

## LOW VISION SPECIALTY CERTIFICATION Occupational Therapy Assistant

### Table of Contents: **Activity Evidence Form EXAMPLES**

- Below is one example for each type of **form**, not for each criterion. The examples are to help you understand how to *complete* each form, regardless of the criterion.
- The forms that are included are [hyperlinked](#) in the table of contents below.
- Please note that these are *examples only* to help guide you in the type of information to include. For many reflections, your style may be different; for example, more narrative or more bulleted.
- Note that unused forms (pages) are not included in this document. Please do the same with the final set of evidence forms you submit with your application.

#### **Criterion 1. Knowledge: Diagnostic Considerations**

- Formal Learning– Minimum 10 contact hours needed
- [Independent Learning](#)–Minimum 10 contact hours needed
- Publication – Peer-Reviewed

#### **Criterion 2. Knowledge: Assessment**

- Formal Learning–Minimum 10 contact hours needed
- Independent Learning–Minimum 10 contact hours needed
- Publication – Peer-Reviewed

#### **Criterion 3. Knowledge: Intervention**

- Formal Learning–Minimum 10 contact hours needed
- Independent Learning–Minimum 10 contact hours needed
- [Publication – Peer-Reviewed](#)

#### **Criterion 4. Knowledge: Regulation & Payers**

- [Formal Learning](#)–Minimum 3 contact hours needed
- Independent Learning–Minimum 3 contact hours needed
- Publication – Peer-Reviewed

#### **Criterion 5. Assessment: Performance Skills**

- Client-Based Case Study
- Mentee (does not include supervisory relationship)
- [Self-Analysis of Video Recording](#)

#### **Criterion 6. Intervention: Performance Skills**

- Client-Based Case Study
- Mentee (does not include supervisory relationship)
- Self-Analysis of Video Recording

#### **Criterion 7. Intervention: Critical Reasoning**

- Client-Based Case Study
- [Formal Specialized Consultation for Intervention](#)
- [Mentee](#) (does not include supervisory relationship)
- Program Development
- Research

#### **Criterion 8. Psychosocial Critical Reasoning**

- [Client-Based Case Study](#)
- Formal Specialized Consultation for Psychosocial
- Mentee (does not include supervisory relationship)
- [Program Development](#)
- Research

**Criterion 9. [Ethical Practice](#)** – The 3 ethical practice scenarios are found within the application itself.

#### **Criterion 10. Establishes Networks**

- Formal Specialized Consultation
- [Marketing Activities](#)
- Presentation
- Volunteer Leadership

#### **Criterion 11. Advocating for Change**

- [Advocacy Efforts](#)
- [Advocacy Case Study](#)
- [Presentation](#)
- [Public Awareness Efforts](#)
- [Volunteer Leadership](#)

**INDEPENDENT LEARNING**[Back to Criteria](#)**Criterion 1**–Knowledge: Diagnostic Considerations**Demonstrates knowledge of primary and secondary conditions that impact occupational engagement related to low vision.****Guidelines**

- **Minimum of 10 contact hours** required.
- Multiple activities may be used to meet the hour requirement for the criterion.
- Learning must have occurred in the past 5 years.

**Please identify the type of independent learning activity in which you participated:** [Independent reading from AOTA-Approved Independent Learning List in low vision.](#)

- Independent reading of recent peer-reviewed, professional articles, or chapters in textbook not associated with a formal learning course.
- Independent review of professional electronic resources (e.g., NIH, CDC, CanChild).
- [AOTA Journal Club Tool Kit](#) (reading & discussion time). *Must be AOTA member to access the kit.*
- AOTA Critically Appraised Paper (CAP, includes submission to the [AOTA Evidence Exchange](#)).

## 1. Why did you choose this activity?

 [Clinical reference for specific population, program, or individual](#)

- Invited peer review of scholarly work or publication (print or online)
- Preparation for poster or presentation
- Preparation for academic lecture
- Literature review for research project
- Preparation for serving as a mentor
- Other, please specify:

2. Bibliography of select item(s) used for independent learning. List in APA format.

[M. Warren & E. A. Barstow \(Eds.\), \*Occupational therapy interventions for adults with low vision\* \(pp. 359–402\). Bethesda, MD: AOTA Press.](#)

3. Date(s) of independent learning

[Unscheduled activity that occurred from April 23 through June 4, 20XX.](#)

## 4. Time spent engaged in independent learning.

- For reading, estimate 8–12 published pages/hour. *Not required for AOTA-identified independent learning list of resources.*
- For journal club, discussion time counts toward 10-hour requirement.

[N/A – AOTA publication \(400+ pages\)](#)

5. Describe the relevance of the independent learning activity to your practice in low vision. (*average word guideline–200*)

I had been practicing as an OTA for 4 years when I first started focusing on providing low vision services. My education was mostly “on the job” training, and I had an experienced OT as my mentor for several months. I learned about visual and non-visual ADL strategies, adaptive devices, and optical devices. However, I felt that there were gaps in my learning and wanted to do more in-depth study. During that time, I decided to also pursue independent learning initially with this textbook.

6. Describe how the knowledge acquired from this activity “*demonstrates knowledge of primary and secondary conditions that impact occupational engagement related to low vision.*” How did the activity influence the way you practice, or how did it affect your client outcomes? (*average word guideline–200*)

I feel the book provided a lot of useful information. One example of how my practice benefitted was from my increased understanding of age-related macular degeneration (AMD), a diagnosis typically seen with my clients:

- I gained greater understanding of the relationship between the data obtained from the assessments and the intervention strategies the OT selected to achieve the reading goal.
- I learned about the different types of macular scotomas and how a person adapts by using one or more preferred retinal locus (PRL), and that a client may switch to a different PRL location when lighting or task distance changes. This helped me understand the importance of observing how the client moves the eye and head when viewing text. I began to observe the how a client moved during different reading tasks and began providing feedback to the OT so we could modify the reading intervention.
- I learned about the relationship between reading speed and text size and the need to select appropriate sized font for reading materials to ensure a successful reading experience.
- I began to provide more useful documentation of the intervention session.

Since this textbook, I have engaged in many professional development opportunities. This book, however, was foundational to my learning when I started with low vision rehab 14 months ago. Although I was an experienced OTA, learning about the diagnostic considerations specific to low vision was invaluable.

**PUBLICATION – PEER-REVIEWED**[Back to Criteria](#)**Criterion 3—Knowledge: Intervention****Demonstrates knowledge of relevant evidence specific to *intervention* in low vision.****Guidelines**

- Examples of peer-reviewed publication include journals such as *AJOT* or *OTJR*.
- May include a chapter in an occupational therapy or related professional textbook, if chapter has gone through *peer review* (a process in which subject matter experts, using a formal system and defined guidelines, provide content guidance to an author and recommend publication, revision, or rejection of a work).

1. Submit APA reference for the publication. For in-press publication, also include a verification letter or e-mail identifying applicant and anticipated date of publication.

Smith, A., Jones, B., & Brown, C. (20XX). The impact of lighting modifications on daily activities in older adults with low vision. *American Journal of Occupational Therapy*, XX(X), XXX–XXX. <http://dx.doi.org/xxxx>

2. If applicant is not identified as first or second author, please describe your contribution/involvement in the development of the publication. *(average word guideline–200)*

Applicant is the second author.

