

Multi-Tiered Advocacy for Occupational Therapy in Schools ... 16

Project-based Learning for Students to Understand the OT Process ... 20

Evidence-Based Sensory Resource for New School-Based OTs ... 24



# Practice

April 2026

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## Editor's Note

# Fresh Ideas, Shared Purpose

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**F**or many, April is all about fresh ideas, new connections, and getting re-energized—and that makes it the perfect time to talk about the AOTA INSPIRE | 2026 Annual Conference & Expo in Anaheim, California, April 23 to 25.

Attending AOTA INSPIRE is a reminder that we're part of something bigger—a profession that's constantly changing and evolving. There is something for everyone at AOTA INSPIRE, including more than 3,000 sessions and events. And it's not too late to register to be a part of the largest gathering of occupational therapy practitioners and students in the world (<https://bit.ly/4ryZnO3>).

In this issue of *OT Practice*, you'll find articles with ideas you can use right away in your daily work. From innovative approaches to familiar challenges, I hope this issue feels both useful and encouraging.

Jennifer Lawson explains that individualized care is the heart of meaningful and effective pediatric therapy—that it's about listening deeply, creating goals that matter, honoring natural cycles of therapy and life, and advocating for children and families (p. 12).

Ellie Bute, Lisa Kittleson, and Hannah Oldenburg put forth that returning to everyday habits and routines can be difficult for burn survivors, and that social participation is a key occupation that occupational therapy can address throughout each phase of burn recovery (p. 29).

Sean Weir expresses that we must stand up for children with anxiety, as their potential should be nurtured rather than constrained by the projections of others (p. 27).

Enjoy this issue, and if you're heading to AOTA INSPIRE, I look forward to seeing you there!

All the best,



Lisa Gwaltney  
Editor, *OT Practice*  
[lgwaltney@aota.org](mailto:lgwaltney@aota.org)



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## IN MEMORIAM

### Paula Carey

After a brief illness, Paula D. Carey, OTD, OTR/L, age 73, passed away peacefully surrounded by love and care in November 2025. Paula began her occupational therapy career as an occupational therapy assistant (OTA) after earning an Applied Science Degree in Occupational Therapy from Herkimer County Community College (HCCC) in 1982.

Always interested in her personal and professional development, Paula earned a Bachelor of Science in Occupational Therapy from Utica College in 1984, a Master of Science in Adult Education from Syracuse University in 1990, and a Post-Professional Doctorate in Occupational Therapy from Chatham University in 2011. She also earned 60 hours of doctoral work in Cultural Foundations of Education in Disability Studies at Syracuse University. Throughout



her career, Paula remained fiercely proud of her OTA roots and was a staunch advocate for intraprofessional respect and collaboration.

As a practitioner, Paula provided direct services to people with developmental and intellectual disabilities and consultative services to skilled nursing facilities and community-based programs. She began her full-time academic career at Utica University with a primary focus on teaching theory and mental health practice in the fall of 1987 after teaching as an adjunct in the spring.

In 1992, Paula founded Utica's weekend graduate program in occupational therapy and remained its coordinator until her retirement. As an early designer of and advocate for this unique format, she remained a driving force and anchor for non-traditional students

throughout her teaching career. From 1999 to 2006, Paula assumed primary leadership for and stewardship of Utica's Occupational Therapy Department by serving as its Program Director. During her 32-year tenure at Utica University, Paula's teaching, service, and scholarship were firmly grounded in a commitment to student success.

Paula's dedication to supporting our profession's future practitioners was highly evident in her over 20 years of teaching exam preparation courses and tutoring aspiring occupational therapists and OTAs for their certification/licensure exam. After retiring from Utica University in 2019 as Associate Professor Emeritus, she remained actively involved in this role, gently and effectively guiding exam candidates towards attaining their goal to become licensed occupational therapy practitioners (OTPs).

Paula took great joy in knitting and in exploring her family's ancestry, passionately researching her parents' lineage. She deeply loved her family and her faithful canine companion Obi and found happiness in every moment she shared with them. She was predeceased by her beloved husband Charlie.

