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: Lifespan & Conditions**
- Formal Learning
- Independent Learning
- Mentee
- Publication – Peer-Reviewed

**Criterion 2: Knowledge: Evaluation**
- Formal Learning
- Independent Learning
- Mentee
- Publication – Peer-Reviewed

**Criterion 3: Knowledge: Intervention**
- Formal Learning
- Independent Learning
- Mentee
- Publication – Peer-Reviewed

**Criterion 4: Knowledge: Systems**
- Formal Learning
- Independent Learning
- Mentee
- Publication – Peer-Reviewed

**Criterion 5: Evaluation: Uses Relevant Evidence**
- Client-Based Case Study
- Program Development
- Research
- Self-Analysis of Video Recording

**Criterion 6: Evaluation: Prioritizes Needs**
- Client-Based Case Study
- Program Development
- Research

**Criterion 7: Intervention: Design & Implementation**
- Client-Based Case Study
- Formal Specialized Consultation for Intervention
- Mentee
- Self-Analysis of Video Recording

**Criterion 8: Intervention: Wellness & Prevention**
- Client-Based Case Study
- Formal Specialized Consultation for Intervention
- Mentee
- Self-Analysis of Video Recording

**Criterion 9: Outcomes**
- Formal Specialized Consultation for Outcomes
- Program/Service Evaluation
- Research

**Criterion 10: Holistic Practice**
- Holistic Practice Case Study

**Criterion 11: Ethical Practice** – The 3 ethical practice scenarios are found within the application itself.

**Criterion 12: Advocating for Change**
- Advocacy Case Study
- Advocacy Efforts
- Volunteer Leadership

**Criterion 13: Accessing Networks & Resources**
- Networking Case Study
MENTORING RELATIONSHIP–MENTEE

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Criterion 1–Knowledge: Lifespan & Conditions

Demonstrates acquisition of current knowledge of the effects of the interaction between lifespan issues and relevant conditions that impact occupational performance related to pediatrics.

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
   
   **Feb 1 - April 1, 20XX**

2. Approximately how many hours did this represent in total?
   
   **15**

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

   - A) Learn about logistics of a peer-based mentoring program to support increased social involvement for adolescents with an autism spectrum disorder.
   - B) Learn about effective factors to promote positive self-identity, occupational engagement and social participation for adolescents with autism.
   - C)

4. Mentor
   
   **Ms. Jane Doe**

   Position/Role of Mentor
   
   **Clinical Psychologist- oversees transitional services for adolescents with autism who are graduating from high school.**

   Workplace of Mentor
   
   **Director, Center for Autism**

   Contact Information for Mentor (email or phone number)
   
   **jdoe@email.com**

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

   The mentor wrote an article on a peer mentoring program consisting of university age students who volunteered to mentor adolescents with autism. I contacted the mentor to learn how she designed the format and content of a peer-based social group so that I could use this information to help me design a social group consisting of adolescents with and without autism.

   I selected the mentor since I have worked with adolescents with autism, either individually or on a consultative basis within the classroom, but not as part of a social group that includes peers without disabilities.
6. Briefly describe how the skills acquired from this mentoring activity influenced your service delivery with clients, specific to your ability to "demonstrate acquisition of current knowledge of the effects of the interaction between lifespan issues and relevant conditions that impact occupational performance related to pediatrics." (average word guideline–350)

Through my mentoring experience, I learned some of the barriers that my mentor experienced when garnering support for her peer-mentoring group, such as financial impact and attitudinal barriers. I worked to minimize these barriers by examining the perceptions of administration regarding a peer-based social group, and shared with key personnel evidence-based research regarding the benefits of a social group.

With the knowledge I gained from my mentor, I worked with administration and teachers to discuss the benefits of a peer-based social group to promote relationship-building, positive self-identity, and increased social participation of adolescents with and without autism. I reflected on additional ways to design a group with a balance of structure and spontaneity to promote the natural flow of conversation and relationship building. I re-examined how common interests and joint engagement in meaningful occupation can provide a foundation for the development of friendships and foster social participation.

As a result of this mentoring relationship, I collaborated with the speech therapist to develop a social group entitled “book of the month club.” This group consists of adolescents with autism and peer mentors who are high school seniors interested in healthcare careers. The group promotes socialization among peers who have a common interest in reading.

This mentoring relationship influenced my practice in that I now examine additional opportunities to work with adolescents with disabilities in a group format with non-disabled peers rather than in a 1:1 setting in order to promote inclusion and increased social participation.
Criterion 3 – Knowledge: Intervention

Demonstrates acquisition of current knowledge of relevant evidence specific to intervention in pediatrics.

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.*
- [x] 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.

<table>
<thead>
<tr>
<th>Activity Title</th>
<th>Clinical Reasoning in Evaluation and Intervention with Sensory Processing Issues</th>
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<tbody>
<tr>
<td>Provider/Instructor</td>
<td>John and Jane Doe</td>
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<tr>
<td>Activity Date(s)</td>
<td>June 5-10</td>
</tr>
<tr>
<td>No. of Contact Hours</td>
<td>2.85 CEU</td>
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</tbody>
</table>


| A) Expand clinical knowledge related to SPD evaluation and treatment. |
| B) Learn about new assessment measures for SPD.                       |
| C) Write better evaluation reports using quantitative and qualitative data. |
| D) Enhance goal writing through the development of functional sensory related goals. |
| E) Learn the key principles of Ayer’s Sensory Integration Intervention. |
3. Describe the relevance of the activity to your practice in pediatrics. *(average word guideline – 200)*

| This week long continuing education course directly relates to pediatrics board certification since it focuses on interventions commonly used by pediatric therapists in multiple settings as well as the primary population of children with sensory processing disorders or co-morbid sensory processing disorders. Furthermore, it intertwined intervention, evaluation, best practice, and best evidence as it relates to the treatment of individuals with sensory processing disorders. |

| It is important to note that the topic corresponds with approximately 50% of my client caseload as an independent contractor within an outpatient rehabilitation clinic, school system and 0-3 program. I was able to apply the content across age ranges, settings and varying subtypes of sensory processing disorders. |

4. Describe how the knowledge acquired from this activity “demonstrates acquisition of current knowledge of relevant evidence specific to intervention in pediatrics.” How did the activity influence the way you practice, or how did it affect your client outcomes? *(average word guideline – 200)*

| There are several aspects of my clinical practice that were enhanced through my participation in this intensive mentorship course. First and foremost, the course validated several clinical hypotheses that I had been developing as I routinely provided services to children with sensory processing disorders. The course provided information about new tools, both standardized and non-standardized, to screen and evaluate sensory processing difficulty in a shorter amount of time and with limited resources. |

| I learned and have applied the process of generating Goal Attainment goals with a percentage of my clients at the outpatient rehabilitation clinic as a way of piloting the process. From an intervention standpoint, I was able to incorporate some of the evidence that was presented. Also, if the client’s family and the 3rd party payer were in agreement, I transitioned the client to episodic care plans that focused on intensive services with built-in therapeutic breaks. |

| As I designed and implemented client-centered intervention plans, I gained a greater understanding of the components for Ayers Sensory Integration Intervention. This helped me focus more on therapy session goals and to follow the clients’ lead while still framing/shaping activities that were therapeutic and geared towards these goals. |

| With some clients and their families, I believe I saw increased functional outcomes through the use of the intervention strategies and the use of more sensitive goals and outcome measures. By using videotaped footage of assessment procedures with the child and/or early therapy sessions that occurred in the plan of care, and then comparing it with footage at the end of an episode of care, I was able to show the family qualitative changes in their child that were harder to measure on standardized tests and screeners. |

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

For this example, a verification is not included but should accompany this activity if submitted.
**INDEPENDENT LEARNING**

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**Criterion 3—Knowledge: Intervention**

Demonstrates acquisition of current knowledge of relevant evidence specific to *intervention* in pediatrics.