3. Provide a reflection indicating why this publication was chosen to represent “*knowledge of relevant evidence specific to intervention in low vision*.” *(average word guideline–200)*

This publication is the culmination of 5 years’ work in home lighting intervention. This study was designed to determine the efficacy of client-centered home lighting intervention for older adults with low vision.

As I reflect on my experience completing the project that led to this publication, it is clear that my knowledge of planning lighting modifications for people with vision loss has greatly expanded. I have gained an appreciation for the importance of using a comprehensive, objective lighting assessment to plan lighting interventions as well as the importance of fully involving the client in the process. Our participants were intrigued and motivated by the objective nature of the light meter reading and other portions of the lighting assessment. The process seemed to promote readiness for changes in their lighting. I learned that a lighting intervention must address more than the addition of a task lamp or higher wattage bulb. Positioning the client, reading material, and light source are key intervention components. The influence of glare and outdoor lighting must also be addressed. One of the most important lessons I learned was that clients benefit from comparing and contrasting lighting options in the context of doing tasks relevant to them.

**FORMAL LEARNING**[Back to Criteria](#)**Criterion 4—Knowledge: Regulation & Payers****Demonstrates knowledge of laws and regulations relevant to low vision, including payer sources.****Guidelines**

- **Minimum of 10 contact hours** required.
- Multiple activities may be used to meet the hour requirement for the criterion.
- Learning must have occurred in the past 5 years.

**Please identify the type of activity in which you participated:**

- AOTA CE: Participation in Self-Paced Clinical Course or CE Product from the list of AOTA offerings approved for this certification. *Completion of course will be verified by AOTA. Submission of additional documentation beyond this form not required.*
- Non-AOTA CE: Attending workshops, seminars, lectures, or professional conferences with formal established objectives.

Participation in post-professional academic coursework. *Attach unofficial transcript.*

## 1. Activity information.

Activity Title	XYZ State Community College—Low Vision Rehabilitation for the Older Adult With Low Vision
Provider/Instructor	Jane Doe, MS, OTR/L, SCLV
Activity Date(s)	06-10-XX to 08-30-XX
No. of Contact Hours	2 College Credit hours—30 contact hours—6 modules

2. Activity Learning Objectives. *List up to 5.*

A)	The course had multiple objectives; however, the one specific to this criterion was "Demonstrate knowledge of the ethical, legal, and fiscal regulations in provision of low vision rehabilitation."
B)	
C)	
D)	
E)	

3. Describe the relevance of the activity to your practice in low vision. *(average word guideline–200)*

At the time of this course, I was hired as a new graduate to work in an OT private practice providing in-home low vision rehabilitation services to older adults. I only had one brief lecture on low vision rehabilitation during my OTA education. This online course was offered through an OTA program at 2-year state college. I took the course to increase my knowledge of low vision rehabilitation and the OTA role in providing low vision services. The course covered many topics, including a module on documentation and Medicare rules and regulations regarding billing for low vision clients.

I learned about the Medicare memorandum that established coverage of low vision rehabilitation in 2002, the ICD–9 codes that support medical necessity for low vision services and the appropriate CPT codes for billing. I also learned that Medicare does not cover the cost of optical devices. Much of the module focused on the importance of accurate, clear, and timely documentation to ensure that services were reimbursed. I learned about how poorly worded or incomplete documentation could trigger an audit and jeopardize reimbursement. I completed an assignment on how to properly document my observations of how a client with low vision performs an ADL.

4. Describe how the knowledge acquired from this activity *"demonstrates knowledge of laws and regulations relevant to low vision, including payer sources."* How did the activity influence the way you practice, or how did it affect your client outcomes? *(average word guideline–200)*

The knowledge I acquired in the course helped me understand why clearly worded, accurate, and timely documentation is critical to ensuring the financial solvency of my employer. I now double-check the accuracy of the billing codes and make sure that I have submitted the correct procedural codes and the accurate date for each session. I am also more careful in my documentation of the client session. I make sure that the information I provide is accurate, that everything is spelled correctly, and that my handwriting is legible. The knowledge I gained about the limitations that persons with AMD have in using their vision due to the central scotoma helped me understand the importance of preparing the client to use their remaining vision more effectively as part achieving the ADL goal. I now realize that eccentric viewing training will not just improve reading but also the ability to locate and identify objects needed for ADLs and improve the client's outcome. I now document that the client used eccentric viewing during ADLs to link this preparatory activity to the ADL outcome and justify working on this skill during the therapy session.

5. **Submit** documentation that verifies completion of the activity, such as certificate of completion or unofficial transcript. *Not required for AOTA courses.*

*See attached transcript from XYZ University, Anytown, USA. For this example, verification is not included but should accompany this activity if submitted.*

**SELF-ANALYSIS OF VIDEO RECORDING**[Back to Criteria](#)**Criterion 5**—Assessment: Performance Skills**Administers standardized assessments as delegated by the supervising occupational therapist specific to low vision, consistently integrating clinical observations.****Guidelines**

- Submission of actual video recording is **not** required for application; however, appropriate permissions should be obtained by applicant whenever engaging a client in a video-taped session.

1.

Age of Client	71 years old
Client Diagnosis(es)	Male
Setting for Evaluation	Age Related Macular Degeneration
Date of Video Recording	November 19, 20XX

2. Provide a brief summary of the video contents and how it demonstrates your ability to “administer standardized assessments as delegated by the supervising occupational therapist specific to low vision, consistently integrating clinical observations throughout the evaluation process.” *(average word guideline–200)*

I was trained by my supervising OT to administer tests used in low vision rehabilitation. In the video, I assess the reading ability of my client using the Pepper Visual Skills for Reading Test, a standardized assessment for measuring the reading performance for people with central vision loss due to macular disease. The video demonstrates how I gathered required materials and explain the purpose of the test and procedures to the patient. In the middle of this process, the patient informs me that he no longer reads because he “can’t see” and the glasses the doctor prescribed “are no good.” I ask the patient if he is willing to continue with the assessment, and he agrees. Shortly thereafter, he becomes agitated when he is unable to read the letters and words. He makes disparaging comments about “reading like a second grader” and states “the doctor said there wasn’t more they could do.” Although the client was technically not at a stopping point per standard assessment procedures, my clinical observations indicated that the reading test should be terminated. Given the pattern of errors, I suspected that his inability to compensate for his central scotoma prevented him from reading effectively and efficiently.

3. After reviewing this video, describe the insights you gained, and reflect on how the analysis experience validated or supported change in your practice related to evaluation. *(average word guideline–400)*

After I reviewed the video, I realized that I need to change my evaluation approach by de-emphasizing the need to complete the assessments, and instead, focus more on establishing rapport, reflect on clinical observations, and actively listen. A description of the specific insights I learned include:

- My discomfort with the patient's complaints resulted in behaviors that made me appear nervous. This was not evident to me at the time of the assessment, but was apparent in the video.
- I falsely assumed that the patient's complaints were an indication that he did not want to participate in our session; however, careful review of the video shows that the patient's complaints indicated he truly did not understand that there was hope for his situation. Up to this point, all he heard from his doctor was that there was not much that could be done. I did not focus on this concern or clarify that, while the doctor may not have any medical solutions to offer, there are ways to compensate for his vision loss.
- My emphasis on quickly completing the reading assessment caused me to miss some crucial clinical observations. I missed that the patient was not reading at the recommended reading distance for his bifocals. The low vision optometrist prescribed +400 reading bifocals and recommended a reading distance of 10". I knew this, but did not fully attend to his reading distance during the assessment. In addition, I did not notice that the client intermittently closed his right eye while reading. This had a direct impact on his reading efficiency. I could have intervened to alleviate this problem.
- I forgot to turn on the task lamp. Use of task lighting could have increased his success with the reading assessment. Although use of a task lamp is not part of the assessment protocol, the positive effects of task lighting on reading is well- established in literature.

