehabilitation settings, and much more. The information contained on this Webcast is from AOTA's 87th Annual Conference in St. Louis. Earn .15 AOTA CEUs (1.5 NBCOT PDUs/1.5 contact hours). Order #CSC244-CR, $45 AOTA Members, $64 Nonmembers.

AOTA Conference Session Webcast **Ongoing**

Occupational Therapy In-Home Assessment Program: Meeting the Needs of Older Adults. This occupation-based presentation discusses the evidence, cost–benefits, and outcomes in developing an in-home assessment program using traditional reimbursement sources for community-dwelling seniors who are aging in place. The information contained on this Webcast is from AOTA's 87th Annual Conference in St. Louis. Earn .15 AOTA CEUs (1.5 NBCOT PDUs/1.5 contact hours). Order #CSC128-CR, $45 AOTA Members, $64 Nonmembers.

AOTA Online Course **Ongoing**

Fundamentals of Occupational Therapy for Individuals with Dementia. Learn to evaluate occupational performance and establish goals to reduce disability, simplify objects and tasks, and communicate effectively. Assessment tools and intervention protocols are provided. Videos and slides enhance learning. Earn 1 AOTA CEU (10 NBCOT PDUs/10 contact hours). Order #OLD07-CR, $198 AOTA Members, $280 Nonmembers.

AOTA Online Course **Ongoing**

Advanced Occupational Therapy for Individuals with Dementia. Learn how to develop and monitor interventions that address common but complex problems, such as wandering, agitation, driving difficulties, and resistance to self-care. Assessments and intervention protocols for standardized approaches are provided; strategies for reimbursement are discussed. Earn 1 AOTA CEU (10 NBCOT PDUs/10 contact hours). Order #OLD06-CR, $198 AOTA Members, $280 Nonmembers.

AOTA Online Course **Ongoing**

Occupational Therapy for Family, Professional, and Paraprofessional Caregivers of Individuals With Dementia. Learn how to help family and paid caregivers manage dementia-related symptoms on a daily basis. A library of caregiver assessments is provided, as are research-tested intervention protocols. Earn 1 AOTA CEU (10 NBCOT PDUs/10 contact hours). Order #OLD05-CR, $198 AOTA Members, $280 Nonmembers.

AOTA Online Course **Ongoing**

Using the Fieldwork Performance Evaluation Forms: An Interactive Approach. Five lessons address how to use the Fieldwork Performance Evaluation Forms for OT and OTA fieldwork students. Learn how to identify and write site-specific objectives, rate and score student performance, and much more. The AOTA Press publication, *Using the Fieldwork Performance Evaluation Forms: The Complete Guide,* is necessary for taking the course. Earn .6 AOTA CEUs (6 NBCOT PDUs/6 contact hours). Course only: Order #OL23-CR, $135 AOTA Members, $195 Nonmembers. Course and text: Order #OL23K-CR, $143.10 AOTA Members, $206.10 Nonmembers.

AOTA Online Course **Ongoing**

Understanding and Applying the Occupational Therapy Practice Framework: Domain and Process. Applies user-friendly interactive technology to orient you to the concepts and language presented in the Framework. Learn to differentiate the various aspects included in the occupational therapy domain; recognize the actions taken in each step of the occupational therapy process; identify how the *Framework* can be applied during the OT process; and more. Case studies provide opportunities to apply these concepts to common practice situations. The text, *Occupational Therapy Practice Framework: Domain and Process,* is required for taking this course. Earn .5 AOTA CEUs (5 NBCOT PDUs/5 contact hours). Course only: Order #OL29-CR, $90 AOTA Members, $128 Nonmembers. Course and text: Order #OL29K-CR, $101.15 AOTA Members, $144.50 Nonmembers.

AOTA Online Course **Ongoing**

Occupational Therapy in School-Based Practice: Contemporary Issues and Trends. Gain an understanding of and suggestions for service delivery and intervention strategies in school-based settings based on IDEA, the No Child Left Behind initiative, the philosophy of education, and the *Occupational Therapy Practice Framework.* **The content of the Core Session has been updated to reflect these changes in the 2004 IDEA amendments.** Core session: Service Delivery in School-Based Practice: Occupational Therapy Domain and Process. Earn:

CALENDAR

1 AOTA CEU (10 NBCOT PDUs/10 contact hours). Order #OLSBC-CR, $225 AOTA Members, $320 Nonmembers. Elective sessions: After completing the Core session, choose supplemental sessions to further enhance your knowledge for specific school-based populations, types of settings, and service delivery issues. Each provides .1 AOTA CEU (1 NBCOT PDU/1 contact hour), $22.50 AOTA Members, $32 Nonmembers.

AOTA Online Course **Ongoing**

Low Vision in Older Adults: Foundations for Rehabilitation. This course is an overview of low-vision causes, effects, and interventions, with emphasis on optical considerations and strategies for environmental adaptation. Examines the clinical deficits associated with low vision, and addresses the rehabilitation process. Includes a review of the eye, an overview of the types of optical prescriptions, and the use of specific intervention approaches. Case study format enhances clinical reasoning skills. *From AOTA and SightCare, a program of The Jewish Guild for the Blind.* Earn .8 AOTA CEUs (8 NBCOT PDUs/8 contact hours). Order #OL28-CR, $158 AOTA Members, $225 Nonmembers.

AOTA Online Course **Ongoing**

Driving and Community Mobility for Older Adults: Occupational Therapy Roles. Provides an understanding of the key issues related to community mobility, including driving. Helps therapists working with older adults in all settings identify the desired community mobility outcomes of clients and find resources for specialized driving rehabilitation. Offers professional development guidelines for those who wish to become occupational therapy driver rehabilitation specialists. *Development sponsored by the National Highway Traffic Safety Administration.* Earn .5 AOTA CEUs (5 NBCOT PDUs/5 contact hours). Order #OL25-CR, $112.50 AOTA Members, $160 Nonmembers.

AOTA Self-Paced Clinical Course **Ongoing**

Work: Principles and Practice. Learn at your pace, on your schedule, in your optimum learning environment. This course provides a solid foundation for occupational therapy practitioners to better understand OT's potential in the workplace, both to prevent disability and to engage the person with a disability in work as meaningful occupation. Earn 2.2 CEUs (22 NBCOT PDUs/22 contact hours). Order #3016-CR. **Save Big! Get 50% off regular price.** Sale price: $170 AOTA members, $220 nonmembers.

AOTA Self-Paced Clinical Course **Ongoing**

Occupational Therapy: Making a Difference in School System Practice. Covers how to use assessments, plan interventions, monitor progress, and evaluate outcomes in the educational environment, and provides comprehensive coverage of most school-based problems. Teaches how to address functional and educational outcomes; tailor interventions for the educational environment; and improve relationships with administrators, teachers, and parents. Earn 3.3 AOTA CEUs (33 NBCOT PDUs/33 contact hours). Order #3013-CR, $363 AOTA Members, $463 Nonmembers.

AOTA Self-Paced Clinical Course **Ongoing**

The Hand: An Interactive Study for Therapists. Combines written coursework with interactive, computer-based learning to present the anatomical basis and clinical presentation of problems in the hand and forearm. Using the CD-ROM *The Interactive Hand: Therapy Edition,* explore the multiple layers of complex anatomy while learning about palpation, examination, and common disorders. An excellent preparation tool for the Hand Therapy Certification Exam. Earn 1.6 CEUs (16 NBCOT PDUs/16 contact hours). Order #3017-CR, $260 AOTA members, $360 nonmembers.

AOTA Self-Paced Clinical Course **Ongoing**

Neurorehabilitation Self-Paced Clinical Course Series. This Series includes 4 components—a prerequisite Core SPCC and 3 Diagnosis-Specific SPCCs. Complete the Core SPCC and opt for any or all of the Diagnosis-Specific courses. Each of the Diagnosis-Specific SPCCs is based on a case study model supported by key concepts presented in the Core. Core SPCC: Core Concepts in Neurorehabilitation: Earn .7 AOTA CEUs (7 NBCOT PDUs/7 contact hours) Order #3019-CR, $130 AOTA Members, $184 Nonmembers. Diagnosis-Specific SPCCs: Neurorehabilitation for Dementia-Related Diseases (Order #3022-CR), Neurorehabilitation for Stroke (Order #3021-CR), and Neurorehabilitation for Traumatic Brain Injury (Order #3020-CR). Each: 1.0 AOTA CEU (10 NBCOT PDUs/10 contact hours), $185 AOTA Members, $263 Nonmembers. Call or shop online to purchase the Core plus 1 or more Diagnosis-Specific SPCCs together for significant savings!

AOTA Self-Paced Clinical Course **Ongoing**

Dysphagia Care for Adults. Advance your evaluation and intervention skills in dysphagia care for adult clients in settings such as acute-care hospitals, home health, rehabilitation settings, long-term-care facilities, school settings, nursing homes, residential settings, and outpatient-care environments. Topics include physiology and manifestations of abnormal swallowing; clinical evaluations of swallowing; identifying commonly used instrumental evaluation procedures and when to recommend them; interpreting dysphagia evaluation results and providing appropriate treatment; and more. Earn 1.4 AOTA CEUs (14 NBCOT PDUs/14 contact hours). Order #3018-CR, $259 AOTA Members, $374 Nonmembers.