**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 pediatrics.
- ☑ 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 Toolkit](#) (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.**


- **Dennis, J. L., & Swinth, Y. (2001).** Pencil grasp and children’s handwriting legibility during different-length writing tasks. *American Journal of Occupational Therapy, 55*, 175–183. [http://dx.doi.org/10.5014/ajot.55.2.175](http://dx.doi.org/10.5014/ajot.55.2.175)


3. Date(s) of independent learning

<table>
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<tr>
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<tr>
<td>November 19th, 20XX</td>
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</tbody>
</table>

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.

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

While working in a pediatric outpatient rehabilitation setting and providing services to children (with and without significant motor impairments) who were referred to OT due to poor handwriting legibility, I had questions regarding what the literature had to say about clinical challenges I was observing in my clients. Specifically, I wanted to review what peer-reviewed research revealed regarding grasp pattern, posture and its impact upon functional handwriting performance (legibility and speed) in children.

The continuing education courses I participated in regarding handwriting remediation and curriculums spent little time presenting research that addressed my questions. If they did present information, it seemed too short of an overview but enough to support their claims. Therefore, I generated a “person-intervention-comparison-outcomes” (PICO) question: What is the current evidence regarding OT interventions’ impact on the grasp pattern, posture and handwriting legibility in children with and without significant motor impairments? I started searching the databases, and I had access to AJOT, Google Scholar, & Medline.

6. Describe how the knowledge acquired from this activity “demonstrates acquisition of current knowledge of relevant evidence specific to intervention in pediatrics.” How did the activity influence the way you practice, or how did it affect your client outcomes? *(average word guideline–200)*

There were 2 processes that I believe enhanced my knowledge regarding grasp pattern, posture, and handwriting performance in children.

First, learning how to generate a PICO question and using key terms to search the databases helped me see what evidence is available. This helped me feel comfortable with navigating and obtaining articles from electronic databases to support the development of my clinical reasoning.

Second, and most importantly, I took the literature content that I reviewed to look at the relationship between grasp and posture differently. Specifically, during service delivery there may be grasp patterns that I originally believed to be maladaptive to handwriting performance. Now I am more open with the grasp pattern that a child may have, how long they have used the pattern, and the actual impact the pattern has on writing performance during various writing tasks. I realized that I need to be more flexible in what a child has used to be successful when compared to what I ‘thought’ was the most appropriate grasp based on what I was taught in OT school, especially for clients with specific chronic motor challenges.

During my interventions I now spend more time with the child not only assessing the standard mechanisms of handwriting, but also problem solving with them to see why they hold the pencil in a certain way and why they sit in a particular position. I then gain feedback from the client regarding how any adjustment I make impacts their perception of performance. Furthermore, I have more current information to share with caregivers (parents, teachers, etc.) regarding what may be normal grasps, posture, etc. and how some children work around their motor impairments in order to become successful with writing tasks.
**Criterion 4 – Knowledge: Systems**

**Demonstrates acquisition of current knowledge of laws, regulations, payer sources, and service delivery systems relevant to pediatrics.**

**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.


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)*

   n/a – first author

3. Provide a reflection indicating why this publication was chosen to represent "acquisition of current knowledge of laws, regulations, payer sources, and service delivery systems relevant to pediatrics" and how it influenced your practice. *(average word guideline – 200)*

   I co-authored this publication to disseminate information regarding insurance company reimbursement implications for children with autism receiving outpatient OT services. For this publication, I reported on the results of a systematic review of the literature that examined outpatient insurance reimbursement practices for pediatric OT services. The results of the review showed that insurance reimbursement was denied less often for outpatient services for children with neurological disorders, such as cerebral palsy and spina bifida, in comparison to children with a diagnosis of autism. Further exploration suggested that insurance reimbursement for services for children who had impairments in body systems or structures, such as spasticity or limited range of motion, were less subject to denial than for children with sensory processing difficulties. In addition, insurance reimbursement was denied least often when documentation clearly described the impact of OT services on function in daily activities.

   As a clinic manager, the knowledge I gained while researching information for this article impacted my practice. I examined relationships among systems, such as the legal system (including laws and regulations); as well as financial systems (including insurance reimbursement). I examined factors that payer sources consider when reviewing OT documentation. Since some insurance reviewers are unsure of terms associated with sensory processing, I worked with our clinic team to examine our evaluation and documentation forms. The forms were changed so that a column entitled “impact on function in areas of occupation” was added next to the heading of “sensory–perceptual skills.” This change led to clearer documentation regarding the impact of OT services on function in occupation. In this way, clinic staff is more focused on clearly documenting the relationship between sensory processing and function in occupation.

   I also became more aware of the role that I can play in advocating for change through the political system. Since I learned that children with neuro-motor disorders (other than autism), have had better access to insurance coverage, I worked with advocacy groups to communicate with legislators regarding inequity for children with autism.
RESEARCH

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**Criterion 5–Evaluation: Uses Relevant Evidence**

Uses relevant evidence to establish an occupational profile with the client (person, organization, population) and assess the client’s occupational performance through a variety of measures, including standardized assessments, as appropriate.

What type of research was conducted? Please choose 1.

- **X** Scientific inquiry—Qualitative, quantitative, or mixed-methods approach.
- □ Methodological research/instrument development—Scientific inquiry to establish psychometric properties of (1) a new tool, (2) an existing tool with a new population, or (3) an existing tool translated to a new language.
- □ Systematic review of the literature—Comprehensive search, review, and analysis of the existing literature to answer a focused question.

1. Title of research conducted.
   
   Using Innovative Handwriting Readiness Programs in Pre-School Settings: Exploring the Programs and the Evidence.

2. Mechanism of dissemination:
   
   □ Publication
   
   - **X** Peer-reviewed presentation
   
   □ Grant funding
   
   □ Critically Appraised Topic (CAT, e.g., AOTA Evidence-Based Practice Project Web site)
   
   □ Dissertation/thesis

   Citation: *(average word guideline–25)*


3. Role of applicant in the research. *(average word guideline–25)*

   As the Principle Investigator, I designed the study, completed the IRB proposal, trained researchers on administering and scoring assessments, and supervised/assisted with data analysis.
4. Purpose and rationale of the research. (average word guideline–200)

The purpose of this study was to compare 2 developmentally appropriate, OT-developed handwriting programs (Handwriting Without Tears Get Set for School handwriting readiness program and Fine Motor and Early Writing Curriculum) for their effectiveness in improving fine motor and visual motor skills for pre-school students in a Head Start setting.

Prior research in the literature has addressed handwriting skills of children at various ages. Topics such as pencil grip, legibility, and speed have been addressed. However, little research evidence exists regarding the use of structured handwriting programs to improve handwriting skills of children. Moreover, research indicates that children from low income families are at risk for fine motor delays upon entering school. This evidence supports the need to explore methods to enhance handwriting skills of children prior to formal school years. I completed this study with 3 OT graduate students using learning centers as the means for program implementation.

In my study, there were 48 total students (n=15 control; n=16 experimental with Fine Motor and Early Writing; n=17 experimental with Handwriting Without Tears). The experimental classes participated in handwriting readiness programs during center time twice a week for approximately 35 sessions.