A devoted mother, educator, mentor, and friend, Paula moved through the world with intention and a desire to make a difference in the lives of others. Her legacy of compassion, integrity, and an unwavering dedication to teaching and learning will live on in the countless OTPs she taught, supported, and inspired. Paula has left an enduring mark on every person fortunate enough to work, learn, or play alongside her and will be deeply missed and forever remembered by all who had this privilege.

—Rita Fleming-Castaldy,  
PhD, OTR, FAOTA

### Mary Frances “Francie” Baxter

Francie Baxter, PhD, OT, FAOTA, passed away in late December 2025, surrounded by her family. Francie was a dedicated leader in occupational therapy, serving the American Occupational Therapy Association as



Speaker of the Representative Assembly (RA) and a Texas RA member, including service on the Executive Council. She was deeply involved in the Texas occupational therapy community through the Texas Occupational Therapy Asso-

ciation and the Texas Occupational Therapy Foundation and was a faculty member at Texas Woman's University for nearly 30 years. A neuroscientist, educator, and mentor, Francie was committed to advancing the integration of neuroscience, the arts, and occupation, encouraging learners to bridge science

and creativity in meaningful ways. Her mentorship resulted in numerous student presentations and scholarly works and influenced many student theses and dissertations. Her legacy lives on through the students and colleagues she inspired.

—Noralyn D. Pickens,  
PhD, OT, FAOTA, FNAP

## Annual Lead OTPT Summit

In January 2026, a total of 94 Louisiana school-based therapy professionals, including 59 occupational therapy practitioners, 33 physical therapy professionals, and 2 coordinators, gathered for the Annual Lead OTPT Summit, presented by Health in Education Alliance of Louisiana. Representatives from 39 of 64 parishes and multiple New Orleans area charter organizations participated in the statewide event.

The Summit fosters collaboration and provides essential updates on legislative changes, Medicaid claiming, and emerging topics that support the expanded utilization of occupational therapy in school systems.

The group sincerely appreciates Abe Saffer, MPM, Senior Legislative Representative at AOTA, for delivering an insightful update on federal education policy and current issues impacting school-based practice. Many participants also emphasized the importance of staying connected to national advocacy efforts through AOTA.

One attendee captured the spirit of the day, noting, “This was an absolutely amazing conference, so relevant to current school-based practice.”

### MEMBERSHIP MATTERS

#### Advocacy Action Center: Five Minutes, Real Impact

Advocacy doesn't require a trip to Capitol Hill. Through the Action Center, members receive timely alerts, prewritten messages, and background briefs tied to current policy issues affecting OTs and OTAs. You can personalize and send a message to your legislators in minutes—then get back to your day knowing you helped protect access to services and the profession's future (<https://www.voterveoice.net/AOTA/Home>).

### AOTA news & events

**Celebrate OT Month**—April 1 to 30, 2026—and honor our vital profession and the meaningful differences it makes in the lives of our clients (<https://bit.ly/4qmOKNo>).

The next **Representative Assembly meeting** will occur online April 15 from 6:00 pm to 10:00 pm ET. The RA meets once a year in the spring and is open for members to observe its proceedings with the exception of executive sessions. Registration is required (<https://bit.ly/4rEv20L>).

Don't miss the **AOTA INSPIRE | 2026 Annual Conference & Expo** in Anaheim, California, April 23–25, 2026. AOTA INSPIRE is the place to expand your knowledge about the latest updates on practice, professional issues, and trends (<https://bit.ly/4kiD6BI>).



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## PRACTICE IN ACTION

## Quality Member Spotlight—Kelly Sajdak

**Kelly Sajdak, OTD, MSOLA, OTR/L**, is the Outcome Achievement and Quality Manager at Advocate Health. She spoke to Jamar Haggans, MS, OTR/L, CPHQ, AOTA's Director of Quality, about her current position and how she became interested in quality.

**Jamar:** How did you become interested in health care quality?

**Kelly:** My interest in quality started early in my career as an occupational therapy practitioner (OTP). I was curious about the impact of the care I provided—knowing how much of a difference I was really making. That led me to think about ways to measure my own performance and effectiveness in meeting client needs.