Through this self-analysis activity, I learned that I need to avoid getting too caught up in completing the reading assessment. I need to put patients at ease, focus on their needs, and show empathy towards their concerns. In addition, I need to educate patients about the reasons they are experiencing problems and explain strategies that can allow them to resume valued activities.

**FORMAL SPECIALIZED CONSULTATION FOR INTERVENTION**[Back to Criteria](#)**Criterion 7—Intervention: Critical Reasoning**

**In collaboration with the supervising occupational therapist, selects, plans, and modifies interventions in low vision based on evidence and evaluation data.**

**Guidelines**

- This should **not** be confused with consultation that is part of the ongoing services provided in your routine job duties but is a request to address a particular issue at a particular site, either external or internal.
- Consultation may include (but is not limited to) developing or evaluating a program or service, developing a strategy for long-term planning, establishing outcomes measures, incorporating national guidelines into internal policies and procedures, assessing and addressing staff educational needs, assessing and addressing resource needs, and validating program/service delivery with current evidence.
- Applicant must have had a **minimum of 10 hours** working with the site.

1.

Entity for Which Consultation Was Completed	The Church of Perpetual Love
Date(s) of Consultation	July 1, 8, 15, 22, 29, 20XX
No. of Hours Completed During Consultation	40 hours

2. Objectives for consultation. *Objectives must have been met by time of application. Please list no more than 3.*

A) To educate church board members and a team of construction engineers and architects on the topic of low vision and the role occupational therapy plays in assessing environmental accessibility for people with low vision.
B) To assess the environment, and identify barriers that limit participation of low vision church members.
C) To recommend implementation of adaptive strategies and environmental modifications that promote full member participation in church activities.

3. Summarize the consultation results. *(average word guideline–200)*

<p>The church that sought low vision consultation services is a local, traditional church undergoing a remodeling project. I worked on this project with my supervising OT. The congregation includes 350 members. A majority of the older adults indicated they had an eye condition that made it difficult for them to 1) read in church, 2) move about the church environment due to fear of falling, 3) socialize with friends due to the lighting and glare in the meeting rooms and foyer.</p> <p>We met with church board members and a team of construction engineers and architects 5 times. During the first visit, my supervisor and I gave a presentation to the group to help them understand the impact of low vision on daily activities, reading, socializing and community mobility. In addition, we explained the role of occupational therapy and how we are qualified to identify potential barriers that limit participation for those with low vision. During the second visit, I assisted the OT as she assessed the church environment and identified barriers. We spoke with a group of church members with low vision to gain their perspective. On the third and fourth visits, we presented a variety of environmental modifications, adaptive strategies, and helped the team implement low vision solutions. By the end of the fifth session, church members were safely and fully engaging in activities and navigating their church environment.</p>
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4. Summarize how this professional development activity influenced your ability to “collaborate with the supervising occupational therapist and select, plan, and modify interventions in low vision based on evidence and evaluation data.” (average word guideline–400)

I have limited experience in the consultative process, so this project provided opportunity for growth. I reviewed the literature to prepare for my initial presentation. I explored the latest evidence on the prevalence of low vision in older adults, impact of low vision on daily activities, and lighting efficacy. I normally find it difficult to find time for literature review; however, this project provided the motivation and structure I needed, as well as improved my ability to use PubMed and other databases.

I benefited from observing and providing assistance during the assessment process because it was different than the one used in a direct care situation. The church environment was used by a number of older adults with a variety of vision disorders and range of needs. The OT kept this in mind throughout the assessment process. For example, some congregants required high levels of lighting, while others had light sensitivity and were more comfortable in moderate lighting environments. She used a light meter to provide objective pre- and post-lighting modification data that helped the planning team understand the value of properly directed task lighting for reading, and ambient lighting for safety and socialization. I will carry this lesson back to my low vision practice.

Following my assessment, it was apparent that key components such as lighting, contrast, glare, and pattern were creating barriers for those with low vision. I noticed ambient lighting was too bright, (e.g. main meeting room), or too dim (e.g. sanctuary) which creates problems with reading and identifying people in social situations. Low contrast hazards, such as poorly lit steps and a dark, patterned carpet were present. Glare was a problem in the foyer due to large, east facing windows.

As we developed our recommendations, a new challenge was to find the right balance in meeting stakeholders’ needs. The congregants’ needs were our first priority, but we also had to assist the church board members, architects and contractors with prioritizing environmental modifications so that budget constraints were met. We prepared a list of recommendations in priority order, and provided specific modifications with an evidence-based rationale that included function and safety considerations. Recommendations included additional ambient lighting, use of LED clip-on book lamps in the pews, and adding strips of LED lights in the sanctuary along the pathway to the seating area and on the steps. Glare in the foyer could be reduced with anti-glare window treatments or sheer curtains. To better enhance contrast when entering a new room, installation of contrasting color carpet (with no pattern), was recommended. This experience was particularly gratifying because we were able to influence the planning and decisions made by the team, and help create a more accessible environment for the congregants with low vision.

## MENTORING RELATIONSHIP–MENTEE

[Back to Criteria](#)**Criterion 7**—Intervention: Critical Reasoning**In collaboration with the supervising occupational therapist, selects, plans, and modifies interventions in low vision based on evidence and evaluation data.****Guidelines**

- Must represent a **minimum of 10 hours** over a minimum of 2 months.
- Does **not** include supervisory relationships.
- Relationship must have occurred in the past 5 years.

## 1. Dates of mentoring relationship

Sept. 4, 20XX to Dec. 18, 20XX

## 2. Approximately how many hours did this represent in total?

16 hours

3. Applicant's goals for mentoring relationship. *Goals must have been met by time of application. List no more than 3.*

A) Describe neurological related disease visual diagnoses and the impact on visual skills and participation.

B) Plan and perform interventions for patients with neurologic-related vision loss, including: use of contrast; lighting; appliance marking; optical device use; scanning strategies; various techniques to address ADL, IADL, work, leisure and community mobility; and use of community resources, and including family in the OT process.

C) Modify intervention appropriately with the supervising OT to ensure established low vision goals are met.

## 4.

Mentor	Jane Doe, MA, OTR/L, SCLV
Position/Role of Mentor	Clinical Supervisor
Workplace of Mentor	Total Care Rehabilitation Hospital
Contact Information for Mentor (email or phone number)	<a href="mailto:jdoe@email.com">jdoe@email.com</a>

5. State why the mentor was selected to help you meet the goals identified above relative to the criterion. *(average word guideline–50)*

Jane Doe has 30 years' experience in neurological rehabilitation, with advanced studies in low vision rehabilitation, including a graduate certificate in low vision. She is also Specialty Certified in Low Vision by AOTA. Jane developed a low vision rehabilitation program (including in-patient, out-patient, and home-based programs) at Total Care Rehabilitation Hospital.