The research questions included: (1) Did students in either handwriting readiness program improve in handwriting readiness skills more than the control class on the Shore Handwriting Screen? (2) Did students in either handwriting readiness program improve in motor skills more than the control as demonstrated by change in scores on the BOT-2?

5. Describe how this research demonstrates your use of “relevant evidence to establish an occupational profile with the client (person, organization, population) and assess the client’s occupational performance through a variety of measures, including standardized assessments, as appropriate.” (average word guideline–400)

I knew from reviews of prior evidence and literature that handwriting readiness skills are a challenge for pre-school children. I determined from prior evidence, based on the occupational profile of Head Start students as a collective group, that, they were at risk for increased fine motor delays when they went into formal education. Prior work that I had done at the Head Start had shown that students using a developmentally appropriate program, such as Handwriting Without Tears, had positively impacted student performance.

As I designed the study, I reviewed the occupational performance of students with similar occupational profiles in prior studies I had been involved in. I looked at both standardized and non-standardized outcome measures that had been used. I selected appropriate measures to address handwriting readiness and motor skills that I felt were most viable for the research questions I was exploring. The occupational performance of the students was measured using two assessments; Shore Handwriting Screening and Bruininks-Oseretsky Test of Motor Proficiency – 2. The data was used to determine more of an occupational profile of each classroom in relation to fine motor, visual motor, and handwriting readiness skills. I learned a lot from conducting this study, including how the selection of assessment tools can make quite an impact on the data, which may or may not reflect the perceived benefits of the interventions.

This research was presented in short course and poster format at the 20XX AOTA Annual Conference.
Prioritizes needs related to the client, context, and performance by synthesizing and interpreting assessment data and clinical observations in pediatrics.

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

1. Dates of program development
   October 15 to May 15, 20XX

2. Briefly describe the program purpose, services offered, and clients served. (average word guideline – 250)
   **Name of Program**: Prevocational Club
   **Program Purpose**: Provide opportunities for special-needs high school students to explore and develop work skills, and to assist in transition planning as part of IEP.
   **Services Offered**: A school-sponsored club, run by an OT and vocational counselor that meets weekly for 2 hours during the third and fourth quarter of the school year.
   **Clients Served**: High school students with ASD, LD, or ADHD who qualify for OT services under IDEA.

3. Describe how this program development activity demonstrates how you “prioritize needs related to the client, context, and performance by synthesizing and interpreting assessment data and clinical observations in pediatrics.” (average word guideline – 500)
   High school students with ASD, LD, or ADHD often need to develop prevocational skills that can help them with their IEP transition plan (ITP). During IEP meetings, parents frequently express concerns regarding the vocational future of their children, and pre-vocational goals are often part of IEP transition plans (ITP). However, some students are not successful in meeting their ITP goals. Common issues were related to time management, appropriate job behaviors, self-presentation during job interviews, and social behaviors while on the job.

   As a result of these meetings, I identified a need to develop a program to address these issues. I developed a school-club called the “Prevocational Club.” I also partnered with the high school vocational counselor to identify the club’s activities.

   The main goal of the club is to assist high school students with an ITP to be successful in a vocational setting. Specific goals of the Prevocational Club program are to:
   1. Assist students in identifying vocational interests.
   2. Assist students in finding the “right match” for their skills in a vocational setting.
   3. Provide opportunities for students to practice appropriate social skills for a vocational setting.
   4. Provide opportunities for students to practice job time management skills.
   5. Provide opportunities for students to practice self-presentation as part of a job application and interview.
In order to ensure program consistency, I established the following procedures:

- Based on the potential jobs identified by the vocational counselor, I analyzed the cognitive, social, and physical requirements for each position.
- A list of assessments was established to determine client-fit for each job (assessments included the Bruininks-Oseretsky Test of Motor Proficiency-2 for the assessment of motor skills, the CAPE/PAC to assess activity interests and preferences, and the Behavior Assessment System for Children 2nd edition (BASC-2) to assess social-behavioral skills). These assessment results, combined with clinical observations, helped me to prioritize individual student needs.
- Based on how each student performed on the various assessments, I collaborated with the vocational counselor to present activities (e.g., role playing and task practice) to the students to help them explore their preferred area of job interest.
- Once their preferred job was identified and they were placed, I provided additional support and suggestions as necessary for workplace adaptations regarding behavioral management and work task organization.

Here is an example of how the group was implemented for one student:

A student with autism spectrum disorder (ASD) had limited verbal skills and became highly agitated in crowded situations. He was highly skilled in numbers and number sequencing, and enjoyed working on computers. This student was matched with a job at a local library where he was responsible for cataloging books, data entry, and making sure the books were correctly placed on the library shelves. Due to his limited verbal skills, limited social interaction, and his tendency to become agitated in crowded situations, I worked with the library supervisor to allow him to work during the hours when the library was less crowded or was closed to the public. To limit his anxiety regarding interactions with unfamiliar people, I recommended that only one employee supervise this student on a regular basis until he became familiar with the library and other employees. This enabled the student to gradually become more comfortable with the context and learn to successfully complete his daily job assignments.

The Prevocational Club is now in its second year with 3 students from the previous year and 2 additional students. The format for this club program has been copied for use in other high schools within this school district, and I have met with the OT and vocational counselor assigned to those high schools to assist with implementation.

The Prevocational Club is a good example of how I was able to develop a program based on the needs and priorities of individuals within the group and for establishing a format that can be replicated and used in similar settings.
CLIENT-BASED CASE STUDY

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Criterion 7–Intervention: Design & Implementation

Designs and implements pediatric interventions that are client-centered, contextually relevant, and evidence-based to facilitate optimal occupational engagement.

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.  October – December 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)

John is 11 years old and attends middle school. He was diagnosed in 2nd grade with Asperger's Syndrome (DSM-IV), anxiety, and was at risk for depression. John's parents are active in the local community and donate a great deal of their time to the area drama programs (sewing costumes, building sets, chaperoning, etc.); however, extra money for therapy is limited. John has developed a large and supportive social network through his drama community and shows stand-out talent. He ultimately hopes to attend college and study performance arts. While he can easily remember his lines, he is a disorganized student who has a hard time focusing on written work for more than 15 minutes. He has difficulty completing homework, with his grades suffering as a result.

He struggles to complete assignments in a timely manner; however, school-based OT was determined not to be warranted to support academic achievement. His teacher is concerned with John's organization of work and suggested that he cut back on his drama so that he can prioritize and attend to homework. John's family is very supportive of him pursuing his passion for drama, but they also appreciate the importance of developing habits that will support academic success. The family values the opportunity the drama community provides for John's social development, his increased capacity to develop and sustain friendships, and the improvement in his positive self-concept, which they feel to be protective against the risk of depression. As a student, John identified academic challenges related to his inability to anticipate teacher expectations and he felt frustrated that he couldn't balance his role of student with that of actor.

I completed an occupational profile and assessed a number of client factors, as recommended by the Occupational Therapy Practice Framework. Client factors of attention and memory were identified as areas of dysfunction. Performance skills related to praxis, cognition (sequencing, prioritizing steps and identifying solutions) and less than optimal performance patterns (habits and routines, role conflict) were identified as hindrances to occupational performance.
3. Articulate how this case demonstrates your ability to "design and implement pediatric interventions that are client-centered, contextually relevant, and evidence-based to facilitate optimal occupational engagement." (average word guideline–500)

I used the Model of Human Occupation to guide the intervention focusing on habits, routines and roles needed to optimize performance in multiple contexts. I used two elements identified by National Center on Secondary Education and Transition as predictors of student success: Self-determination (goals related to choice making, goal setting and planning, problem solving skills, development of self-esteem within one’s role of student and creation of a roadmap to mark short term identifiers working toward his longer term goals) and parent support (empowering parents to guide self-determination). I worked with the family to co-create contextually-relevant organizational systems in his home.