As I moved into leadership roles, my focus expanded beyond individual client-level evaluation to programmatic evaluation. For example, if we implemented a new program or modality, I wanted to measure its impact on client outcomes and experience.

Over time, this curiosity turned into a passion. I wanted a clear understanding of how we were impacting clients' lives across all health care disciplines. A major turning point was when CMS [Centers for Medicare & Medicaid Services] introduced value-based purchasing models. That really connected everything—client outcomes, interdisciplinary collaboration, and continuous improvement. To me, that's exciting: understanding what works and making changes to provide the best care possible.

**Jamar:** What is your role in quality now?

**Kelly:** As the Outcome Achievement and Quality Manager for Advocate Health, my role is to partner with clinicians and leaders to evaluate the quality of services provided. I primarily support home health and hospice teams, but I also work with inpatient and outpatient rehab, inpatient rehab facilities, sleep services, home medical equipment, and our Advanced Care at Home programs.

My work focuses on ensuring accurate measurement and influencing improvements. Ultimately, it's about partnering with operational leaders and clinicians to exceed clinical outcomes and ensure clients have the best human experience possible.

**Jamar:** Your role spans multiple disciplines. How have you prepared to engage effectively across these areas?

**Kelly:** Great question. My background as an OT has been a huge asset. I also have a degree in organizational leadership and administration, but I always lead with my occupational therapy background because I'm proud of it—and it surprises people sometimes.

Occupational therapy skills prepare us well for these conversations. I apply the Occupational Therapy Practice Framework daily, just in a different way. My clients are the leaders I partner

with. I help them develop workflows, implement programs, and overcome barriers to improve quality and client experience. This is a unique application of occupational therapy skills—performance coaching, leadership development, and organizational change. Our profession equips us to think holistically, problem-solve, and promote success. Confidence is key: OTPs belong in these rooms and have the qualifications to influence quality and outcomes.

Networking and openness are also critical. Every discipline brings unique strengths and being curious and collaborative helps build trust and drive success.

**Jamar:** How can OTPs incorporate quality principles into their practice?

**Kelly:** Understand the regulations and measures that are used in your practice. That knowledge allows you to adjust and improve care effectively. Regulations change frequently, so staying informed is essential.

**Jamar:** What advice do you have for OTPs interested in health care quality?

**Kelly:** Start by building awareness at both state and national levels. Then, find a mentor and ask questions. Most organizations have quality-focused teams, and people in those roles are usually eager to share knowledge.

Mentorship provides a supportive learning environment. There are also certifications and credentials focused on quality if you want to grow professionally. And don't be afraid to say you're interested in quality. It's okay to pivot away from direct client care and use your skills differently to impact outcomes. Be bold and fearless about exploring this evolving area of practice.

**Jamar:** Is there anything else you would like to add?

**Kelly:** Yes—commit to being a lifelong member of AOTA and your state association. These organizations represent us nationally and locally, advocating for OT inclusion in outcomes, reimbursement, and policy. As OTPs, our voices are critical, and we need to keep them strong. Stay connected to advocacy resources. Follow proposed legislation, implementation dates, and rule changes. Once you have clarity, step up and advocate—attend hearings, participate in OT Day at the Capitol, and engage in conversations. Exposure can ignite your passion and help you make an impact.

We also need to promote awareness of our profession. It's not about arrogance—it's about ensuring that people know the value we bring. If we stay silent, we miss opportunities to advocate and make an impact. Quality, client experience, and outcomes are all connected—and occupational therapy plays a vital role in improving them.

# Expanding Occupational Therapy's Role in CMS's ACCESS and MAHA ELEVATE Models

**Kim Karr**  
**Heather Parsons**

The Centers for Medicare & Medicaid Services (CMS) recently introduced two new models of care that provide exciting opportunities for occupational therapy practitioners (OTPs) to demonstrate our unique value in functional well-being, behavior change, and chronic disease management. These initiatives, run through the Centers for Medicare and Medicaid Innovation (CMMI), reflect a potential shift toward whole person, prevention centered care. The Advancing Chronic Care with Effective, Scalable Solutions (ACCESS) model and the MAHA (Make America Healthy Again) ELEVATE (Enhancing Lifestyle and Evaluating Value-based Approaches Through Evidence) model both aim to improve health outcomes for individuals with chronic conditions while building new evidence to guide future Medicare reimbursement.