6. Briefly describe how the knowledge acquired from this mentoring activity influenced your service delivery with clients, specific to your ability to *“collaborate with the supervising occupational therapist and select, plan, and modify interventions in low vision based on evidence and evaluation data.”* *(average word guideline–200)*

Prior to this experience, I worked on a spinal cord rehabilitation unit with little exposure to patients with vision loss. I now work with patients who have had a stroke or brain injury; and as a result, many have vision impairments. The knowledge gained from this mentoring experience positively influenced my ability to treat patients with vision loss.

I learned about the impact that brain injury and stroke can have on vision, and how these vision impairments affect participation and safety. I gained an understanding of vision assessment results that were unfamiliar to me. Examples include the biVABA and the MNRead. With the patient's goals in mind and Jane's mentoring, I learned to use these assessment results to develop client-centered intervention plans.

Through my observations and discussions with Jane, I acquired an appreciation for how client factors such as cognition, language skills, and behavior influence vision-related intervention planning for people with stroke, brain injury and related vision loss. Intervention approaches were often modified to address factors such as decreased attention, aphasia and disinhibited behavior and were considered as I provided interventions to address scanning strategies, higher level visual processing, etc. Many clients were young adults from low income neighborhoods, with limited social support. Jane guided my consideration of community resources, church congregations, and extended family to assist with OT intervention and discharge planning.

**CLIENT-BASED CASE STUDY**[Back to Criteria](#)**Criterion 8—Psychosocial Critical Reasoning**

**In collaboration with the supervising occupational therapist, recognizes immediate and long-term implications of psychosocial issues related to conditions of low vision and modifies therapeutic approach and occupational therapy service delivery accordingly.**

**Guidelines**

- Client-based case study should **not** include any form of standard client documentation (e.g., evaluation summary, discharge plan) or identification of client name(s) or facility information.

## 1. Date(s) case study represents

April 20XX

2. Describe the client, client factors, and case contexts for the identified case. The context of the case should be adequately communicated so that relevance and merit of the case to the criterion is easily determined. *(average word guideline–500)*Client:

Mrs. Perkins is an 89 year old female whose medical history includes macular degeneration (dry), s/p spinal fracture with subsequent back pain, and depression. She was referred to occupational therapy by her low vision optometrist to address ADLs and IADLs, eccentric viewing, use of optical devices, and home safety.

Relevant client factors:

The following information was gathered from the supervising OT's initial evaluation:

Visual acuity with eccentric viewing: OD20/100; OS 20/125; OU 20/100; moderate contrast impairment. Visual complaints include difficulty reading for information and pleasure and trouble recognizing faces.

Ct. reports difficulty with hearing while talking on the phone and in social situations when background noise is present. Ct. has not been evaluated for hearing aids.

Depression: Geriatric Depression Screen (GDS) - 8/15 indicating possible depression. Client reports that her husband died 3 months ago and she moved from her home of 45 years to live closer to her daughter.

Cognition: 8/28 on Short Blessed indicating moderate cognitive impairment.

Functional UE performance: UE ROM is WNL and UE mm strength is 4+/5 BUE. Tactile sensation is intact BUE.

Pain: Ct. reports 5/10 on analog pain scale due to her spinal fracture.

Relevant case contexts:

Mrs. Perkins lives in a 1 story ranch home accessible by 2 steps, that is located 1 mile away from her daughter. Following the death of her husband 3 months ago, she moved from her hometown that is 6 hours away. The daughter is very supportive and visits her daily. She had several close friends in her hometown, but has not made any social connections since the move.

Mrs. Perkins is being seen in a low vision rehabilitation setting. Typically, clients are seen by the OT for the initial evaluation in the clinic and follow-up home visits are scheduled by the OT or OTA. As the OTA working in this setting, I assumed responsibility.

3. Articulate how this case demonstrates your ability to “collaborate with the supervising occupational therapist and recognize immediate and long-term implications of psychosocial issues related to conditions of low vision and modify therapeutic approach and occupational therapy service delivery accordingly.” (average word guideline–500)

Recognition of psychosocial issues:

The supervising OT shared the initial evaluation results and observations, which included that Mrs. Perkins had a flat affect, stating she felt “blue” and especially misses her husband in the evening when things are quiet. During the first follow-up visit, she spoke of how difficult it was to leave her hometown and lifelong friends and her worries about the extra burden she placed on her daughter. Her daughter confirmed that her mother was struggling with the loss of her husband and her new surroundings. These observations, the client/family report, and GDS scores led to the conclusion that Mrs. Perkins most likely has depressive symptoms that need to be addressed.

Modification of OT approach:

Therapeutic use of self was applied in several ways. First, I needed to focus on how Mrs. Perkins’ sense of loss and myriad of life changes might impact her motivation to participate in OT and her ability to learn new strategies. I listened carefully, observed her non-verbal behavior (facial expression and body language), and asked her how she was feeling. Active listening techniques were used to clarify her feelings and wishes. Encouragement and appropriate use of touch, such as my hand on her arm, were used to comfort her.

Her priorities were carefully explored along with her receptivity to initial recommendations and intervention strategies. This allowed for adjustment of the pace and direction of intervention. For example, Mrs. Perkins was frustrated that she could not operate her new microwave, so this was addressed immediately. She had trouble grasping the concept of eccentric viewing, perhaps due to her cognitive status and possible depression. The decision was made to address other areas of intervention that required less of a cognitive load and revisit eccentric viewing during later visits. All of this was discussed with the supervising OT.

Mrs. Perkins’ frustration level, affect, and other non-verbal signs were monitored throughout all OT sessions. If she began to appear anxious, breaks were offered and efforts were redirected to a simpler task. Time was allotted for talking about any concerns, fears, and feelings of isolation. In addition, her daughter provided input about how she felt her mother was coping.

Mrs. Perkins was encouraged to talk to her doctor about her low mood, anxiety and low back pain. She was referred to a low vision support group and to a senior center to increase socialization and opportunity for activity participation and exercise.

Potential long term implications:

Older adults encounter a variety of stressors including a decline in physical health, role changes, and loss of social support as family and friends pass away. These stressors can lead to feelings of grief and depression. The most challenging emotional issues for those with vision loss are “relinquished activities, lost independence, lost spontaneity, increased effort required, and impact on social interactions” (Teitelman & Copolillo, 2005, p. 412). These psychosocial issues can lead to reduced participation and quality of life and must be addressed by OT practitioners working in LV rehabilitation.

## PROGRAM DEVELOPMENT

[Back to Criteria](#)**Criterion 8—Psychosocial Critical Reasoning**

**In collaboration with the supervising occupational therapist, recognizes immediate and long-term implications of psychosocial issues related to conditions of low vision and modifies therapeutic approach and occupational therapy service delivery accordingly.**

**Guidelines**

- *Program development* refers to the creation of a new program or development of an evolving program.

## 1. Dates of program development

June - September, 20XX

2. Briefly describe the program purpose, services offered, and clients served. (*average word guideline—250*)

**Program:** Keep Moving with Low Vision

**Purpose:** To provide a safe and accessible opportunity for exercise and fitness programs for older adults with low vision.