February

Cocoa Beach, FL **Feb. 4–16**

Lymphedema Management. Certification courses in Complete Decongestive Therapy (135 hours), Lymphedema Management Seminars (31 hours). Coursework includes anatomy, physiology, and pathology of the lymphatic system, basic and advanced techniques of MLD, and bandaging for primary/secondary UE and LE lymphedema (incl. pediatric care) and other conditions. Insurance and billing issues, certification for compression-garment fitting included. Certification course meets LANA requirements. **Also in Ft. Lauderdale, FL and Houston, TX, Mar. 3–15.** AOTA Approved Provider. For more information and additional class dates/locations or to order a free brochure, please call 800-863-5935 or log on to www.acols.com

AOTA AudioInsight™ Seminar **Feb. 6**

Occupational Therapy and Transition Services. Live Audio Conference, 12:00 p.m.–1:00 p.m. ET presented by Kristin S. Conaboy, OTR/L, Susan M. Nochajski, PhD, OTR/L, Sandra Schefkind, MS, OTR/L, Judith Schoonover, MEd, OTR/L, ATP. Occupational therapy practitioners have specialized knowledge and skills that can promote academic success and social participation as students transition through the educational system and prepare for meaningful employment, higher education, and the acquisition of critical life skills. This 1-hour AudioInsight™ Seminar will present an overview of the importance of addressing transition needs as part of a student's IEP and the key role of the occupational therapy practitioner as a potential collaborative member of the transition team. The Dr. Seuss book *Oh, the Places You'll Go!* provides a simple but effective tool that underscores building on a student's strengths and goals when developing a transition plan in order to support student success. Earn .1 AOTA CEU (1 NBCOT PDU/1 contact hour). Order #P2081-CR. $30 AOTA Members, $42.50 Nonmembers. For complete details or to register for the Live Audio Conference **(by February 4)** or Web-Based Extended Replay: www.aota.org/aiseminars or 877-404-AOTA.

Ogden, UT **Feb. 7–9**

The Listening Program® (TLP) Provider Training. Become a TLP Provider, train the auditory-vestibular system, and improve treatment outcomes. This course presents what you need to begin offering The Listening Program® method of Music-Based Auditory Stimulation™. Receive comprehensive training and learn about the New iListen™ iPod system and portable bone conduction technology. Earn 12–23 contact hours. **Also in St. Louis, MO, Feb. 22–23; and Phoenix, AZ, March 7–8.** AOTA Approved Provider. Contact ABT–Advanced Brain Technologies, 1-888-228-1798. To register, for more information, or for 2008 schedule, visit www.thelisteningprogram.com.

Long Beach, CA **Feb. 16–17**

R2K: Research 2008. Sensory Integration, Emotions, and Autism. Pediatric Therapy Network is proud to present its ninth annual research symposium, designed to support evidence-based practice. This year's conference is devoted to the presentation of outstanding research in the areas of neural substrates of autism, emotion, and sensory integration. The program will include applications of neuroscience research to intervention, particularly addressing social and emotional skill development. Earn 12 contact hours/1.2 CEUs through AOTA. Contact Allison Young at Pediatric Therapy Network, 310-328-0276, x202; allisony@ptnmail.org for more information, visit www.pediatrictherapynetwork.org.

Long Beach, CA **Feb. 18**

SticKids Workshop from Canada. Software to easily create visuals for sensory diets, functional events, classroom wellness, child participation, and playful therapeutic activities; for toddlers to teens. SticKids supports SI, SPD, and cognitive motor learning frameworks. Learn tricks and tips to create and customize trackers and activity cards. Product discounts with workshop. Earn 3 contact hrs. Also in Oakland, CA, Feb. 19. For fax registration form & Web registration go to www.stickids.com. Ph/fax 403-932-6517.

Atlanta, GA **Feb. 23–24**

Eval and TX of Visual Perceptual Dysfunction in Adult Brain Injury Part I. Evaluation, treatment, and documentation of visual perceptual deficits after CVA and TBI is addressed using a practical, functional, and reimbursable approach. Topics include hemianopsia, visual neglect, oculomotor impairment, and complex visual processing. **Also in Grand Rapids, MI, April 26–27, and Hartford, CT, Oct. 18–19.** Faculty: Mary Warren MS, OTR/L, SCLV, FAOTA. Contact visABILITIES at www.visabilities.com or 888-752-4364; fax 205-823-6657.

Houston, TX **Feb. 29**

Seminar on Balance. Exploring Opportunities in Balance. A dynamic seminar for clinicians interested in developing or expanding a balance program—and doing it right! Contact: www.ncmseminars.com (866) 890-0631

March

Vancouver, BC, Canada **Mar. 5–8**

24th International Seating Symposium: This international symposium addresses current and future developments in the areas of seating, positioning, and mobility. Over 50 companies will exhibit seating and mobility devices and related services onsite. At the Westin Bayshore. Phone: 604-822-0054; toll-free 1-877-328-7744. For a full brochure, visit www.interprofessional.ubc.ca or e-mail ipconf@interchange.ubc.ca

AOTA AudioInsight™ Seminar **Mar. 5**

News! Updates! Hot Topics! 12:00 p.m.–1:30 p.m. ET. The next hot topic will be announced soon. Mark your calendar and visit www.aota.org/aiseminars for more information. Earn .2 AOTA CEUs (2 NBCOT PDUs/2 contact hours).

CALENDAR

New Orleans, LA — **Mar. 8–9**

Low Vision Rehabilitation: Treatment of the Older Person with Vision Loss. Practical workshop teaches functional evaluation and treatment approach for adults with vision loss from macular degeneration, diabetic retinopathy and glaucoma. Documentation for insurance reimbursement included. Appropriate for all OT/COTAs working with older adults. **Also in Vancouver, BC, May 10–11, and Winchester, VA, Sept. 22–23.** Faculty: Mary Warren MS, OTR/L, SCLV, FAOTA. Contact visABILITIES at 888-752-4364; fax 205-823-6657 or www.visabilities.com

Philadelphia, PA — **Mar. 15–18**

Surgery and Rehabilitation of the Hand: With Emphasis on the Elbow. Sponsored by the Philadelphia Hand Rehabilitation Foundation and endorsed by the American Society for Surgery of the Hand. Hands-on workshops, panel discussions, surgical demonstrations and anatomy labs will compliment the didactic sessions. Pre-conference 3-day tutorial and 1-day research seminar available. Honored Senior Professors: Anne Callahan, MS, OTR/L, CHT; Karen M. Pettengill, MS, OTR/L, CHT; James R. Andrews, MD; Michael R. Hausman, MD; David Stanley, MB, BSc, FRCS (orth); Scott P. Steinmann, MD. Contact Terri Skirven, OTR/L, CHT, at 215.925.4579 or hrf@handfoundation.org. Visit our Web site at www.handrehabfoundation.org

Las Vegas, NV — **Mar. 17–18**

Pediatric Feeding Assessment & Treatment. This intermediate level conference will address a variety of topics concerning feeding and swallowing for children infancy through school age with a range of feeding challenges. The course will be presented from an interdisciplinary team perspective. Speakers include, Dr. Diane Cullinane/Developmental Pediatrician, Karla Ausderau, MA, OTR/L, SWC and Patricia Novak, MPH, RD, CLE from Pasadena Child Development Associates. CEUs available for OTRs, RDs, SLPs (CASHA). AOTA Approved Provider. Contact: Barb (626) 793-7350 ex: 219; barb@pasadenachilddevelopment.org for more information.

April

Orlando, FL — **Apr. 2–5**

Brain Injuries CE Conference. Attend this multidisciplinary conference for a clinically-based tune-up on how to better treat persons who have been affected by this life-altering event! Key topics include: Emotional and Behavioral Sequelae to TBI, Evidence-Based Use of Functional Electrical Stimulation, Brain Injury Competencies for TBI Staff, Management of the Agitated TBI Patient, Community Reintegration, Blast Injuries, and Psychopharmacotherapy for Individuals with Brain Injury. Four Preconferences you won't want to miss! Contact Contemporary Forums at 800-377-7707 or visit us online at www.contemporaryforums.com.

Montreal, Quebec, Canada — **Apr. 9–12**

Association of Children's Prosthetic–Orthotic Clinics, 2008 Annual Meeting. Hosted by Center de Readaptation Marie Infant Hospital. CME and ABC accredited. **Highlights**: Scientific papers and posters, creative solutions, challenging cases, symposia, workshops. Preliminary program and registration at www.acpoc.org. Contact Melody Raymond at 847-698-1637; e-mail: raymond@aaos.org

Long Beach, CA — **Apr. 10–13**

AOTA's 88th Annual Conference & Expo. *Imagine the Possibilities.* Pre-Conference Institutes and Seminars on Thursday, April 9. 500 timely, relevant sessions in 25 primary topic areas; hundreds of exhibitors at the Expo; non-stop networking! Plan to register **by February 13** to save with the Early Registration discount. Mark your calendar now and visit www.aota.org/conference for details.