A home program was established to:
- Develop more useful habits for organizing school related materials;
- Balance commitments associated with his two primary roles, student and actor; and
- Identify and effectively use family resources.

The family and I worked collaboratively to develop a systematized approach to prioritizing steps embedded in an assignment (especially long term assignments) and establish routines and checklists to support John’s ability to identify materials needed before beginning a project. John and I created the sketch of a ‘road map’ toward stardom and he and his family embellished it as a way to visualize how short term goals (homework) will lead to long term success (school success and successful participation in his drama program). The parents and I collaborated to establish a homework station with all materials necessary (glue, scissors, sharpened pencils) and eliminate visual distractions. The family created a homework ‘box’ with all needed resources and John decorated it with images of favorite Hollywood memorabilia. John can pull this box out before he begins his homework. We began to use a student planner to establish the habit of writing his homework assignments down on a daily basis. His mother checks that he has accomplished this task and the family has created a system of rewards that John can earn when he is 100% accurate. John has identified a buddy in his class with whom he can check if he forgets to write down his homework, and this buddy’s phone number is written prominently across the front page of the academic planner.

Since low arousal appeared to impact attention to task and John needs to re-alert his system to make steady progress, a plan was established. He now takes a 1 minute movement/stretch break every 10 minutes to promote optimal attention, and he and his mother prepare a snack to have while he is working. I used sensory strategies to help John identify that mint gum, apples, and cold lemonade in a sports water bottle help contribute to optimal alertness. John has begun a home exercise program using a therapy ball to improve stamina and core strength.

John is now able to complete his homework in a timely manner and balance his role of student with that of aspiring actor.
MENTORING RELATIONSHIP–MENTEE

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Criterion 7–Intervention: Design & Implementation

Designs and implements pediatric interventions that are client-centered, contextually relevant, and evidence-based to facilitate optimal occupational engagement.

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
   **July 15, 20XX - December 12, 20XX**

2. Approximately how many hours did this represent in total?
   **Approximately 12 hours over 3 months.**

3. Applicant’s goals for mentoring relationship. **Goals must have been met by time of application.**
   List no more than 3.
   
   A) Develop sufficient skills to independently plan and lead social skills intervention following evidence-based protocol.

   B) Develop and implement a method for contextually-relevant (on the playground) assessment of social participation for child with ASD before and after therapeutic intervention.

   C)

4. Mentor
   Jane Doe, PhD, OTR/L, BCP

   Position/Role of Mentor
   Clinical Director

   Workplace of Mentor
   Anytown County School Office Special Education

   Contact Information for Mentor (email or phone number)
   jdoe@email.com

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

   The mentor is a researcher who has completed applied efficacy outcome studies. She has over 20 years’ experience in translating evidence-based social skills curriculum into clinical practice for individuals with autism spectrum disorders.

   I selected this mentor to learn how to create evidence-based programs that support the socialization of children ages 7-12 with autism spectrum disorders. I also wanted to create a way to evaluate evidence-based and clinically feasible outcomes of my interventions targeted toward optimizing social and occupational engagement for students with ASD.
6. Briefly describe how the skills acquired from this mentoring activity influenced your service delivery with clients, specific to your ability to "design and implement pediatric interventions that are client-centered, contextually relevant, and evidence-based to facilitate optimal occupational engagement." (average word guideline – 350)

Through this experience and observing in the PI’s research lab, I learned how to interface with school administrators, parents, and teachers to identify and recruit group members following pre-established eligibility criteria for research-based group intervention as distinct from clinical intervention. I now understand concerns related to informed consent, assent and fidelity of treatment protocols. I was able to select developmentally appropriate client-centered activities that met research fidelity that are simultaneously engaging and motivating for students.

Through my mentored experience, I learned different, realistic ways to assess social participation and social coherence using fidelity measures both in school settings and in real-world social contexts. This led me to re-examine the important performance skills of being a friend, the contextual relevance on social competency, and how one can feasibly incorporate these criteria in therapeutic group intervention.

This experience with my mentor strengthened my resolve to work with children with ASD, partner with researchers, and support students with ASD to develop a larger social network with typical peers in their classroom.

Related to this, my practice has changed and each of my social skills groups now includes pre- and post-data collection to measure treatment outcomes. To translate the findings that include typical peer models as one of the active ingredients in optimal social success, I advocated with school administration and parent groups to allow this design for my group interventions.

Finally, I have established relationships that enable me to partner with Principle Investigators in the future, furthering my continued interest and ability to participate in pragmatic research, and I look forward to producing a manuscript based on my experience to share my findings with my peers.
Criterion 8–Intervention: Wellness & Prevention

Provides pediatric intervention that incorporates wellness and prevention for clients (persons, organizations, populations) to optimize present and future occupational engagement.

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.

<table>
<thead>
<tr>
<th>Age of Client</th>
<th>14 year old transitioning from Middle to High School</th>
</tr>
</thead>
<tbody>
<tr>
<td>Client Diagnosis(es)</td>
<td>Myelomeningocele at S1-S2 (Spina Bifida); shunted hydrocephalus; obesity</td>
</tr>
<tr>
<td>Setting for Evaluation</td>
<td>Outpatient rehabilitation</td>
</tr>
<tr>
<td>Date of Video Recording</td>
<td>May 2, 20XX</td>
</tr>
</tbody>
</table>

2. Provide a brief summary of the video contents and how it demonstrates your ability to "provide pediatric intervention that incorporates wellness and prevention for clients (persons, organizations, populations) to optimize present and future occupational engagement." (average word guideline–200)

During the initial evaluation, I learned that “Darla” was ambulatory and independent for all ADLs 1 year ago. Over the last 12 months, she gained excessive weight, negatively impacting both her ADLs and mobility. She now uses forearm crutches for mobility. Throughout the initial evaluation, the mother frequently interrupted to answer questions posed to Darla, usually in a negative tone of voice. The occupational profile revealed notable differences between the mother and Darla’s perception of her current ADL status. Treatment goals focused on restoring the client’s ADL independence and integrating strategies to improve her overall health and wellness.

This video depicts our first intervention session. Darla was accompanied by her mother. I gave Darla 3 task options, and she chose to focus on her morning dressing routine. When I addressed Darla, the mother often interjected with her own response or comments, some of which were critical. Darla acknowledged her mother only 50% of the time. As I watched the video, Darla’s emotional reaction to her mother’s critical comments became quite apparent.

During the dressing intervention, there were at least 5 instances where the mother immediately negated an idea/solution to a dressing dilemma that Darla offered during the session. The mother never missed an opportunity to identify Darla’s weight and size as her biggest problem.

As we were wrapping up the session, I asked Darla what she typically ate for breakfast. She said that she used to make her own breakfast and pack her own lunch in the morning. Lately she has been grabbing a danish or muffin to eat in the car on the way to school, and buying lunch in the school cafeteria every day. I suggested that we focus on breakfast/lunch meal planning and preparation during a future visit. Darla was clearly excited about this idea: “Yes! I would love that!”