**Services Offered:** Exercise and fitness programs for older adults with low vision, including chair-based and aquatic exercise classes designed to progressively build strength, flexibility, and endurance in a refreshing and joint-supportive environment. The aquatic classes use the water's buoyancy and resistance to help improve joint flexibility.

**Clients Served:** Individuals with vision deficits due to glaucoma, diabetic retinopathy, macular degeneration, cataracts, and other low vision diagnoses.

3. Describe how this program development activity, including description of resources used, demonstrates your ability to “collaborate with the supervising occupational therapist and recognize immediate and long-term implications of psychosocial issues related to conditions of low vision and modify therapeutic approach and occupational therapy service delivery accordingly.” (*average word guideline—500*)

Exercise programming is not a typical area of intervention for OTs working in LV rehabilitation; however, the department where I work was approached by the local Jewish Community Center (JCC) to assess the needs of their older adult members with vision loss. The JCC wanted to know if their facility and exercise classes met the needs of member with low vision. They were also interested in environmental modifications to make the facility more visible, and requested program development services to implement exercise classes for those with vision loss. I was asked by my supervising OT to assist her in this process.

Use of Evidence

My first step was to review the literature on the benefits of exercise. Physical activity is linked to lower mortality rates and decreased risk of cardiovascular disease, stroke, diabetes and depression (Brach, Simonsick, Kritchevsky, Yaffe & Newman, 2004; Chodzko-Zajko). Benefits of physical activity for persons with low vision has also been established (Knudtson, Klein & Klein, 2006; Seddon, Cote, Davis, & Rosner, 2003; Williams, 2009). Despite strong evidence supporting the benefits of regular exercise, the CDC (2007) reports that the majority of adults, age 65 and over, do not engage in physical activity.

Needs Assessment Process

I assisted the OT with conducting a needs assessment process using a 4-step approach: 1) 22 older adult members (14 female, 8 males) agreed to complete the Physical Fitness and Exercise

Activity of Older Adults Scale (Melillo, Williamson, Futrell, & Chamberlain, 1997) and the Exercise Benefits/Barriers Scale (Sechrist, Walker, & Pender, 1987), 2) We facilitated a group discussion for 8 additional older adult members that focused on their interests, needs, perceived barriers to exercise, etc., 3) We met with JCC certified trainers and exercise class instructors to gain their perspective, 4) The OT and I completed an environmental assessment of the facility. We combined this information with our expertise in low vision to address the JCC's goals. In addition, we frequently consulted with members and exercise instructors, who participated in the needs assessment at key points in the program planning process to ensure that our recommendations fit their needs.

### Intervention/Recommendations

Recommendations for increasing general and visual accessibility of the JCC included glare reduction strategies in the lobby and indoor pool area, adding lighting in the locker room, enlarging numbers on the lockers, increasing contrast on floor surfaces, steps and railings, marking controls on exercise equipment, making boundaries on the basketball and volleyball courts more visible, organization of exercise equipment, modification of signage and use of large print class schedules.

We partnered with 2 certified trainers/exercise instructors to create a chair-based and aquatic exercise class tailored to members with low vision. First, we recommended that participants be screened for vision, hearing, balance, strength, general fitness level and history of falls. For both classes, the instructors wore solid, bright leotards and gloves and used a microphone. For the chair-based class, JCC staff set up the room in advance with contrasting chairs placed in rows and equipment placed underneath the chairs. Trekking poles and beeping balls were available if needed. The instructor stood in front of a plain wall so that her motions would be more visible, and she used descriptive language to help patrons visualize required movements. For example, she would tell them to make motion like "kneading bread." People in the aquatic aerobics class were paired with a buddy to help safely access the pool area, which had many low contrast features that could not be easily modified.

Three months after the project ended, we surveyed members and staff to determine whether program outcomes had been achieved and maintained. We found that the instructors for the aquatic and exercise programs had continued to use the teaching strategies identified above, and enrollment in these programs had increased by 25%. The facility had implemented most of the lower cost modifications, including adding more lighting, providing large print materials, and larger signage. More expensive modifications, such as modifying windows to reduce glare, were in the budget process.

### Summary

This program development experience challenged and strengthened my critical reasoning abilities. I learned the importance of completing a needs assessment as the first step in developing a program. The information we compiled helped me understand our clients' needs and ensure that our recommendations met those needs. I learned how to balance the needs and goals of multiple parties (JCC members, administrative staff, and exercise class instructors) and negotiate and compromise when needed. I also learned the importance of frequently soliciting feedback from stakeholders during program development, and to add a program evaluation piece to determine if program outcomes were met.

## MARKETING ACTIVITIES

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### Criterion 10—Establishes Networks

**Establishes and collaborates with referral sources and stakeholders to help the client and relevant others achieve outcomes that support health and participation in the area of low vision.**

**Type of media used for marketing:** (check all that apply)

- Presentation to potential referral source audience
- Presentation to potential clients
- Participation in community event such as health fairs

**X Speaking to community groups**

- Development and dissemination of marketing materials (e.g., brochures, Web sites, podcasts)
- Participation in media interview (e.g., television news, newspaper)
- Other

1.

Target Audience of Marketing	Low vision support groups
Date(s) of Marketing Efforts	8/15/20XX, 9/12/20XX, 10/18/20XX, 11/21/20XX
Approximate Total Hours Engaged in Marketing Activity	5 hours: 1 hour to design and create the presentation and 4, 45 minute presentations each with a 15 minute question & answer period