EMPLOYMENT OPPORTUNITIES

Faculty

ROCKHURST UNIVERSITY
A Jesuit University

Faculty Position

Rockhurst University announces the search for a full-time, tenure-track faculty position in the Master of Occupational Therapy Program, beginning in August 2008. The appointment combines teaching responsibilities in the areas of pediatrics, research methods, and/or adult physical disabilities with scholarship and service commensurate with academic life. **Qualifications include:** doctoral degree in occupational therapy or a related field (consideration will also be given to candidates who have made substantial progress toward the completion of a doctorate); 2+ years of clinical experience; previous teaching experience; eligibility for licensure in MO or KS. Salary, rank, and benefits will be determined based upon experience and qualifications. Submit a letter of intention, current curriculum vitae, and names and contact information of three professional references to:

Kristina Ursick, OTD, OTR/L
Department of Occupational Therapy Education
Rockhurst University
1100 Rockhurst Road
Kansas City, MO 64110
Email:
kristina.ursick@rockhurst.edu

Review of applicants will begin immediately and will continue until the position is filled. For further information, visit our web site.
http://www.rockhurst.edu/academic/ot/index.asp

Rockhurst University is an Equal Opportunity Employer and encourages applications from women and minorities.

F-2521

Faculty

THE UNIVERSITY OF UTAH

Occupational Therapy
ASSISTANT/ ASSOCIATE PROFESSOR

We are currently seeking additional faculty members to join our occupationally-based team at the University of Utah, a Doctoral Extensive Research Institute. This fully accredited, entry-level master's program has an integrated curriculum design with emphasis on occupation, evidence-based practice, research, rural practice, and the development of strong professional skills. Fieldwork is closely tied to the curriculum. We have established strong partnerships with many of the state's community agencies. The program has quickly gained a national reputation for successfully preparing practitioners to work in traditional, nontraditional, and emerging practice areas. For more information visit our Web site at: www.health.utah.edu/octh

Position: Assistant or Associate Professor, Occupational Therapy. Full-time, tenure track, 9-month position (with summer negotiable).

Qualifications: PhD or EdD, OTR, eligible for Utah licensure.

Responsibilities: Teaching in an innovative, occupation-based curriculum, research, student advisement, and program development.

Areas of Expertise: Pediatric/Adolescent Population, Mental Health Community Practice, Specialty Areas, and/or Assistive Technology

Interested candidates should submit a resume and contact information for three references to:

Louise Dunn, ScD, OTR/L, Search Chair,
520 Wakara Way, Salt Lake City, UT 84108,
Tel: 801-585-9356

The University of Utah is an Equal Opportunity/Affirmative Action Employer

F-2741

Faculty

DOMINICAN UNIVERSITY of CALIFORNIA
1890

Department of Occupational Therapy
Faculty Position ▲ Fall 2008

Seeking dynamic individual for 9.5-month, tenure track appointment in BS/MS Program, with entry-level master's option. We are a small, team-oriented department, providing a well-integrated, occupation-based, culturally diverse and community-focused program. Seeking candidate with experience in physical rehabilitation and/or geriatric practice. Responsibilities include teaching courses, academic advising, mentoring student theses, and university service. Candidates should be occupational therapists with an earned doctoral degree, teaching experience, and a demonstrated potential for scholarly or creative endeavors. Will consider an applicant who has made substantial progress toward a doctoral degree. For more information visit our Web site, www.dominican.edu

Dominican is located 13 miles north of San Francisco's Golden Gate Bridge in beautiful Marin County. As an institution of higher learning, the University seeks to attract an active, culturally and academically diverse faculty and staff of the highest caliber.

Submit a letter of interest and CV to:
Dominican University of California,
Human Resources, 50 Acacia Avenue,
San Rafael, CA 94901-2298
or fax to (415) 257-1395
or e-mail jobs@dominican.edu.

Equal Opportunity Employer

F-2748

AD REGION COLOR KEY

Faculty opportunities in education

Northeast Connecticut, Washington, D.C., Delaware, Maine, Maryland, Massachusetts, New Hampshire, New Jersey, New York, Ohio, Pennsylvania, Rhode Island, Vermont

South Alabama, Arkansas, Florida, Georgia, Kentucky, Louisiana, Mississippi, North Carolina, Oklahoma, S. Carolina, Tennessee, Texas, Virginia, West Virginia

Midwest Illinois, Indiana, Iowa, Kansas, Michigan, Minnesota, Missouri, Nebraska, North Dakota, South Dakota, Wisconsin

West Alaska, Arizona, California, Colorado, Hawaii, Idaho, Montana, Nevada, New Mexico, Oregon, Utah, Washington, Wyoming

National Multiple locations within the U.S.

International All countries outside the United States

South

Occupational Therapist

Comanche County Memorial Hospital, a not-for-profit regional medical provider in Lawton, OK, is seeking 2 full-time Occupational Therapists to join our staff of 4 OTRs and 9 COTAs. New grads are welcome. Scholarships and relocation available.

CCMH is a JCAHO-certified, 283-bed hospital that also has Home Health, a skilled nursing unit, a CARF-accredited inpatient rehab unit, and two outpatient clinics.

We are seeking one OTR to work in an outpatient setting with pediatrics and general outpatients; and one OTR to work in our inpatient settings of hospital, a skilled unit, and a geriatric psychiatric unit, all on one campus.

CCMH is an EEOC employer. Please contact HR at 580-355-8620, ext. 5505, or visit our Web site @ **www.ccmhonline.com**

S-2788

Northeast

OCCUPATIONAL THERAPISTS

Excellent opportunity to work with special needs preschool and EI children at our Manhattan and Bronx locations. Both sites conveniently located next to the subway. Must have at least 1 year of experience and NYS licensure. Competitive compensation and excellent benefits offered. EOE/AA

Send resume to:
Kennedy Child Study Center
Attn: HR Dept.
151 E. 67th Street, New York, NY 10065
Fax: (646) 422-0046
E-mail: jplanchart@kenchild.org

N-2800

Faculty

Creighton University Medical Center School of Pharmacy and Health Professions

Faculty Position in Occupational Therapy Omaha, Nebraska

Creighton University, a Catholic Jesuit institution, invites applications for a 12-month, tenure track faculty position in Occupational Therapy at the rank of Assistant or Associate Professor. Candidates should have an earned doctoral degree and be eligible for licensure in Nebraska. Responsibilities include teaching content related to neuroscience and neurorehabilitation, serving as academic advisor to students, engaging in a research program, and participating in related service. Evidence of prior college teaching is desirable. The position is available immediately and screening of applicants will continue until the position is filled. Submit a letter of application and curriculum vitae, and have three letters of reference sent to:

Kathy Flecky, OTD, OTR/L
Department of Occupational Therapy
Creighton University Medical Center
School of Pharmacy and
Health Professions
2500 California Plaza
Omaha, NE 68178
Phone: (402) 280-1864
Fax: (402) 280-5692
E-mail: kflecky@creighton.edu

Creighton University is an equal opportunity employer.

F-2765

Faculty

Misericordia University Department of Occupational Therapy Three Faculty Positions

Three Positions: The Department of Occupational Therapy is currently accepting applications for two full-time (12 month), tenure-track positions and a visiting professor position (one year) in our newly expanding occupational therapy program.

The Department of Occupational Therapy is a fully accredited program that includes a five-year professional entry-level master's degree program and a weekend college program for COTAs and individuals already possessing a baccalaureate degree in another discipline. We also offer a postprofessional pediatric certificate program. Starting in 2008, the department will begin to offer a postprofessional clinical doctorate in occupational therapy.

Misericordia University is a teaching-centered institution with a commitment to community service. The curriculum has a strong foundation in occupation, and also evidence-based practice and community-based practice. Successful candidates will join an experienced faculty who are doctorally prepared with diverse clinical and educational backgrounds.

OTD Program Director: The OTD curriculum is a 33-credit degree with options for specialization in pediatrics or geriatrics, offered in a hybrid distance-learning format.

Responsibilities include administrative oversight and coordination of all OTD courses, ongoing curriculum development and program evaluation, recruitment of faculty, teaching in areas of expertise, directing graduate research projects, advising students, and participating in related college and community service.

Qualifications for OTD Program Director: Postprofessional doctoral degree in occupational therapy or related field. ABD will be considered. A minimum of five years of clinical experience and a minimum of five years of academic experience is required. Experience with online coursework is preferred. Must have NBCOT certification and be eligible for Pennsylvania licensure.

Starting date for the OTD Program Director Position: Spring or Summer 2008.

Full-Time Faculty Position: Responsibilities include teaching in areas of expertise in undergraduate and graduate programs, supervising graduate research projects, advising students, and participating in related college and community service. Will consider candidates with varying clinical and academic backgrounds.

Qualifications for Full-Time Faculty Position: Postprofessional doctoral degree in occupational therapy or related field. ABD will be considered. A minimum of five years of clinical experience and previous teaching experience is desirable. Must have NBCOT certification and be eligible for Pennsylvania licensure.