The mother immediately informed me that Darla’s access to the kitchen in their home has been restricted since she started using crutches again. She elaborated by describing the damage that crutches will do to her kitchen cabinets, and how dangerous it will be for her daughter to manage knives, pots on the stovetop, or retrieve hot dishes from the oven or microwave.
After reviewing this video, describe the insights you gained, and reflect on how the analysis experience validated or supported change in your intervention practice. (average word guideline – 400)

I chose to video-tape this session because the mother had indicated that time constraints and Darla’s risk for injury necessitated her close supervision and hands-on assistance during the morning dressing routine. I expected this video to: 1) help me assign initial time values to each component of the dressing process, and 2) enable me to review current function and the things we tried that day from another point of view that might lead to solutions that were not obvious during the session.

An unexpected benefit of reviewing this video was the ability to focus more closely on Darla’s reaction to her mother’s comments. I was aware of tension in their relationship, but I had not fully appreciated the pain, and perhaps embarrassment, reflected in Darla’s non-verbal reactions until I viewed the video. I heard Darla beg her mother to “stop saying that!” and eventually lash out in anger at something her mother said, but I did not appreciate the extent of Darla’s distress until I watched this video.

Recognizing that negative home dynamics were contributing to Darla’s loss of independence, I decided to arrange for individual sessions with Darla without her mother present. I wanted Darla to play an active role in identifying accommodations or procedural changes that might increase her independence in dressing and/or meal prep routines. I also hoped to incorporate activities designed to improve her overall health and wellness. Reflecting on the enthusiasm Darla exhibited during our discussion, I decided to shift the focus of our next sessions to meal planning and preparation.

I called the mother to request 3-4 sessions alone with Darla, in order to work on and practice a plan for safely navigating around the kitchen during meal preparation activities. The mother agreed that she would consider allowing Darla to work in their kitchen again when we demonstrated solutions to her concerns.

This example demonstrates my ability to adjust my intervention plans for this client because I quickly recognized and incorporated strategies to address the psycho-social factors that were impacting my client’s self-image and ADL independence. Darla wanted to do more for herself than she was currently being allowed to do, and it was clear to me that increased engagement/activity would result in health and wellness benefits.

Engaging in this self-analysis helped me realize that I need to pay closer attention to non-verbal communication during my therapy sessions. I was too focused on the activity and conversation to notice clear signals my client was sending.
**Criterion 9—Outcomes**

**Evaluates effectiveness of services delivered, either for caseload or programs, in order to validate service delivery and make changes as appropriate to maximize outcomes related to pediatrics.**

**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**
   - Child Crisis Center, Anytown, USA

2. **Date(s) of Consultation**
   - January 13 – April 25, 20XX

3. **No. of Hours Completed During Consultation**
   - 30 hours over 8 visits

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

   A) Complete a needs assessment with Child Crisis Center facility staff to identify areas of program development for young residents ages 4-13.

   B) Design a program based on the outcomes of the needs assessment

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

   **Children who are residents at the Child Crisis Center have been removed from their families because their home situation is not safe, and most of the children have experienced neglect and/or abuse. The Child Crisis Center provides family training and support in the hopes of returning school-age children (ages 4-13) back to their families, or the Center provides support in foster/adoption placement for those who cannot return to their homes.**

   The Center did not have the funding to employ an OT as part of their regular staff and asked for pro bono OT consultation to develop some type of program for their young residents.

   **Starting January 13, 20XX, I met with the educational director and pediatric nurse practitioner regarding specific children; however, the Crisis Center staff expressed other programming interests. From February to April, 20XX, I met twice a month with the educational director, behavioral health specialist and/or unit staff to complete a needs assessment to identify areas of program development for the young residents. The needs assessment was completed through interviews and focus group discussions with administration and unit staff. Outcomes from the needs assessment revealed that the children needed summer programming as well as additional opportunities to develop life skills in mealtime management, self-care, and appropriate behavior/social skills for success at school. The development of a life-skills summer day camp was initiated as a result of the needs assessment.**
This experience started as a pro bono OT service when the pediatric nurse practitioner at the Child Crisis Center requested consultation for a specific child resident with feeding and sensory issues. After the feeding issues were resolved for the child, the staff asked me to informally observe other children, and I recognized sensory-based behavioral issues and social development issues.

After discussing my observations with the staff, I realized they had other programming concerns and interests. Thus, the idea of completing a more formal needs assessment to collaborate on program development was initiated. The objective of the needs assessment was to identify areas where the young residents needed more programming support. Based on a needs assessment method from a text entitled, Community Psychology: Linking individuals and communities (Dalton, Elias, & Wandersman, 20XX), I held focus group discussions with unit staff and met individually with administration.

Several themes emerged from these discussions. The main themes from the needs assessment identified that the children needed structured summer programming and more opportunities for development of life-skills in self-care, social skills, and school readiness behaviors. I met with staff to report the outcomes and we agreed upon a summer day camp idea that would include activities promoting life-skills development. After the discussion, staff and I began to problem-solve how to implement this idea.

I was personally challenged to illustrate how OT services could enhance the current programming at the Child Crisis Center and how additional services for programming could be funded. The OT consultation service for the needs assessment that occurred between February and April, 20XX was pro bono, and funding for a summer camp was going to be a challenge. As an adjunct faculty for a local university OT program, I knew that fieldwork experiences, especially in mental health, were challenging to find. As a result of my consultation experience, I facilitated a community partnership between the Child Crisis Center and the local university OT program to help fund and staff the camp.

Through this experience, I developed an understanding of how to use a needs assessment to create community partnerships to support the needs of a particular population. The consultation experience resulted in the development of a summer day camp program in 20XX for the young residents that met the needs identified by the staff.

To document outcomes of the summer day camp, I developed and completed pre- and post-camp assessments through the use of the Short Child Occupational Performance Evaluation (SCOPE) and the Pediatric Volitional Questionnaire (PVQ). Twenty-four children between the ages of 5 and 11 participated in the camp. All children demonstrated improvements in behavioral self-regulation, task engagement, and social skills as identified by categories of the SCOPE and the PVQ. There are plans to continue the camp for the next summer. In addition, OT students that completed their Level 1 fieldwork experience at the Crisis Center summer day camp learned the value of community service and participated in fund-raising efforts for programming at the Child Crisis Center.

**Criterion 9—Outcomes**

Evaluates effectiveness of services delivered, either for caseload or programs, in order to validate service delivery and make changes as appropriate to maximize outcomes related to pediatrics.

**Guidelines**

- Refers to an activity implemented in a program, department, facility, or organization.
- 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. **Type of Program/Service Being Evaluated**

<table>
<thead>
<tr>
<th>Date(s) of Evaluation</th>
<th>Outpatient Feeding Therapy group meeting once a week for 12 weeks focused on increasing food acceptance for “picky” eaters, or children with extremely rigid food preferences.</th>
</tr>
</thead>
</table>

2. Describe the caseload or program being evaluated. The context should be adequately communicated so that relevance and merit to the criterion is easily determined. *(average word guideline—300)*

   This was an outpatient group with sessions 1.5 hours in length. It followed the Sequential-Oral-Sensory (SOS) approach, wherein the steps to eating a new food are arranged in a hierarchy – from tolerating being in the same room with food (step 1) to chewing and swallowing food independently (step 32). Children move up the Steps to Eating hierarchy through the use of systematic desensitization, and the experience of playing and interacting with food. Social modeling and positive reinforcement are the main teaching strategies utilized in this approach (Toomey & Ross, 2011). Four families participated in the initial program, and two families attended 10 of 12 sessions. All parents completed pre and post questionnaires. These, along with parent report, were used to make changes to the group moving forward.