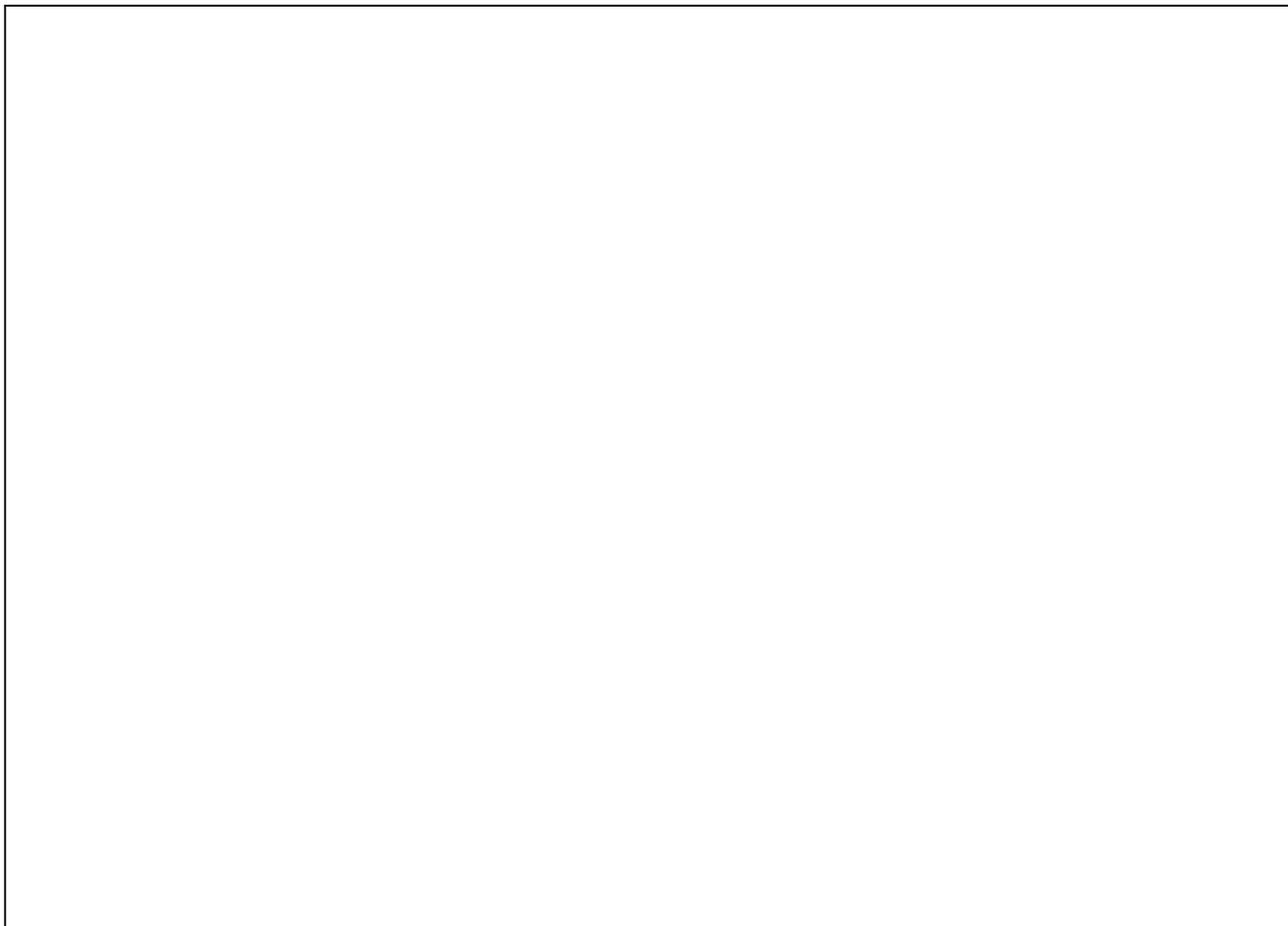
2. Provide a brief summary of the marketing activity. *(average word guideline–50)*

An interactive and educational presentation for local low vision support groups designed to promote the benefits of low vision rehabilitation and how to obtain occupational therapy services. Includes hands-on experience for each participant to facilitate understanding of how therapy can maximize the ability to use remaining vision.

3. Applicant's objectives for the marketing. *List no more than 3.*

- |   |
|---|
| A) Develop participant understanding of how low vision rehabilitation fits within the continuum of vision care for persons with age-related eye disease including how, when and from whom to seek referral for services.  |
| B) Provide local and national resources to assist participants in locating services and accommodations to help them live well with low vision.  |
| C) Demonstrate occupational therapy interventions such as lighting, contrast, use of other senses, organization, training in the use of optics, and eccentric viewing training to assist participants understand how they can improve their ability to use remaining vision and increase safety and independence. |

4. Describe how this marketing activity demonstrates how you "establish and collaborate with referral sources and stakeholders to help the client and relevant others achieve outcomes that support health and participation in the area of low vision." (average word guideline–200)



## ADVOCACY EFFORTS

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### Criterion 11— Advocating for Change

**Influences services for clients (person, organization, population) in low vision through independent or collaborative education or advocacy activities.**

#### Guidelines

- Active involvement in or facilitation of advocacy activities at the local, regional, state, or national level for the purpose of influencing decision-makers about policy, procedures, services, reimbursement, or occupational justice issues.
- Merely serving as a participant does **not** constitute advocacy efforts.
- **Minimum of 10 hours** over at least 2 months.

#### Type of advocacy activity: (check all that apply)

- Development and dissemination of advocacy materials (e.g., letters, brochures, Web sites, podcasts)
- Lobbying to/education for policy-makers
- Organizer of community event (e.g., fundraising, health fair)
- Subject expert in media interview (e.g., radio, television news, newspaper)
- Presentation to stakeholder
- Other

1.

Description of Activity	Target Audience	Date(s)	No. of Hours Involved
Presentations on low vision and need for optical devices to obtain support for the fundraiser.	Priest, church outreach committee, center staff, community center, Rotary club, Knights of Columbus, Polish Society	8/XX/XX, 8/XX/XX, 8/XX/XX 9/XX/XX, 9/XX/XX, 9/XX/XX, 9/XX/XX	20 hours
Contact with optical device vendors to obtain donations, discounts	XYZ Vendor QRS Vendor	10/XX/XX, 10/XX/XX	5 hours
Planning committee meetings	Members involved in planning event	9/XX/XX, 9/XX/XX, 10/XX/XX, 10/XX/XX, 10/XX/XX, 10/XX/XX, 10/XX/XX, 11/XX/XX, 11/XX/XX	20 hours
Marketing the event	Media outlets: newspapers, radio, television; Community events	10/XX/XX, 10/XX/XX, 10/XX/XX, 10/XX/XX, 10/XX/XX, 10/XX/XX	10 hours

2. Applicant's objectives for advocating for change. *List no more than 3.*

A) Obtain assistive technology, low vision devices and eyeglasses for residents in a low-income housing facility for older adults.
B) Raise community awareness of low vision and the need for good eye care in a low-income neighborhood.
C)

3. Discuss the results, outcomes, or progress toward change affected by this advocacy effort that demonstrates how you *“influence services for clients (person, organization, population) in low vision through independent or collaborative education or advocacy activities.”* (average word guideline–350)

I worked with clients residing in a low-income housing facility for older adults. Most residents lived on social security only and were under-insured. In providing services, I became well-acquainted with the facility and staff, including social workers, activities director and facilities director. The facility is located in a large urban area in a poor neighborhood known as Poletown. Most of the residents grew up here and were members of a large Catholic church located across the street from the housing facility. The church provided several outreach services to the neighborhood. My clients responded well to low vision rehabilitation but most could not afford the cost of optical devices that could help them maintain their independence.

After a client and I made a batch of cookies to learn meal preparation skills, I joked that we should sell them to raise money to buy optical devices. My client, a life-long activist, took the idea to her church circle. They agreed that they should have a bake sale to raise money. From that idea came “Sweet Sights,” an annual bake sale and food event featuring Polish delicacies. The event, now in its third year, has raised over \$7,000 to purchase optical devices and eyeglasses for facility residents.

I played an active role in bringing this idea to fruition. To solicit support for the project, I met with the priest, church outreach committee, and housing facility staff to explain low vision and how optical devices enable people to complete important ADLs. I served on the planning committee, and approached several optical device vendors for donations and discounts. I helped market the event, including talking to media, and speaking at community gatherings about the challenges seniors experience paying for devices and the difference these devices can make in their lives. In year 2, we had a vision health fair. I arranged for optometry students to complete vision screenings. In addition to serving as a standing member of the planning committee, I serve on the budget and finance committee to help determine how funds will be used to purchase devices.

Our efforts have raised awareness of low vision and the need for good eye care within the community. We have purchased a stand-alone CCTV for all of the residents to use, along with devices for individual residents. We created a lending library of devices to share among residents and purchased new eyeglasses for 25 residents.