Starting date for full-time position: August 15, 2008.

Visiting Professor Position: Responsibilities include teaching in areas of expertise in undergraduate and graduate programs. Will consider candidates with varying clinical and academic backgrounds.

Qualifications for Visiting Professor Position: Occupational therapist with master's degree in OT or related area. A minimum of five years of clinical experience and previous teaching experience is desirable. Must have NBCOT certification.

Starting date for full-time position: August 15, 2008.

Salary is commensurate with education and experience.

Misericordia University is committed to excellence and actively supports cultural diversity. To promote this endeavor, we invite individuals who contribute to such diversity to apply, including minorities.

Misericordia University, an 83-year-old institution sponsored by the Sisters of Mercy of Dallas, offering baccalaureate and master's degrees, is located adjacent to the Pocono Mountains region of Northeastern Pennsylvania, approximately 2–3 hours from New York City, Philadelphia, and Baltimore. The university's approach of combining a quality liberal arts education with professional preparation and service leadership has resulted in its wide regional acclaim.

For confidential consideration, please enclose in your application package, a letter of application, curriculum vitae, and three letters of recommendation to Gwen Bartolacci, OTD, OTR/L, Search Committee Chair, c/o Office of Human Resources, Misericordia University, 301 Lake Street, Dallas, PA 18612, or e-mail: hr@misericordia.edu.

F-2814

EMPLOYMENT OPPORTUNITIES

Faculty

Assistant/Associate/Full Professor
Department of Rehabilitation Sciences
Occupational Therapy Program

The University of Texas at El Paso

The University of Texas at El Paso (UTEP) is seeking a full-time,, tenure-track appointment for its growing, dynamic Master's of Occupational Therapy Program. UTEP is a research doctoral-intensive university located in West Texas, along the scenic Rio Grande river. The occupational therapy program is one of three programs in the Department of Rehabilitation Sciences, including Physical Therapy and Speech-Language Pathology. Located within the college of Health Sciences, the Department of Rehabilitation Sciences joins other programs such as Nursing, Health Promotion, Kinesiology, Pharmacy, and Clinical Laboratory Science.

El Paso is shielded by mountains on three sides and is rewarded with more than 300 days of sunshine annually, making it possible to enjoy outdoor activities year-round. The city of El Paso adjoins both the state of New Mexico and the country of Mexico, making it the nation's leading area for cultural diversity and border health issues.

The UTEP OT program began in 1992 and accepts graduate students on a competitive basis. With comfortable teaching loads, a 12:1 student-faculty ratio, and a strong commitment to faculty research, the College of Health Science at UTEP provides a generous start-up research package and unique opportunities for collaborative research both within the University and throughout its diverse community. The OT faculty is involved in teaching within the MOT program, Interdisciplinary Health Science Ph.D program, and other professional programs through joint appointment.

Qualifications: • An earned doctorate in occupational therapy or related area (ABD will be considered) • Minimum of 5 years of practice with preference in adult rehabilitation • Ability to establish a record in scholarly activity, research, and clinical practice • Ability to demonstrate effective teaching and advising of students • Commitment to service-learning and community outreach opportunities • Eligible for licensure to practice in the State of Texas • Member of the American Occupational Therapy Association

Interested candidates may send their curriculum vitae and names and contact information for three references to: **Karen Funk, OTD, OTR, Chair, Occupational Therapy Search Committee, 1101 N. Campbell Box 410B, El Paso, TX 79902; phone: 915-747-8226; e-mail: kfunk@utep.edu.**

The search committee will begin reviewing applications immediately. The position will remain open until a candidate is identified.

The University of Texas at El Paso is an Equal Employment Opportunity/Affirmative Action Employer. The University of Texas at El Paso does not discriminate on the basis of race, color, national origin, sex, religion, age, disability, veteran status, or sexual orientation in employment or in the provision of services.

F-2778

Faculty

Chicago State University
Department of Occupational Therapy
College of Health Sciences

Chicago State University invites applications for a **9-month tenure-track faculty position** in the Department of Occupational Therapy for the combined Bachelor in Health Sciences and Master in Occupational Therapy program. Academic rank and compensation are commensurate with qualifications and experience.

QUALIFICATIONS: Candidates must be a currently certified occupational therapist licensed or eligible for licensure in Illinois. An earned doctoral degree or doctoral candidacy preferred. A minimum of five years of clinical experience required and teaching experience preferred. Experience in mental health or pediatrics preferred.

Responsibilities will include teaching in area(s) of expertise, student supervision (research and clinical), student advisement, independent scholarship, and participation in university and professional service activities.

APPLICATIONS: Review of applications will begin on February 25, 2008. Apply by January 25, 2008, for initial consideration. Thereafter, every month applications will be reviewed until position is filled. The position will begin in August. A letter of application, curriculum vitae, and three letters of professional reference should be addressed to:

Regina Smith, MS, OTR/L
Chair, OT Search Committee, DH 132
Department of Occupational Therapy
Chicago State University
9501 King Drive, Chicago, IL 60628
Telephone: **(773) 995-2531** • E-mail: **Rsmith31@csu.edu**

Chicago State University is an Equal Opportunity Employer

F-2760

Faculty

Philadelphia University

Philadelphia Inmate Services and Health (PhISH) Program Coordinator

Philadelphia University has an immediate opening for a dynamic occupational therapist to serve as program coordinator of the new, grant-funded *Philadelphia Inmate Services and Health (PhISH) Program*. Responsibilities include the development and implementation of an occupational therapy-based, transitional, correctional healthcare program for female inmates with psychiatric disorders at the Riverside Correctional Facility within the Philadelphia prison system.

The successful candidate will have a minimum of a master's degree, demonstrated leadership, effective interpersonal and communication skills, and professional experience in mental health and community-based practice; preferably with knowledge in prison populations and treatment approaches.

Send letter of application and resume: Catherine V. Piersol, MS, OTR/L, Director of Occupational Therapy, Philadelphia University, School House Lane and Henry Avenue, Philadelphia, PA 19144.

Review of resumes will begin immediately and continue until position is filled. Philadelphia University is an Affirmative Action/Equal Opportunity Employer.

For more information about Philadelphia University, visit www.PhilaU.edu.

F-2790

Faculty

Concordia University Wisconsin
Occupational Therapy Faculty Position—Fall 2008

Applications are invited for a full-time, renewable contract position. Candidates must be registered occupational therapists with a post-professional master's degree in OT or related field (PhD preferred) and eligible for licensure within the state of Wisconsin. Minimum qualifications include five years of clinical experience of which at least two must include teaching in higher education. Teaching responsibilities in graduate-level courses in OT and Rehabilitation Science Programs using both traditional and online formats. Send letter of interest, CV, completed employment application, and names and contact information for 3 references to:

Human Resources, Dept. OT-2
Concordia University Wisconsin
12800 North Lake Shore Drive
Mequon, WI 53097

For more information or to download an employment application, please visit our Web site: http://www.cuw.edu/hr

F-2858

EMPLOYMENT OPPORTUNITIES

Faculty

SETON HALL UNIVERSITY

Occupational Therapy Faculty Position
Department of Occupational Therapy

Seton Hall University, School of Graduate Medical Education, is searching for a faculty member in the Department of Occupational Therapy. This is an open rank, 12-month faculty appointment. Responsibilities include: teaching, research, and service. Candidates must have academic experience, strong interpersonal skills, a record of scholarship, and a record of teaching effectiveness. Preference will be given to applicants with an earned PhD or other terminal degree in Occupational Therapy or a related field who can teach in the areas of aging and/or rehabilitation, disability, and participation. Applicants must be eligible for New Jersey licensure. Applications will be accepted until the position is filled.

The School of Graduate Medical Education offers opportunities for collaborative research, teaching, and grant development across a number of disciplines. The mission of the School is to have a significant national presence in health sciences education. Salary and benefits are extremely competitive and include full tuition remission for spouses and dependents.

To apply, please send a cover letter* indicating the position for which you are applying, a current curriculum vita, representative samples of publications, and the names and contact information of three (3) references that we may contact to:

Office of the Dean
School of Graduate Medical Education
Attn: Faculty Position, Occupational Therapy
Seton Hall University
400 South Orange Avenue
South Orange, NJ 07079

*The cover letter should address one's qualifications for the position and one's philosophy and specific goals for teaching and scholarship. All information will be held in confidence and references will not be contacted without prior notification to the candidate.

Seton Hall University is committed to programs of equal opportunity and affirmative action (EEO/AA) to achieve our objectives of creating and supporting a diverse racial, ethnic, and cultural community. Seton Hall University encourages applications from individuals who represent a broad spectrum of backgrounds and welcomes applications from women and minority groups. Applicants must possess an understanding of, and a willingness to support, Seton Hall University's Catholic mission.

For further information about the position, please contact: Meryl M. Picard, MSW, OTR, Chair, Search Committee, **picardme@shu.edu**.