3. Identify methods or tools used for the program/service evaluation. *(average word guideline—200)*

   - Pre and post questionnaire from parents at the beginning and end of the 12 weeks.
   - Therapist documentation indicating interaction with food items presented during each session using the 32-step sequence defined by the SOS protocol.
   - Data sheets completed by caregivers at home indicating when non-preferred foods were presented and the results of the presentation.
4. Summarize evaluation findings. *(average word guideline–200)*

The feeding therapy group had two primary goals:

1. **Parents will make at least one recommended change in their home mealtime routine.** At the end of the 12 week feeding group, 50% of the families reported they sat down to eat together more often. Seventy-five percent of these parents reported they offered non-preferred foods more frequently and routinely offered more food choices at mealtimes. All parents reported they were offering at least 3 to 4 food choices at mealtimes. This outcome was met.

2. **Children will eat a wider variety of foods, including more fruits and vegetables.** The pre-participation 3 day food diary provided the family with a nutritional analysis of their child’s current diet, and documented the homogeneity of the participants. The data sheets documented only the child’s interaction with foods offered during each therapy group, and with parent selected target foods at home. Our data gathering strategies did not allow us to draw any conclusions concerning whether or not the participants were accepting a greater variety of foods overall.

All parents anecdotally reported that after participating in the feeding group, their children were more engaged in meal preparation activities at home (i.e. sets table, selects and handles a wider variety of food items) and were less frustrated by the “advice” received from family and friends about their eating behaviors.

We need to refine our pre and post-participation data gathering strategies in order to capture more of the qualitative and quantitative changes we observe and that parents report about the participant’s mealtime/eating behaviors. We continue to struggle with the challenge of getting parental “buy-in” (follow-through at home).

5. What actions were taken in response to the findings? *(average word guideline–300)*

With the treatment team, I analyzed the content and structure of our pre and post-participation questionnaire and made changes to elicit the information and insight we needed to evaluate outcomes more specifically.

Moving forward, we plan to ask parents to complete a 3 day food diary during the week prior to our last group session so that we can specifically compare pre and post participation food variety.

All parents reported experiencing stress at mealtime on their pre-participation survey, but this was a subjective self-report. Based on this feedback, I began exploring the literature and learned that high levels of negative emotion in parents were associated with childhood eating problems. We determined the need to obtain a valid measure of parent stress both before and after feeding therapy group participation. The **Parenting Stress Index- Short Form** is an example of a tool being considered.

We also considered adding a homework requirement asking families to video record a meal experience at home to be analyzed by the team during a session, or offering a home visit during a mealtime at the 6 (of 12) week point. It is extremely challenging to find non-threatening ways to help parents make meaningful changes to (or create) a family mealtime routine.

We discussed the possibility that a more intensive, shorter duration protocol (meeting twice a week for 6 weeks) might improve our outcomes.
6. Summarize how this program evaluation demonstrates your ability to "evaluate effectiveness of services delivered, either for caseload or programs, in order to validate service delivery and make changes as appropriate to maximize outcomes related to pediatrics." (average word guideline–300)

Program evaluation is ongoing in the example I offer. We ran 5 different feeding therapy group sessions over the last 4 years. Our data gathering strategies improved each time based on prior lessons learned (i.e. a pre/post participation questionnaire). Similarly, our parent instruction protocol, homework planning, and food selection were modified to capture what parents were reporting anecdotally.

My critical analysis of outcomes after each 12 week session, along with changes we implemented to date plus changes planned for the future, demonstrate my ability to evaluate the effectiveness of the feeding program and foster improved outcomes for our pediatric clients.
HOLISTIC PRACTICE CASE STUDY

Criterion 10—Holistic Practice

Holistically addresses the client’s needs, including physical, social, and emotional well-being, that may impede occupational performance.

1. Identify the primary reason for referral:
   - X Physical
   - ☐ Social
   - ☐ Emotional

2. Date(s) case study represents. October 20XX

3. Describe the client, client factors, and case contexts for the identified case. (average word guideline–300)

A 13 year-old girl was referred for OT services during an acute hospital admission following a 2-week drug induced coma during a battle with meningitis. She was referred for OT once consciousness was regained to address ADLs and mobility.

During the initial evaluation she was opening her eyes, had limited purposeful movement, but was not following directions. She had been weaned from the ventilator but would not respond verbally or engage in any occupation. Taking a holistic approach, I began looking at psychosocial components that may be influenced by social and emotional concerns. I questioned whether cognitive deficits might be playing a role in her lack of engagement. Limited information was known concerning her occupational profile prior to the onset of meningitis. Initial treatment goals were set for basic physical skills such as bed mobility, transfers, simple grooming, and feeding tasks. Due to her limited demonstration of following directions, treatment goals were added that focused on following directions, sequencing activities, and making needs known to caregivers.

4. Describe the other client needs (physical, social, emotional) you identified over the course of service delivery and how you addressed these needs. (average word guideline–100)

During the first 2 intervention attempts, the client was awake and alert but did not participate much with me. However, nursing was reporting minimal participation with her feeding, bathing, and toileting skills, which was an improvement from her initial state. During a Saturday intervention session, the client’s mother was present. I noticed that when the mother was present, the client’s demeanor improved and she participated more in therapy. The mother explained that she is a single parent who has to work during the day, and that is why she was unable to be present during prior weekday therapy sessions. I interviewed the mother to investigate further the social and emotional profile to see if that would shed some light on this case.

I learned that the client had been very active in many social activities such as church youth group, dance, and soccer. The mother indicated that these activities were very important to the client. Upon hearing this, I decided that emotionally, depression may be a factor limiting the client’s participation. I wanted to see if there was a way to tap into meaningful occupations of the client from the social perspective for improving her participation and ultimately her recovery. Since the client’s social network was such an important part of her daily functioning and meaningful occupations, it would appear that she had become depressed due to the illness she had just endured, along with the lack of any meaningful social contact for nearly 3 weeks.
The answers to parts 2 and 3 above began to uncover the holistic practice involved in this case. As the treatment moved from focusing on physical deficits, I also incorporated emotional and social elements. I noticed the emotional connection the client had with her mother when she was present during treatment, and I used that to my advantage. Since their connection was so strong, we discussed the mother’s desire to be present for OT sessions. She wanted to be involved, and her employer was flexible with her schedule to allow her to be present 3 afternoons a week. I coordinated therapy sessions with the mother that fit into her schedule.

As I continued to think holistically, I thought including some of her friends that she had not seen for a long time might help her both emotionally and socially in her recovery. I spoke with the client and her mother to see if the mother would be willing to contact a few of her daughter’s friends from the youth group and invite them to participate in a therapy session with the client. Another step I took to address the social needs of the client was to ask the mother to bring in the client’s cell phone so that we could work on communicating with her friends using her fine motor skills or her voice with the phone.

In addition, I switched my schedule for one week day to come in an hour later and stay an hour later so that the client’s friends could come and have a “dinner date” with her. During this session, I worked with the client on the physical need of feeding skills while she was able to sit at a cafeteria table and interact with her friends. I noticed improved eye contact, as well as postural control and motor skills to engage in the activity while her friends were present that enhanced her emotional self and her demeanor. Towards the end of the session, the mother came after work and had tears in her eyes watching her daughter interact with her peers. She said she could see the sparkle return to her daughter’s eyes again, and she knew they were on the road to recovery.

The client continued to progress over the next several visits and was ultimately transferred to the inpatient rehabilitation unit for more intensive therapy. I collaborated with the rehabilitation team on this unit regarding the treatment and progress that had occurred so far. This collaboration resulted in continued efforts to address not only the physical but the social and emotional needs of the client by including her friends in daily activities when possible.
Criterion 11—Ethical Practice: Fiscal & Regulatory

Identifies ethical implications associated with practice in physical rehabilitation and applies ethical reasoning 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 #4

Scenario #5
A new edition of a commonly used standardized assessment is released with new normative data, updated procedures, and has better reliability and validity than the former edition. This updated assessment has been purchased by the facility. The OT has been asked to use the new edition, but continues to use the former edition because the OT is more familiar with it.