## ADVOCACY CASE STUDY

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### Criterion 11— Advocating for Change

**Influences services for clients (person, organization, population) in low vision through independent or collaborative education or advocacy activities.**

#### Guidelines

- Efforts toward change that influence access to services or promote the health and occupational engagement of clients.
- This should **not** be confused with routine job duties associated with expected occupational therapy service delivery. For example, submitting letters of necessity for equipment would not meet intent.

1. Describe the client (person, organization, population) or program and the context as it applies to an identified need for change. *(average word guideline–100)*

I work in a university-based clinic serving older adults. My typical client is female, in her mid 80's, widowed, retired from driving, and struggling to remain independent and in her own home. Though my clients are not diagnosed as clinically depressed, they frequently express that they feel alone and isolated because of their eye disease and frustrated by their limitations. At discharge they often express concern that they will lose ground or miss out on new developments in treatment. Our clinic does not offer a support group because it is not a billable service, and there are no community support groups.

2. Summarize your efforts to influence change. *(average word guideline–200)*

I realized that there were no services in place to meet the long-term needs of our clients with low vision. I conducted a needs survey of current and recently discharged clients. Sixty percent of the respondents expressed an interest in attending a group, and identified their primary barrier as transportation and their primary motivation as receiving up-to-date education and resources.

Recognizing my facility's concern about resource allocation, as well as the clients' concern regarding access to a group, I met with 2 potential partners: 1) an OT faculty member, who agreed to use the process of exploring group development as a student research project, and 2) a private organization that provided transportation for children to medical appointments on campus.

Ultimately the school's Student Occupational Therapy Association (SOTA) agreed to take the group on as a permanent project and provide long term volunteer help.

3. Describe the change outcomes or progress toward change as a result of your efforts. *(average word guideline–200)*

- Six months were required to develop and launch the support group, which has now been operating for 2 years.
- The group meets once a month and 2 SOTA student volunteers attend and help facilitate each meeting.
- The transportation service continues to transport 4 persons to the meeting.
- Quality assurance measures were established for attendance and client satisfaction. These measures have shown that monthly attendance averages between 15 and 20 clients and family members. Usually 1-2 new participants join the group each month.
- Participants report that they find the educational content and resource information to be useful; they also report that they enjoy interacting with the SOTA students and receiving support from each other.

4. Articulate how this case demonstrates your ability to *“influence services for clients (person, organization, population) in low vision through independent or collaborative education or advocacy activities.”* *(average word guideline–500)*

When advocating for this support group, I had to balance the needs of the consumers (clients and families) with those of the low vision clinic. To be sustainable, the program had to provide useful information and support to the consumers on a day and time when they could attend; but also, not interfere with the clinic’s service delivery or reducing the billable treatment units for OT.

I could not provide the low vision support group by myself without reducing my caseload, so I sought a collaborative relationship with the university’s OT program to provide volunteer manpower for the group. I was aware that OT students were required to conduct research and provide community service with a faculty advisor, so I presented the low vision group as an opportunity for an ongoing community health research project, and I offered to supervise the student effort. This also aligned with our clinic’s mission to provide educational opportunities to students, which increased the clinic’s support for the project. Obtaining SOTA support guaranteed that I would have volunteers capable of developing good educational and resource programs for the participants.

The initial needs assessment identified transportation as a barrier for some. I was aware of a well-funded private organization that provided transportation for children to doctor’s appointments and arranged a meeting with the executive director. A major objection was the estimated amount of time required and the demand for services, which could take away from their primary mission to serve children. I emphasized that we only needed assistance one day per month, and that our clinic was located close to the children’s hospital clinics. To make it easier for the drivers, our student volunteers would meet the clients as they arrived and also deliver them to the bus for pick up.

This case represents a good example of how I was able to influence both the creation of and accessibility to services. My initial observations of client need were substantiated with data, and I was able to work with multiple groups to meet these identified needs.

**PRESENTATION**[Back to Criteria](#)**Criterion 11— Advocating for Change**

**Influences services for clients (person, organization, population) in low vision through independent or collaborative education or advocacy activities.**

**Type of presentation:**

In-service to professionals

Academic program lecture

Professional level workshop (e.g., state conference)

Community

## 1. Presentation information.

Title	Low Vision Simulations: Understanding the Lived Experiences of Individuals with Low Vision
Target Audience	State Blindness Association caseworkers
Date and Time of Presentation	October 18, 20XX and October 25, 20XX

2. Brief description of the presentation, including content focus. *(average word guideline–50)*

I used glasses that simulated visual changes from age-related eye diseases to help the audience experience how low vision affects performance of tasks requiring reading, writing, mobility, and eye hand coordination. I then provided information on simple task and environmental modifications to enhance vision use in people with low vision.

3. Applicant's objectives for advocacy. *Objectives must have been met by time of application. Please list no more than 3.*

A) Enable participants to understand that people with low vision have impaired but useable vision that can be enhanced with adaptive techniques.

B) Demonstrate how low vision rehabilitation can improve occupational performance.

C) Provide information on how to obtain a referral to receive low vision therapy services.

4. Describe how this presentation demonstrates that you “influence services for clients (person, organization, population) in low vision through independent or collaborative education or advocacy activities.” (average word guideline–200)

The majority of blindness association members in my community are completely blind. However, people with low vision are increasingly joining the organization. My OT supervisor and I discovered that blindness association caseworkers in our area had a limited understanding of how the needs of people with low vision differ from those who are blind, and were not aware of the benefits of low vision rehabilitation. We planned 2 presentations with this group to address the need.

Audience feedback indicated that our presentation increased the caseworkers’ understanding of how low vision affects ADL performance and how low vision rehabilitation can help people use their vision more effectively. The presentation significantly increased my interaction with the caseworkers. I consult with them frequently now on individual member needs and help locate resources. They have referred numerous clients to our private practice. Since we need a physician’s referral to see a client, we were able to introduce our services to eye care professionals when we contacted them for a referral. The greater awareness of our services helped to increase direct referrals from these providers.

As a result of the presentation, we have been able to establish a larger network of referral sources for our low vision practice.

**PUBLIC AWARENESS EFFORTS**[Back to Criteria](#)**Criterion 11— Advocating for Change****Influences services for clients (person, organization, population) in low vision through independent or collaborative education or advocacy activities.****Guidelines**

- Development of public awareness media for a broad audience to promote topic(s) relevant to the specialty area.

**Type of media developed:** (check all that apply)

- Presentation to potential referral source audience
- Presentation to potential clients
- Participation in community event, such as health fairs
- Speaking to community groups
- Development and dissemination of marketing materials (e.g., brochures, Web sites, podcasts)
- Participation in media interview (e.g., television news, newspaper)
- Other

## 1. Target audience(s) of public awareness.

Target Audience of Public Awareness Efforts	Public radio audience
Date(s) of Public Awareness Activity	<ul style="list-style-type: none"> <li>• Interview: October 18, 20XX</li> <li>• Response to web postings: October 19-November 15, 20XX</li> </ul>
Approximate Total Hours Engaged in Public Awareness Activity(ies)	<p>Approximately 7 hours:</p> <ul style="list-style-type: none"> <li>• 2 hour preparation time</li> <li>• 1 hour panel with ophthalmologist, low vision optometrist, older adult with low vision and her daughter</li> <li>• 4 hour follow-up answering questions from listeners via email and radio station web site</li> </ul>

2. Brief Summary of the Public Awareness Message (*average word guideline–50*)

Interview message: Low vision rehabilitation can assist people in continuing to live independently in their homes and participate in valued occupations. There are many resources available. Ask your eye doctor if low vision rehabilitation can help you or contact a local agency for more information.