For further information on Seton Hall University and the Department of Occupational Therapy, visit our Web page at **http://www.shu.edu/academics/gradmeded/ms-occupational-therapy/.**

F-2859

Faculty

Quinnipiac University

DIRECTOR OF ONLINE POST-PROFESSIONAL MASTER'S PROGRAM IN OCCUPATIONAL THERAPY

The Department of Occupational Therapy at Quinnipiac University seeks an experienced faculty member to direct an innovative, professionally oriented, online post-professional graduate program in occupational therapy.

The proposed Post-Professional online MS program in Occupational Therapy will provide two options for students: to earn a master's degree or to earn a certificate of advanced graduate study. Both of these options provide the learner with opportunities to advance knowledge in evidence-based practice and research.

This is a 12-month administrative appointment with a nontenure track faculty appointment. Duties include overall responsibility for the development and delivery of the program, working closely with the Associate Vice President for Online Programs on marketing and recruitment efforts, working as a member of the occupational therapy department on curriculum design, and student advising. The Director will also teach in the program. This position is available July 2008.

Experience teaching in online environments and designing courses for distance learning, strong leadership abilities, and excellent communication skills are essential; previous administrative experience preferred. Candidates should be occupational therapists with an appropriate terminal degree and must hold or be eligible for State of Connecticut licensure as an occupational therapist.

Consideration of candidates will begin January 25, 2008 and continue until position is filled. Send letter of application including a clear statement of your experience in online learning environments, curriculum vitae, and names and contact information for three references to :

Kimberly Hartmann, PhD, OTR/L, FAOTA,
Chair of Occupational Therapy
Quinnipiac University, EC-OCC
275 Mt. Carmel Avenue
Hamden, CT 06518
or Kimberly.Hartmann@quinnipiac.edu

Quinnipiac University has a strong commitment to the principles and practices of diversity throughout the university community and we welcome candidates who would enhance that diversity.

F-2758

Faculty

THE RICHARD STOCKTON COLLEGE OF NEW JERSEY
Occupational Therapy Faculty Position

The Richard Stockton College of New Jersey seeks applications for a tenure-track faculty member in occupational therapy, to be appointed at the level of assistant or associate professor.

Stockton is a progressive college located 12 miles west of Atlantic City, and is surrounded by 1,600 acres of southeastern New Jersey Pinelands. It has received national recognition for its distinctive academic programs and interdisciplinary approach to learning. Stockton's diverse faculty and student body combine a sense of tradition with a spirit of innovation to achieve academic excellence.

Stockton offers other health care degrees including physical therapy, nursing, speech pathology and audiology, public health, and social work. Excellent clinical support is available.

Responsibilities include teaching, participation in program and college service, and involvement in clinically relevant scholarship or research. We are specifically looking for candidates who can teach in the area of research (methods, development, and implementation of student research projects). The successful candidate will also be expected to act as research mentor and preceptor to graduate students.

Qualifications include an earned doctorate degree and an active research program pertaining to health care. Teaching experience is preferred. Experience in successful grant writing a plus. Preferred qualifications include occupational therapists who are eligible for licensure in New Jersey and have at least three to five years of clinical experience. However, persons who are not occupational therapists but otherwise meet the requirements are welcome to apply. Rank and salary will be commensurate with experience.

Screening begins immediately and will continue until the position is filled. Submit letter of application, résumé, and three letters of recommendation to Dr. Marc Lowenstein, Dean of Professional Studies, The Richard Stockton College of New Jersey, AA106, PO Box 195, Pomona, NJ 08240. Visit our Web site: www.stockton.edu. Stockton is an AA/EOE.

F-2776

EMPLOYMENT OPPORTUNITIES

Faculty

Academic Program Director
Occupational Therapy Department
University of Wisconsin-Milwaukee

We are seeking talented individuals to fill the position of Program Director as an Associate or Full Professor in the Department of Occupational Therapy beginning Fall 2008. Candidates must be initially certified in occupational therapy, possess a PhD or research doctorate, have expertise in higher education in occupational therapy, have expertise or potential to generate research funding, and evidence of a commitment to diversity. Finalists will be required to submit a written research plan. Administrative, clinical, and teaching experience will be considered as well as good interpersonal and communication skills.

Responsibilities include leadership in the Occupational Therapy Department, teaching occupational therapy courses, research activities, and advisement of graduate students to support our masters and doctoral programs in the department and college.

The University of Wisconsin-Milwaukee (UWM) is a major research institution located in Milwaukee, Wisconsin, close to the shores of Lake Michigan on a 90-acre campus and has a total enrollment of over 29,000 students. For more information about the university, please visit http://www.uwm.edu. For more information about the College of Health Sciences and the Occupational Therapy Department, please visit http://www.uwm.edu/chs.

The Department of Occupational Therapy has ten full-time faculty positions and three full-time academic staff positions. It offers a BS/MS entry-level occupational therapy degree and a post-professional MS degree. The OT Graduate Program is rated in the top 15 in the United States. The Department of OT also houses the Center for Ergonomics and the Rehabilitation Research Design & Disability Center, both offering services and research opportunities. The Department of Occupational Therapy actively participates in the College of Health Sciences interdisciplinary PhD in Health Sciences. Startup funds for the development or continuation of a research program are available. Web sites for the university and this position are found at www.uwm.edu/chs and www.chsiobs.uwm.edu.

Review of applications will begin January 7, 2008 and will continue until the position is filled. The names of those applicants who have not requested in writing that their identities be withheld and the names of all finalists will be released upon request. This position may require a Criminal Background Check.

The University of Wisconsin-Milwaukee is an affirmative action, equal employment opportunity employer. For the UWM Campus Security Report, go to http://www.cleryact.uwm.edu, or call the Office of Student Life, 118 Mellencamp Hall at (414) 229-4632 for a paper copy.

Applicants should send a letter of application and a vita to:

Carol Haertlein Sells, PhD, OT, FAOTA , Chair, Search and Screen Committee, Department of Occupational Therapy
University of Wisconsin-Milwaukee, P.O. Box 413, Milwaukee, WI 53201-0413
Phone: (414) 229-2611 • E-Mail: chaert@uwm.edu

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Molly Asks

A monthly column in which Associate Editor Molly Strzelecki profiles your peers.

Fred Somers, executive director of the American Occupational Therapy Association (AOTA) and a member of the Centennial Vision Commission, is at the helm of steering the national organization toward its Centennial in 2017. Here, he discusses the role of this group and the six priority initiatives for the Vision.

Q What is the function of the Centennial Vision Commission?

Any time an organization embarks on a long-range, multiyear plan like the Centennial Vision, you want to make sure the process stays on track, and you want to make sure that there is appropriate oversight to help keep it on track. Once the Vision was designed, there was a desire to institutionalize that oversight process by creating the Commission. It was set up via a specific charge from the Representative Assembly (RA), and we basically monitor the progress of the Centennial Vision. We report to the membership, the RA, and the Board of Directors on an annual basis. We also monitor the external climate and make recommendations to the Board for any kinds of corrections that may be needed to make sure we stay true to the goals of the Centennial Vision. The composition of the Commission represents all of the primary stakeholders within the organization, including the chair of the Affiliated State Association Presidents, the chair of the Assembly of Student Delegates, the speaker and vice speaker of the RA, the two chairpersons of the Program Directors Education Councils, and the president of AOTA. It's chaired by the vice president of the Association [currently Dr. Florence Clark]. During our periodic meetings throughout the year, each of the commissioners provides an update as to what their particular group has been doing around the Centennial Vision, and what is planned over the next several months.

What is AOTA doing to promote the Centennial Vision?

The leadership, the volunteers, and staff all are involved in communicating to members and nonmembers—everybody in the occupational therapy community—about the Centennial Vision; what it's all about, and why it's important to the future of the profession. President Penny Moyers, officers, Board members, and staff are holding town hall meetings around the country and giving keynote addresses at state conferences and other events, where we're talking specifically about the Centennial Vision, why it's relevant, and what it means to you as an occupational therapy practitioner.

We've created a variety of resources on the AOTA Web site to help others understand what the Centennial Vision is and why it is relevant to them. That's what promoting and communicating the Vision is all about.

How is AOTA pursuing the Vision?

The Centennial Vision is broad, and it addresses a range of key initiatives to position the profession and our members for a successful future. When we first started this, the Board distilled three or four dozen specific recommendations that emerged from the Centennial Vision process to six initial priorities that are necessary precursors to us pursuing other priorities. In other words, what are the things that have to be accomplished that set the stage for us to pursue other initiatives? These six priority initiatives—many of which are multiyear projects—have been our focus over the past 12 months.

First is to create a model curriculum, which will help us enhance the quality of occupational therapy and occupational therapy assistant education and provide more consistency across programs. It's taking a look at what really needs to be taught to prepare our professionals for 21st century practice.

Second is to strengthen linkages between our research, education, and practice communities, so they can become stronger, more effective, and mutually supportive.

Third is to create a database for outcomes to demonstrate to payers and policymakers that they're getting value for the money they're paying for occupational therapy services, and documenting the difference that our practitioners are making in improving the health and quality of life of their consumers.