Scenario #6

1. To which scenario are you responding? 5
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
☐ 2. Nonmaleficence
☐ 3. Autonomy, Confidentiality
☑ 4. Social Justice
☐ 5. Procedural Justice
☐ 6. Veracity
☐ 7. Fidelity
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 therapist has an ethical obligation to be proficient in the administration of the updated edition of the test, and use the most current scoring tables when reporting results.

AOTA Code of Ethics and Standards (2010) Principle 1: **Beneficence** states that OT personnel shall:

D. Avoid the inappropriate use of outdated or obsolete tests/assessments or data obtained from such test in making intervention decisions or recommendations.  
G. Take responsible steps (e.g., continuing education, training) and use careful judgment to ensure their own competence.

Principal 5: **Procedural Justice** states that we have a professional obligation to:

F. Take responsibility for maintaining high standards and continuing competence in practice, by participating in professional development and educational activities to improve and update knowledge and skills.

Principal 4: **Social Justice** addresses the importance of limiting the impact of social inequality on health outcomes.

F. Provide services that reflect an understanding of how occupational therapy service delivery can be affected by factors such as economic status, age, ethnicity, race, geography, disability, culture, and political affiliation.

The reliability and validity of any test will depend, in part, on the characteristics of the normative sample participating in the standardization process. The second edition of a test will incorporate better representation (e.g., geographical, age/gender, numerical) from the diverse populations we serve. Some shift in the normative data will occur as broader demographics are incorporated. If this standardized tool is being used to determine a client’s need for therapy service, then the use of outdated norms might inappropriately deny service to some.

The therapist needs to learn the updated test administration and scoring procedures. She can engage in self-study, and practice the new procedures with colleagues or typically developing children until she feels competent. If support from colleagues is not available, the therapist should pursue a formal professional development activity or a mentor who can support this learning.
Advocacy Case Study

Criterion 12—Advocating for Change

Advances access to services or influences policies or programs that promote the health and occupational engagement of clients (persons, organizations, populations) in the pediatrics practice area.

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. Date(s) case study represents.  
   February – September, 20XX

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

   The client was an organization, ABC Autism Society in XYZ region of the state, whose mission is to support families of children with an autism spectrum disorder by providing “advocacy, support, and education.” This agency offers workshops for families of children who are newly diagnosed with autism.

   The workshops provide information regarding therapy services, including OT, that are available to children with autism; however, the educational materials used by the client during workshop sessions stated that parents should proceed with caution when considering certain therapy services, including OT. The organization’s view was that OT services had not been found to be effective for children with autism.

   Thus, the need for change was to educate the organization regarding the beneficial impact that OT services can provide for children with autism. The assumption was that education was needed for the agency to remove the “cautionary” consideration regarding OT services.

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

   Members of the state OT association contacted me for my opinion on how best to proceed in educating the ABC Autism Society regarding the impact that OT can have on children with autism. I shared information on recently published evidence-based research regarding OT outcomes for children with autism. I also recommended contacting several parent advocates who have a history of considering the merits of OT services for children from a consumer perspective.

   As a result of my initial suggestions, I was asked to join a task force to assemble resources needed to educate key leaders of ABC Autism Society. As a member of the task force, I networked with therapists from other states to learn how they positively affected change when faced with similar issues. I engaged in a series of meetings with parent advocates, legal advisors, and other individuals to collaborate and assemble necessary resources. Finally, I met with the leaders of ABC Autism Society to present information and encouraged them to reconsider the “caution” regarding OT services for children with autism.
4. Describe the change outcomes or progress toward change as a result of your efforts. *(average word guideline—200)*

As a result of my efforts and the efforts of others on the task force, ABC Autism Society reconsidered and revised the educational materials used during workshop sessions for parents of children with autism. The society removed all negative connotations regarding OT services from their educational materials. Although progress was made, the society notes that they are continually revising their materials as new information becomes available. This will require ongoing efforts to keep abreast of information the society is sharing with parents regarding OT services.

5. Articulate how this case demonstrates your ability to "advance access to services or influences policies or programs that promote the health and occupational engagement of clients (persons, organizations, populations) in the pediatrics practice area." *(average word guideline—500)*

This case demonstrates my ability to advance access to OT services by influencing the educational policies of the ABC Autism Society. Prior to my involvement with the task force, cautionary information regarding OT services was disseminated by the ABC Autism Society. Through contacts that I made while on the task force, I learned that this cautionary information was confusing to parents of children that were newly diagnosed with autism. This led some parents to refrain from or delay pursuing OT services.

My involvement with the task force led to the removal of the "cautionary" statement regarding OT services. Thus, families that attend educational workshops provided by the society will not be exposed to the cautionary statement regarding OT services. Although the impact of removal of the statement is too early to determine, the hope is that families who attend the workshops will not hesitate in pursuing the potential benefit of OT services for their child. Current research, including information stated in the American Occupational Therapy Association’s *Practice Guidelines for Children and Adolescents with Autism* (AOTA, 2009), indicates that one of the key factors associated with positive outcomes in children with autism is early intervention. My work on the task force may have led parents that attend these workshops to pursue OT intervention earlier than they may have if they were exposed to the “cautionary” statement. Thus, my actions may have led to earlier access to services to promote the health and occupational engagement of children with autism.
Advocacy Efforts

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**Criterion 12—Advocating for Change**

**Advances access to services or influences policies or programs that promote the health and occupational engagement of clients (persons, organizations, populations) in the pediatrics practice area.**

**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**
--- | --- | --- | ---
1. Present about OT services to parents at autism support group | Parents of children with ASD and service providers | March 5, 20XX | 5 – Includes preparation & presentation
2. OT resource booths at local fundraising and resource events | Stakeholders, parents of children with ASD, related service personnel, community members | April 27, 20XX and May 10, 20XX | 7 – Includes preparation of materials and presentation

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

A) **To advocate for OT services for children on the autism spectrum despite service funding cuts and empowering parents to express their concerns to legislators and local stakeholders.**

B) **Identify access to services and problem-solve with parent support groups on how OT needs can be met in our community.**

C) **Through the presentation, offer resources and answer questions on the sensory processing needs of children both on the autism spectrum and with ASD and how to obtain services.**
3. Discuss the results, outcomes, or progress toward change affected by this advocacy effort that demonstrates how you “advance access to services or influences policies or programs that promote the health and occupational engagement of clients (persons, organizations, populations) in the pediatrics practice area.” (average word guideline – 350)

I was asked to present to the local chapter of the Autism Society about OT services. I researched what was currently going on in legislation related to this diagnosis to look for a few “hot topics” and current events to present. I discovered that funding cuts had recently been made for children with autism and were impacting not only the assistance parents were receiving, but also impacting therapy services. I researched the names and contact information for the state legislators to contact regarding these recent cuts, and as part of my presentation I decided to educate parents on how to advocate for their children’s needs.

During the Autism Society meeting, I discussed with parents the current funding cuts and problem-solved with them on strategies for accessing services. One possibility we explored was a summer handwriting camp at the university where I worked, whereby the Society would pay minimal operating expenses for the children to attend and could also serve as a research project for the OT students to implement under my supervision.