3. Applicant's objectives for advocacy/change. *List no more than 3.*

- A) Develop awareness and understanding among the public of low vision rehabilitation as part of the continuum of care for older adults with low vision due to age-related eye disease.
- B) Develop awareness among the public of the variety of services available to older adults with low vision and how to obtain services.
- C) Develop awareness and understanding among the public of the benefits of receiving low vision rehabilitation to increase safety and independence within the home and community.

4. Summarize the changes that have occurred (or progress toward change) as a result of your public awareness efforts and how this activity demonstrates that you “influence services for clients (person, organization, population) in low vision through independent or collaborative education or advocacy activities.” (average word guideline–200)

I served as the low vision rehabilitation expert on the panel and covered services available within the community. The media interview was made available as a podcast and was rebroadcast twice in the month following the original interview. It was posted on the station website and is available for download. The website includes a public forum for people to post comments and ask questions. The web site received 25 comments and questions during the 1 month period following the interview. Nearly half of the viewer posts focused on low vision rehabilitation services and I provided answers to any questions. This public response suggests that the radio program increased the public’s awareness and interest in low vision rehabilitation.

The web site postings came from a broad range of stakeholders, including general practitioners, nurses, social workers, people with low vision, family members, and caregivers. As a result of the interview, I received a request from the local senior center to provide a talk on low vision rehabilitation. In addition, our center was invited to provide a booth and speak about low vision rehabilitation at a large, local health fair for older adults. Involvement in these activities served to further enhance public awareness of the role of low vision rehabilitation and related community services.

## VOLUNTEER LEADERSHIP

[Back to Criteria](#)**Criterion 11— Advocating for Change**

**Influences services for clients (person, organization, population) in low vision through independent or collaborative education or advocacy activities.**

**Guidelines**

- Service with a local, state, national, or international agency or organization that has relevance to the criterion.
- **Minimum of 25 hours** for at least 1 year.

## 1. Name of organization

*Low Vision Support Group, local affiliate of the International MD Support group ([www.mdsupport.org](http://www.mdsupport.org)).*

## 2. Dates of service

*2 years from July 1, 20XX through June 30, 20XX.*

## 3. Approximate number of hours of service

*75 hours.*

## 4. Identification of the volunteer leadership role served (must be leadership in nature, e.g., officer, chair, committee member, board member)

*Chairperson*

5. Describe how this leadership activity helped you *“influence services for clients (person, organization, population) in low vision through independent or collaborative education or advocacy activities.”* *(average word guideline–400)*

*I served as the chairperson for the *Low Vision Support Group*. I helped organize monthly meetings and secure local vision specialists as speakers. I worked with the MD Support group liaison to set up networking sessions or obtain videos for the meetings. I helped to market the support group by distributing flyers to a local senior center, several assisted living centers, and offices of optometrists, ophthalmologists and medical clinics. I also chaired the committee that wrote and distributed public service announcements to local radio stations and newspaper.*

*During my term, the size of the group doubled through my close work with local media outlets and distribution of marketing materials to local stakeholders serving older adults. Regular distribution of materials to eye care specialists and doctors enabled us to establish relationships with these professionals and expand the diversity of our speaker pool. Our speaker bureau now includes: 5 optometrists, 4 ophthalmologists (including 2 retinal specialists), a social worker, a certified diabetes educator and several primary care physicians. The diversity of speaker backgrounds has enabled us to offer information on a variety of topics that are important to our members’ ability to live well with low vision.*

*The increased number of participants attending each month has added more energy to the meetings. Members provide emotional support to each other by sharing experiences and discussing strategies to accomplish ADLs in more efficient ways. Members have formed car pools to help each other get to meetings. One of the most important outcomes that I have observed is the improved mood and optimism among members who attend regularly.*

## ETHICAL PRACTICE SCENARIO (Part 1 of 3)—Client Based

[Back to Criteria](#)**Criterion 10—Ethical Practice: Client-Based**

**Identifies ethical implications associated with the delivery of services in [area] and articulates a process for navigating through identified issues.**

**Guidelines**

- The applicant identifies ethical implications associated with the delivery of services and articulates a process for navigating through the identified issues.
- The applicant shall review the [AOTA Code of Ethics and Ethics Standards](#) and align the dilemma with the ethical principle(s) that is/are challenged.

**Ethical Scenarios****Scenario #1**

An OT practitioner works for an optometrist who sells every client at least 2 magnifiers before they are referred for therapy. All sales are final and the client cannot return the device unless it is defective. *[For sample purposes only]*

**Scenario #2****Scenario #3**

1. To which scenario are you responding? **Scenario #1**

2. From the [AOTA Code of Ethics and Ethics Standards](#), which ethical principle(s) has/have been challenged in this scenario? *Select the top ethical principle(s) that apply, up to a maximum of 3.*

1. Beneficence

5. Procedural Justice

2. Non-maleficence

6. Veracity

3. Autonomy, Confidentiality

7. Fidelity

4. Social Justice

3. Describe how you would apply the ethical principles identified above to guide you toward a resolution for the concern noted. *(average word guideline—500)*

The central ethical concern is one of fairness for the client. The client deserves to be provided with the best magnifier to meet their needs. The optometrist's policy places the client at risk for receiving less than optimum intervention to meet their occupational therapy goals. For example, it is possible that the optometrist prescribed a magnifier that worked well during the low vision exam, but does not satisfy the client's needs for completing ADLs at home. I should be able to collaborate with the optometrist to identify a more effective magnifier, and the client should be able to return the magnifier for a full refund.

To resolve this issue, I would use principles 1-B and 2-C to guide my decision-making. Principle 1 addresses beneficence and requires me to "demonstrate concern for the well-being and safety" of the client, and 1-B requires me to provide an appropriate intervention specific to client needs. Magnifiers are the principal adaptive device people use to compensate for reduced acuity. A poorly prescribed device could limit the client's ability to complete ADLs and reduce the client's independence and well-being. It could also potentially affect safety if the device is used for a high-risk area like medication management.

Principle 2 addresses non-maleficence and the duty to refrain from harming the client. 2-C directs me to avoid a relationship that exploits a client psychologically, emotionally or financially. Requiring a client to purchase a non-refundable device before they are trained to use it in ADLs has the potential to inflict harm by causing frustration, reduced self-efficacy and hopelessness if the device does not meet their needs. In addition, the client could be financially harmed because devices are not covered by insurance, and 2 devices can cost over \$100 which is a significant amount for clients on a fixed income.

I would also draw on principle 5, procedural justice, directing me to advocate for fair treatment of clients. I would use principle 5-B and 5-N to address the issue with the optometrist. 5-B directs me to open a dialogue with the optometrist to discuss the no return policy so I can understand why the policy exists. If a device is not working, 5-B also directs me to explain to the optometrist why it is necessary to refund the cost of the device. 5-N directs me to advocate for revising the policy to permit the return of devices and identify the conditions under which they can be returned.