Fourth is to enhance public awareness of the profession. Occupational therapy is not as well understood or as well appreciated as it should be, so we're embarking on a long-term national campaign. We want the brand of occupational therapy in the minds of consumers and our different publics, to make sure they understand and ask for it.

Fifth is to expand our advocacy efforts. We need to do even more advocacy to support traditional practice and reimbursement sources, but we also need to help foster new areas of practice that speak to the emerging needs of society.

Sixth is to develop a contemporary research agenda for the profession. This agenda is focused around the questions, How do we build the unique knowledge that is occupational therapy? How do we build our research capacity as a profession? And then how do we link that information to broader agendas?

As part of this goal, the American Occupational Therapy Foundation and AOTA have jointly formed the Research Advisory Panel, chaired by Dr. Joan Rogers, and are committed to taking specific steps to raise our profile and our interaction with federal agencies funding research so that we are more prominently on their radar screens. We're also looking at ways to build our capacity in research and science, create more scientists and researchers, and mentor young scientists, to increase our research capacity, and add to the knowledge base of the profession. ■

AOTA Continuing Education Article
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The Infants and Toddlers With Disabilities Program (Part C of IDEA)

GLORIA FROLEK CLARK, MS, OTR/L, BCP, FAOTA
Heartland Area Education Agency 11
Adel, Iowa

ABSTRACT

The Infants and Toddlers with Disabilities Program (Part C) of the Individuals with Disabilities Education Improvement Act of 2004 (IDEA 2004; Public Law 108-446) is a federal grant program that provides early intervention for children under 3 years of age and their families. All states and U.S. territories currently participate in this program. Occupational therapists and occupational therapy assistants who provide early intervention services under IDEA must adhere to federal and state laws and regulations, requiring that they understand key concepts of the law and regulations. This article highlights the legal requirements for states, service coordinators, and service providers under Part C of IDEA. The occupational therapy role also is discussed, and resources are provided.

Note: The term *occupational therapy practitioner* will be used throughout this article when the information applies to both the *occupational therapist* and the *occupational therapy assistant*. When the role or responsibility applies only to the occupational therapist or occupational therapy assistant, these individual terms will be used.

LEARNING OBJECTIVES

After reading this article, you should be able to:

1. Identify the key components of the IDEA Part C requirements.
2. Recognize the occupational therapy practitioner's role under Part C.
3. Select resources to increase knowledge and awareness about Part C.

INTRODUCTION

Many occupational therapists and occupational therapy assistants work in early intervention programs, providing important services to infants and toddlers and their families. To be effective, these practitioners must understand the myriad federal and state rules and rationale for service delivery. Sometimes agencies set up procedures and allow the practitioners to think that these are the federal or state requirements; therapists who do not understand the "true" requirements may follow what they have been told and not realize that they may be out of compliance with the law. This article walks through some of the legal requirements and offers suggestions and resources that occupational therapy practitioners can use to strengthen their services to infants and toddlers with disabilities and their families, as well as to support the state in providing the IDEA Part C program.

Early intervention services are supported by Part C of IDEA, which is a voluntary program (meaning states can choose whether to participate), unlike preschool and school services that are mandated under Part B (Assistance for Education of All Children With Disabilities) of the law. At the time of this writing, all states, the District of Columbia, and U.S. territories participate in the Part C program. The focus and intent of Part C is much different than Part B. Under Part C, each state has considerable flexibility in meeting the requirements, whereas in Part B each state has similar providers and a similar system. This flexibility may mean that two neighboring states have very different eligibility criteria and services for children. This difference also means that the state department that monitors and carries out the early intervention program (known as the lead agency) may be different in the neighboring states.

Part C is built upon five "urgent and substantial needs" focused on

1. "enhancing development to minimize potential for developmental delay,
2. reducing educational costs to our society,
3. maximizing the potential for individuals with disabilities to live independently in society,
4. enhancing the capacity of families to meet the special needs of their infants and toddlers with disabilities and
5. enhancing the capacity of the state, and local agencies and services providers to identify, evaluate, and meet the needs of all children" [20 U.S.C. §1431(a)].

These needs should serve as foundations for early intervention programs. Part C places emphasis on all children, "particularly minority, low-income, inner city, and rural children, and infants and toddlers in foster care" [20 U.S.C. §1431(a)(5)]. The Keeping Children and Families Safe Act of 2003 (Public Law 108-136) added a provision to the Child Abuse Prevention and Treatment Act of 1974 (Public Law 93-247) that requires states to have procedures for referring infants and toddlers who are involved in substantiated cases of child abuse and neglect to early intervention services (Zero To Three, 2006). This requirement also was included in the 2004 reauthorization of IDEA. When providing services to children and families within the state structures, occupational therapy practitioners must be cognizant of how the

state is working to meet the needs of infants and toddlers with disabilities and their families.

With the 2004 reauthorization of IDEA, some changes were made to Part C. Typically, regulations that explain the law in more detail are written shortly afterward; however, Part B regulations were written first and finalized in 2006 before work on Part C regulations was begun. Part C draft regulations were proposed and sent out for comment in May 2007. (For a side-by-side comparison of proposed and current regulations, go to the Policy & Advocacy page on the Council for Exceptional Children Web site at www.cec.sped.org/Content/NavigationMenu/PolicyAdvocacy/IDEAResources/ideapartc.htm.)

Final regulations are expected in 2008. The American Occupational Therapy Association (AOTA, 2007) has prepared a response to the proposed regulations that supports the focus on families and natural environments (e.g., "home and community settings such as early Head Start, and child care programs" [p. 5]). AOTA does not support allowing one person to represent multiple perspectives in the multidisciplinary evaluation, and notes that qualification standards must align with state practice acts.

Past regulations do not correspond to all the changes in IDEA 2004, but current regulations are not yet in force. At this time, states do not have federal regulations as a resource to use; however, they do have a strong directive from the law about minimal requirements that they must meet, which are discussed in the next section.

STATEWIDE EARLY INTERVENTION REQUIREMENTS

Part C requires states to "maintain and implement a statewide, comprehensive, coordinated, multidisciplinary, interagency system to provide early intervention services for infants and toddlers with disabilities and their families" (20 U.S.C. § 1433). The IDEA lists the following 16 components as a "minimum" that each state must have:

1. Rigorous definition of development delay
2. Early intervention services based on scientifically based research
3. Multidisciplinary evaluation
4. Individualized family service program (IFSP)
5. Comprehensive Child Find system
6. Public awareness program
7. Central directory
8. Comprehensive system of personnel development
9. Personnel qualifications
10. Lead agency
11. Policy pertaining to service providers
12. Timely reimbursement of funds
13. Procedural safeguards
14. Data collection
15. State interagency coordinating council
16. Services provided in natural environments

The National Early Childhood Technical Assistance Center (NECTAC) provides each state's Part C policies on its Web site (www.nectac.org/partc/statepolicies.asp; click on the state desired).

1. Rigorous Definition of Developmental Delay

IDEA 2004 allows each state to determine its definition for developmental delay, requiring that the definition be "rigorous" [20 U.S.C. § 1435(a)(1)]. This definition is important because it determines whether an infant or toddler will be eligible for early intervention in a given state. IDEA defines infant or toddler with a disability as

> (a)…an individual under three years of age who needs early intervention services because the individual
> (1) Is experiencing developmental delays, as measured by appropriate diagnostic instruments and procedures in one or more of the areas of cognitive development, physical development, communication development, social or emotional development and adaptive development; or
> (2) Has a diagnosed physical or mental condition that has a high probability of resulting in developmental delay [20 U.S.C. § 1432(5)(a)]

States also can choose to include at-risk (environmental and biological risk) infants and toddlers in their definition, but not many have done so. Another new requirement in IDEA would allow states to continue to provide Part C services, under certain conditions, for children until they enter a kindergarten or an elementary school program; no state had implemented this provision at the time this article was written.

A review of state eligibility definitions indicated that most states have established quantitative criteria for delay, such as a percentage of delay (typically 20% or 25% delay, with some states as high as 50%) or as a standard deviation below the mean on a norm-referenced instrument (typically 2.0 or 1.5 standard deviations). Some states use qualitative information, such as informed clinical opinion, to determine eligibility. Because of the unavailability of appropriate instruments or questionable predictive validity for instruments for infants and toddlers, many states have included informed clinical opinion as part of the eligibility determination process. Informed clinical opinion includes qualitative and quantitative information based on professional judgment (Shackelford, 2006). According to Bagnato, Smith-Jones, Matesa, and McKeating-Esterle (2006), "Available evidence suggests that clinical judgments or informed opinion holds promise as a potentially effective strategy for use in early intervention for eligibility determination with the proper use of the identified practice characteristics" (p. 6). Occupational therapy practitioners must know their state's eligibility criteria and the process to determine whether infants and toddlers are eligible for Part C services in their state.

2. Early Intervention Services Based on Scientifically Based Research

IDEA requires that each state have a policy in effect to ensure that appropriate early intervention services based on scientifically based research, to the extent practicable, are available to all infants and toddlers with disabilities and their families. This requirement includes children on Indian reservations, who are homeless, and who are wards of the state.