I was informed of the upcoming annual Autism Walk and another autism resource fair. The walk also has a resource fair. I worked with my graduate OT students to develop a resource binder for parents that included local resources of interest as well as general information about OT services. I attended both resource fairs to answer questions and provide advocacy information to parents and general OT information to community members. Through these activities, I was able to advocate for OT services, provide information to interested individuals, and promote how to advocate for change through family members directly impacted by policy changes.
Criterion 12–Advocating for Change

Advances access to services or influences policies or programs that promote the health and occupational engagement of clients (persons, organizations, populations) in the pediatrics practice area.

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
   Parents Helping Parents

2. Dates of service
   One and a half years, from January 1, 20XX – July 1, 20XX

3. Approximate number of hours of service
   42 hours

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

5. Describe how this leadership activity helped you to "advances access to services or influences policies or programs that promote the health and occupational engagement of clients (persons, organizations, populations) in the pediatrics practice area." *(average word guideline-400)*

Parents Helping Parents (PHP), a non-profit organization that provides training and resources to parents of children with special needs, received a grant to establish an educational series on the importance of early intervention for at-risk children ages 0-5.

I had worked with this organization in the past as a trainer, and was asked to volunteer to create and deliver an educational program for stakeholder groups, including parents, early childcare workers, educators, administrators, special education paraprofessionals, and foster families. The goal of the program was to educate parents and caregivers concerning the important role they play in their children’s first years. I helped to identify topics, recommend presenters, and deliver content.

My content focused on providing participants with information on developmental milestones (sensorimotor and emotional), the neurology of sensory learning mechanisms, ways to embed play routines in daily living activities and experiential, hands-on play activities. I provided a guided learning experience related to affordable sensory-rich play and set up 7 stations: an oral motor/gustatory station (straws and whistles), a gross motor/proprioception station (bouncy balls, zoom ball), a fine motor/tactile station (gingerbread scented homemade play dough with cookie cutters), a visual motor station (homemade kaleidoscope), an auditory station (hidden bells and other items in boxes), vestibular/movement (hula hoops, bubbles to pop) and olfactory (scented cotton balls in mustard/ketchup bottles to squeeze and guess the scent). Each station had multiple items to explore and I was able to have enough volunteers to ‘man’ the stations, demonstrate occupational engagement with materials, and answer questions.

Through this volunteer effort I was able to ensure that decision-making stakeholders at the state level (e.g., policy makers, funders) would recognize the evidence and science-driven nature of OT and seek to include our services in its early intervention programs. I was able to demonstrate the role that OT has in promoting the health and occupational engagement of clients, ages 0-5.
Children with congenital muscle diseases supported by the Muscular Dystrophy Association (MDA) attend our Neuromuscular clinic 1-2 times per year from diagnosis to 19 years old. The clinic team includes a Pediatric Neurologist, RN, OT, PT, & MDA liaison. A 16-year old client with Nemaline Myopathy has attended clinic regularly since age 2, and lives in a small rural community 3 hours away from the clinic. This family is well prepared for clinic visits and has excellent follow-through. The client is a good student, enrolled in regular education classes, and just finished his sophomore year of HS. His IEP verification is OHI; OT is a related service. He has had 5 different school OT’s in 7 years, and each new OT has reported no prior experience with clients with MD.

This client can walk short distances independently, but uses a power scooter for mobility in the community and at school. His goal is to obtain a driver’s license so that he can pursue paid employment and social opportunities; however, the local driver’s education instructor does not feel qualified to teach him. His family is prepared to provide a vehicle with necessary modifications, but they don’t know where to go for a driver’s evaluation or training.

He also wants to go to college, live on campus, and study computers/technology. He will need some financial assistance to accomplish this goal, and has no idea where to begin looking for scholarships. Most of his cohorts plan to work on a farm with their parents. His parents are supportive of their son’s personal and educational goals, but neither has had experience planning for college and independent living. His annual IEP meeting was upcoming.

The identified problems were family education and skill development, access to driver evaluation and training, and college and independent living planning.

I provided the following for the family:

1. The family did not appear to be familiar with the IEP Transition plan mandate at age 16. In order to involve them as active team members, I gave them a Transition Planning Inventory as a resource and encouraged them to complete the inventory with the client to prepare for his upcoming IEP meeting. I also encouraged this young man to participate in his IEP meeting with his parents, which he had never done before.

2. I had an already established network from Vocational Rehabilitation (VR) and I provided
the family with written information describing the supports available through VR for post-high school education planning along with contact information for VR counselors in their district.

3. A web-link for the EducationQuest Foundation http://www.educationquest.org. This is a resource I became familiar with that provides information on financial assistance options and other information for persons with disabilities.

4. Information for the specialized driving evaluation program closest to their home, as well as the link to a pdf document on the State Department of Education/Transition web page entitled Driver’s Evaluation & Training for Students with Disabilities, that had been updated within the last 3 months.

5. Information for the Disability Services Coordinators at the colleges and university near his home town, as well as a link to http://ahead.org/ (Association on Higher Education and Disability). I also encouraged the family to begin making campus visits as early as next year.

With the family’s permission, I made telephone contact with his school-based OT.

7. Articulate how this case demonstrates your ability to "negotiate the service delivery system to establish networks and collaborate with team members, referral sources, or stakeholders to support clients’ occupational engagement.” (average word guideline–500)

This young man is experiencing a slow, progressive loss of motor function, but has the intellectual ability to pursue very ‘typical’ post high school educational goals given support for these motor issues. There was an upcoming IEP meeting was to address transition planning; however, the family did not seem to know that school personnel could help address any of these issues. I knew this young man was highly motivated to ‘blend in’ at school. He doesn’t ask for or use the accommodations available to him on his IEP, and he doesn’t like to talk about his disability. In addition, he never has the same school-based therapist long enough to develop the trust necessary for him to “risk” discussing his goals and personal concerns.

My role in this clinic is medical, but my understanding of school system services facilitated my discussion with this family. They were comfortable talking to me and knew that I had seen other teenagers with MD successfully navigate the path to college or post-HS employment. My verbal description of the agencies and personnel they needed to contact, coupled with written materials I provided, gave this family the support they needed to make those contacts. Clients seem to ‘give up’ quickly when left to figure out who to call and what to say on their own, so I have learned to communicate often with my community partners so that I can offer current information.

I did not want my follow-up phone call to pose a threat to the school OT, so I emphasized that my understanding of the needs and potential of individual’s with MD has developed over two decades. I shared a little about the range of outcomes I have seen for students with MD, and offered some web-based resources while also describing what I knew about VR services, driving evaluations, etc. I offered my contact information for any follow-up questions she or any educational team members might have. This therapist has contacted me several times via e-mail since that conversation.

I initially contacted the Driver Rehabilitation Specialists in our state to learn about their referral and evaluation process, and payment options. I wanted to make sure that I wasn’t offering this resource to a (hopeful) client whose degree of physical and/or perceptual impairment was too significant to be a candidate for evaluation. If I have any concerns, I call these specialists prior to making a direct referral.

I have been on our state Transition Advisory Committee (TAC) for several years. I value this role because it puts me in direct contact with a variety of individuals working with transition age youth in our state, including the VR director, win ahead (our regional AHEAD group) liaisons, and transition coordinators from school districts across our state. TAC members share regular updates.
concerning available supports/services, special projects in process, and recent publications. My involvement with this committee provides me with a number of personal contacts that I can utilize (or offer, if appropriate) to support client’s occupational engagement, as illustrated in this case example.

This case demonstrates how I establish networks in the community and collaborate with team members, including family members, to negotiate the service delivery system to support each individual client’s unique needs for occupational engagement.