Occupational therapy practitioners must identify and conduct scientifically based research related to interventions. To assist practitioners in identifying and using evidence-based practices, AOTA and other agencies have developed Internet resources. For example, to find more information about using infant massage in your practice, go to www.researchtopractice.info and check the research review for that intervention. This Web page also contains a one-page summary of the information (see "Bottomlines") that can be copied and shared with parents.

3. Multidisciplinary Evaluation

States must ensure a timely, comprehensive, multidisciplinary evaluation of each infant or toddler with a disability. Previous regulations have defined "timely" as within 45 calendar days from the time of the referral. This timeline could be changed if the May 2007 proposed regulations are approved; rather than start on the date a referral is received, the proposed "start date" would begin when the family (or guardian) signs the consent for evaluation. Until that happens, states are following the 45-day requirement, or they run the risk of being out of compliance with the C7 indicator (explained in Table 1).

The Part C evaluation must focus on the following areas of development: physical (including vision and hearing), cognitive, communication, socioemotional, and adaptive development. According to AOTA (2004), "When evaluating infants or toddlers, the occupational therapist considers their strengths and needs with respect to these areas of development and their ability to participate in the environment at home, school, day care, and community" (p. 683). Occupational therapists must consider the state procedures for determining eligibility and advocate for a process that promotes use of appropriate tools for specific purposes. For example, screening tools are used to determine whether further evaluation is necessary. Diagnostic tools are used to determine whether there is a developmental delay. Curriculum measures are useful in developing an intervention strategy. Outcome assessments are used when measuring progress toward goals.

The state also must ensure that a family-directed assessment was completed (unless the parent declines). This assessment should identify the family's needs to assist in the development of the infant or toddler. Occupational therapists have the knowledge and skills to conduct this assessment and may do so within the scope of practice and procedures of their state.

Table 1. Lead Agencies by State

Department of Education (10)
Iowa, Maine, Maryland, Michigan, Minnesota, Missouri, Oklahoma, Oregon, South Dakota, Tennessee

Department of Health (18)
Arkansas, Delaware, Florida, Hawaii, Idaho, Kansas, Kentucky, Massachusetts, Mississippi, New Jersey, New Mexico, New York, North Carolina, Ohio, South Carolina, Utah, Wisconsin, Wyoming

Department of Human Services (or Resources) (7)
Alaska, Colorado, Georgia, Illinois, Nevada, North Dakota, Rhode Island

Other (or combinations of the previous three) (15)
Alabama, Arizona, California, Connecticut, Indiana, Louisiana, Montana, Nebraska, New Hampshire, Pennsylvania, Texas, Vermont, Virginia, Washington, West Virginia

4. IFSP

States must ensure that an IFSP is written for each eligible infant and toddler with a disability and his or her family. The IFSP must include a statement of the infant's or toddler's present levels of development (e.g., physical, cognitive, communication, socioemotional, adaptive) based on objective criteria; statement of family's resources, priorities, and concerns; statement of measurable results or outcomes for the infant or toddler and the family; statement of specific early intervention services based on peer-reviewed research; statement of natural environments; projected dates for initiation of services and the anticipated length, duration, and frequency of the services; identification of the service coordinator; and the steps to support the transition to preschool or other appropriate services.

Occupational therapy practitioners must be aware of the required contents of the IFSP. Measurable outcomes should be written within a family-centered practice approach. For more information about family-centered practices and examples, go to the Iowa Department of Education Web site (www.state.ia.us/earlyaccess/doc/fcs04.pdf).

5. Comprehensive Child Find System

The Part C Child Find System is consistent with the Part B Child Find System. This system must include a method for making referrals to service providers that includes participation from the primary referral sources and meets the timelines (45 calendar days). The lead agency must develop rigorous standards to appropriately identify infants and tod-

dlers with disabilities. Occupational therapy practitioners support the system by distributing Child Find materials and participating in screenings of infants and toddlers.

6. Public Awareness Program

The lead agency is charged with developing a public awareness program, including preparing and disseminating materials to all primary referral sources, especially physicians and hospitals. These materials should include:

- Information for parents (especially parents of premature infants or infants with other physical risk factors associated with learning or developmental complications) about the availability of services under Part C and Section 619 (preschool).
- Procedures for primary referral sources to disseminate information to parents.

Occupational therapists may assist the state in the development and dissemination of these materials. Physician's offices, hospital newborn packets, and child care settings are great locations for public awareness materials on services. I gave a copy of AOTA's *Watch Me Grow* wall chart to my child's physician, and the physician's office had so many compliments on this chart that it purchased enough to put one in each of its patient offices.

7. Central Directory

The state must compile a directory of early intervention services and resources, including state research and demonstration projects.

8. Comprehensive System of Personnel Development

Congress recognized that training professionals and paraprofessionals is a critical component of the statewide early intervention systems. Recruitment and retention of service providers and preparation of and training for personnel for transition services are specifically listed in IDEA [20 U.S.C. § 1435(a)(8)(A)(i–iii)]. Particular attention for training also is given to specific areas of development (emotional and social development) and to providers who work in rural and inner city areas. Occupational therapy practitioners can work with their states to enhance recruitment and retention of occupational therapy personnel. They also can work with states to set up a plan for ongoing continuing education for practitioners.

9. Personnel Qualifications

States are required to ensure that all personnel who provide early intervention services are appropriately and adequately prepared and trained to work under Part C; therefore, states must set policies and procedures to establish and maintain personnel qualifications. Specifically, they must ensure that these qualifications are "consistent with any state-approved or recognized certification, licensing, registration, or other comparable requirements that apply to the area in which such personnel are providing early intervention" [20 U.S.C. § 1435(a)(9)]. For occupational therapy, this policy is the state practice act. Some states are establishing additional requirements with regard to occupational therapy practice in the early intervention system; in some instances, the requirements may restrict the role of occupational therapy. Occupational therapy practitioners must work with their state lead agency, regulatory agency, and state association to ensure that these Part C requirements do not restrict occupational therapy practice within the state.

10. Lead Agency

The governor of each state is responsible for designating a single line of authority (i.e., the lead agency) for administering the early intervention system. The lead agency plays a crucial role in the implementation, supervision, and monitoring of the system. Table 1 on page CE-3 summarizes the primary lead agency for each state (for a complete listing, go to the NECTAC Web site [www.nectac.org]). As the table shows, there is great diversity among the lead agencies and in the way each state runs its program.

Even though the lead agency in some states is Education, occupational therapy practitioners must remember that the Infants and Toddlers With Disabilities Program is about *infant and toddler development and health and family services*, not education services. Part C involves, and service providers deliver, health, developmental, and instructional services.

11. Policy Pertaining to Service Providers

The state must have contracts or arrangements with service providers to provide early intervention services in the state. Conditions of these contracts must be included.

12. Timely Reimbursement of Funds

States must have a procedure for reimbursement. Federal funding for states has risen significantly since 1986 when the Part C program (then known as Part H) was enacted. According to NECTAC (2007b), states received $50 million in federal dollars in 1987. In 2006, states received $436.4 million in federal Part C funds to serve 298,150 children. Federal funds have risen by more than 2.10% each year for the past 3 years.

This funding, however, does not cover all the costs of implementing and maintaining the early intervention system. States set up interagency agreements between the public agency and the lead agency to provide services to children. By law, parents cannot be charged for service coordination, screening and evaluation, or IFSP development. The implication is that parents can be expected to pay for other services, including occupational therapy, provided the state has established a system of payments, such as a sliding fee scale

for families. Certain "birth mandate states" must provide all services at no cost to the family. Many states turned to Medicaid as a funding method for services. Occupational therapy practitioners billing for early intervention services must be aware of the various funding sources and meet the requirements of each source.

13. Procedural Safeguards

IDEA lists eight procedural safeguards (or rights) required in the statewide system: (a) the right to timely resolution of complaints by parents, (b) the right to confidentiality of personally identifiable information, (c) the right to accept or decline any early identification services, (d) the right to examine records, (e) the right to protect infants or toddlers if parents are unknown or cannot be found, (f) the right to written prior notice of initiated changes or refusal to initiate changes, (g) an assurance that the notice fully informs parents in their native language of all procedures, and (h) the right of parents to use mediation. Occupational therapy practitioners must be aware of these rights and, when serving as a service coordinator, review these rights with the family.

14. Data Collection

One of the new requirements for Part C is the development of a State Performance Plan (SPP) that identifies how states will address 14 federal indicators (see Table 2 on page CE-6). The targets for the indicators are set by either the Office of Special Education Programs (OSEP) (e.g., compliance indicators of 100%) or the state. The SPP must be submitted to the U.S. Department of Education along with an Annual Performance Report (APR) that describes current performance and compares it to the previous year and target performance. The APR and the SPP are posted on each state lead agency's Web site. The Department of Education responds to each state's SPP and APR in writing and posts unofficial copies on its Web site (www.ed.gov).

In addition to the 14 federal indicators, states also must collect data on specific Early Childhood Outcomes in response to the C3 indicator (see Table 2 on page CE-6). The OSEP announced these new reporting requirements in April 2005, with data due in the February 2007 APR. The three areas are (a) positive socioemotional skills (including social relationships), (b) acquisition and use of knowledge and skills (including early language and communication), and (c) use of appropriate behaviors to meet infants' and toddlers' needs. IFSP teams must report the child's performance in these three areas at the initial IFSP meeting, at the annual review, and at transition. Occupational therapists working with IFSP multidisciplinary teams must be aware of these requirements. Because occupational therapists possess knowledge and skills that could address these three areas, their input informs the team of the scope and expertise of occupational therapy and helps to document the infants' and toddlers' progress.

15. State Interagency Coordinating Council

To receive Part C funds, states must establish an interagency coordinating council, which comprises parents; service providers; and state legislature, personnel preparation, agency for early intervention services, agency for preschool services, state Medicaid agency, Head Start agency, child care agency, agency for health insurance, office of coordination of education of homeless children and youth, state foster care representative, state mental health agency, and other representatives (e.g., Bureau of Indian Affairs). The governor appoints the members and the chairperson of the council. The interagency coordinating council meets at least quarterly to advise and assist the lead agency in identifying support (e.g., fiscal, other) for the Part C system and in transition and other program needs the state may have. The council's role in guiding the statewide system is crucial. Occupational therapy practitioners should consider serving on an interagency coordinating council, for their voices could provide strong direction for children and services in their state.

16. Services Provided in Natural Environments

The state is required to develop policies and procedures to ensure that early intervention services are provided in natural environments to the maximum extent appropriate. Occupational therapy practitioners must be aware of the literature around natural learning opportunities (Dunst et al., 2001; Hanft & Pilkington, 2000) and innovative teaming (Hanft, Rush, & Shelden, 2004). Research indicates that children's learning is enhanced and development is facilitated "when competence production is responded to contingently and when caregivers support and encourage the production of new competencies" (Shankoff & Phillips, 2000, as cited in Dunst et al., 2001, p. 69). The occupational therapy profession has always embraced the natural context.

> For every parent and family, there will be a preferred and optimal way to communicate; the professionals who practice family-centered care will take the time to identify these strategies and implement them in the interest of supporting the family's development as informed advocates for their child. (Dunn, 2000, p. 5)

CONCLUSION

All states have developed procedures for providing early intervention services under Part C of IDEA 2004. Occupational therapy practitioners must be aware of these federal requirements as well as the state's rules in order to fully understand and provide appropriate early intervention services. Through AOTA lobbying efforts, occupational therapy practitioners are able to serve as a primary service under Part C and to be a service coordinator as well as a service provider, working together with families, agencies, and the lead agency to promote efficient and effective services. ■

Table 2. Office of Special Education Programs Requirements for Part C

Number	Indicator	Description
C1	Timely services	Percentage of infants and toddlers with IFSPs who receive the early intervention services in a timely manner.
C2	Natural environment	Percentage of infants and toddlers with IFSPs who primarily receive early intervention services in the home or programs for children who are typically developing.
C3	Early childhood outcomes A. Socioemotional B. Knowledge and skill C. Appropriate behavior	Percentage of infants and toddlers with IFSPs who demonstrated improved: A. Positive socioemotional skills (including social relationships) B. Acquisition and use of knowledge and skills (including early language and communication) C. Use of appropriate behaviors to meet their needs
C4	Family-centered services survey	Percentage of families participating in Part C who report that early intervention services have helped families to: A. Know their rights B. Communicate effectively their children's needs C. Help their children to develop and learn
C5	Child Find 0–1	Percentage of infants and toddlers birth to 1 year with IFSPs compared to: A. Other states with similar eligibility definitions B. National data
C6	Child Find 0–3	Percentage of infants and toddlers birth to 3 years with IFSPs compared to: A. Other states with similar eligibility definitions B. National data
C7	Timely evaluation and assessment	Percentage of eligible infants and toddlers with IFSPs for whom an evaluation and assessment and an initial IFSP meeting were conducted within Part C's 45-day timeline.
C8	Transition C to B	Percentage of all children exiting Part C who received timeline transition planning to support the transition to preschool and other appropriate community services by their third birthday, including: A. IFSPs with transition steps and services B. Notification to local education agency (LEA) if child is potentially eligible for Part B C. Transition conference if child is potentially eligible for Part B
C9	General supervision	General supervision system (including monitoring, complaints, hearings, etc.) identifies and corrects noncompliance as soon as possible but in no case later than 1 year from identification.
C10	Complaints resolved within 60-day timeline	Percentage of signed written complaints with reports issued that were resolved within the 60-day timeline or a timeline extended for exceptional circumstances with respect to a particular complaint.
C11	Due process hearings	Percentage of fully adjudicated due process hearing requests that were fully adjudicated within the applicable timeline.
C12	Hearing requests to resolution sessions resolved	Percentage of hearing requests that went to resolution sessions that were resolved through resolution session settlement agreements. (Applicable if Part B due process procedures are adapted.)
C13	Mediations that resulted in agreements	Percentage of mediations held that resulted in mediation agreements.
C14	Timely and accurate data	State-reported data (618 and SPP and APR) are timely and accurate.

Note. IFSP = individualized family service program; SPP = State Performance Plan; APR = Annual Performance Report.

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RESOURCES

AOTA Evidence-Based Practice Resource Directory and Evidence Briefs Series: www.aota.org/Educate/Research/EvidenceDirectory.aspx

Council for Exceptional Children: www.cec.sped.org

Division of Early Childhood: www.dec-sped.org

Early Childhood Outcomes Center: www.the-eco-center.org

IDEA Infant and Toddlers Coordinators Association: www.ideainfanttoddler.org

IDEA Partnership Project: www.ideapartnership.org

National Early Childhood Technical Assistance Center: www.nectac.org

National Dissemination Center for Children with Disabilities: www.nichcy.org

The Center on the Social Emotional Foundations for Early Learning: www.vanderbilt.edu/csefel

The Promising Practices Network on Children, Families and Communities: www.promisingpractices.net

The Research and Training Center on Early Childhood Development: www.researchtopractice.info

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Final Exam

CEA0108
The Infants and Toddlers With Disabilities Program (Part C of IDEA) • January 21, 2008

Learning Level: Intermediate
Target audience: Occupational therapists and occupational therapy assistants
Content Focus: Category 3: Professional Issues, Legal, Legislative and Regulatory Issues

1. Occupational therapy practitioners working in early intervention services under the Infant and Toddlers with Disabilities Program (Part C of IDEA) must follow:
   A. Federal law and regulations
   B. Lead agency rules and procedures
   C. Mandates from the occupational therapy regulatory agency in the state
   D. All of the above

2. Part C is **not**
   A. For any children over 3 years of age in any state
   B. The same as Part B
   C. Designed to enhance families' capacity to meet the special needs of their child
   D. A voluntary government program for states

3. Part C regulations at the time this article was published are:
   A. Currently in "proposal" form and not finalized
   B. Finalized
   C. Not planned to be finalized for 5 years
   D. The same as Part B regulations

4. Annually, states must report their performance to the Office of Special Education Programs based on how many Part C indicators?
   A. 10
   B. 12
   C. 14
   D. 16

5. The timeline for evaluating and assessing a new infant or toddler and having an initial IFSP meeting is currently:
   A. 30 calendar days
   B. 45 calendar days
   C. 60 calendar days
   D. up to the states to decide

6. Which is **not true** about the lead agency for Part C?
   A. It is chosen by the governor of the state.
   B. It is different departments in different states.
   C. It is responsible for overseeing the Part C program for the state.
   D. It is always the Department of Education.

7. The definition used by the state for developmental disability is:
   A. Set by the each state based on criteria that it determines
   B. Set by the federal government
   C. Set by the governor
   D. Set by Congress

8. Which is **not true** about informed clinical opinion?
   A. It appears to be an effective strategy for use in early intervention eligibility determination.
   B. It is similar to professional judgment.
   C. Part C says that it can never be used in eligibility determination.
   D. It is important to use due to questionable validity in instruments and assessment procedures for infants and toddlers.

9. Which is **not** an area of development that must be evaluated for every infant and toddler under Part C?
   A. Physical (including vision and hearing)
   B. Cognitive and communication
   C. Socioemotional and adaptive
   D. Autism

10. After the family has signed a consent for evaluation, which type of instrument would be used, along with other procedures, for the purpose of determining whether there was a developmental delay?
    A. Screening tool
    B. Diagnostic instrument
    C. Curriculum program
    D. None of the above

11. The IFSP for a 5-month-old child should **not** include:
    A. A statement of specific early intervention services
    B. A statement of the child's present level of development in all five areas
    C. A statement of the family's resources, priorities, and concerns
    D. Steps to transition the child to preschool

12. The IDEA provides procedural safeguards to families. Which of the following is **not** a safeguard?
    A. The right to accept but not to decline any early intervention services without specific reasons
    B. The right to written prior notice of initiated changes or any refusal to initiate change
    C. The right to timely resolution of complaints
    D. The right to confidentiality of personally identifiable information