## **MAHA ELEVATE Model: Whole-Person, Prevention-Focused Care**

CMS's MAHA ELEVATE model is a first step in promoting whole-person care focused on lifestyle medicine interventions that are not currently covered by Medicare. CMS will invest approximately \$100 million over a 3-year period to support up to 30 cooperative agreements. The model emphasizes lifestyle-based approaches such as healthy eating, regular physical activity, restorative sleep, stress management, and social connection.

The overall goal of MAHA ELEVATE is to create an evidence base that shows the cost and quality impacts of non-pharmacologic, non-procedural interventions. This emphasis aligns closely with occupational therapy, as the model reinforces principles that are at the core of occupational therapy practice, such as helping individuals to adopt sustainable health behaviors and establish daily routines that support wellness. MAHA ELEVATE provides OTPs the opportunity to demonstrate their expertise in habit formation, environmental modification, and self-management to address lifestyle and impact health and social engagement.

MAHA ELEVATE is an exciting opportunity to show the effectiveness of occupational therapy in chronic disease management, and to develop evidence for these interventions that could lead to reimbursement under Medicare. Eligible applicants for the program include private practices, health systems, academic organizations, community-based groups, senior living communities, and state or local governments, with demonstrated experience regarding data collection. At press time the first Notice of Funding Opportunity was expected to be released in early 2026, but a second one will be released later in the year for funding in early 2027. Visit the CMS website to find the most current information on this opportunity (<https://bit.ly/4rdQnhj>).



MINISERIES / GETTY IMAGES

### Technology-Enabled Chronic Care: Opportunities in the ACCESS Model

The Advancing Chronic Care with Effective, Scalable Solutions (ACCESS) model is a new, voluntary, Medicare Part B payment initiative designed to use digital- and technology-enabled care to better support individuals with chronic conditions. The model seeks to bridge the gap between traditional fee-for-service systems and modern approaches by leveraging remote tools. These include telehealth platforms that connect patients to clinicians from home; wearable devices that track movement, sleep, heart rate, and blood sugar; and mobile apps that guide lifestyle changes.

ACCESS focuses on a wide range of chronic conditions such as hypertension, high cholesterol, obesity, diabetes, chronic kidney disease, heart disease, chronic musculoskeletal pain, and depression and anxiety. The model's integrated approach requires participating organizations to deliver care in person,

virtually, asynchronously, or through other technology-supported methods. They will receive Outcome-Aligned Payments (OAPs) tied to measurable improvements or validated patient-reported outcomes on pain. By integrating OTPs' expertise in functional, behavioral, and environmental factors that influence how individuals manage chronic conditions, ACCESS organizations can improve patient engagement, better support adherence to treatment plans, and help achieve CMS's performance thresholds for the program.

Participating organizations, which could include occupational therapy private practices with the infrastructure necessary to meet participation requirements, must be accepted into the model by CMS, be enrolled in Medicare Part B, and have a designated Medical Director overseeing care coordination. Beneficiaries can enroll in an ACCESS program directly, or through referral from their primary care providers. For more

information about participating in the ACCESS Model, visit the AOTA website (<https://bit.ly/46uFb7U>).

### A Strategic Moment for Occupational Therapy

Together, the MAHA ELEVATE and ACCESS models demonstrate a shift in thinking about health that we hope will be a powerful moment for occupational therapy. Both initiatives recognize that chronic disease management and prevention depend on behavior change and functional support—areas where occupational therapy excels. While participation is not the central message of these new models, they offer clear avenues for OTPs and organizations to play a larger role in shaping patient outcomes and contribute to emerging Medicare reimbursement policies. 🔄

**KIM KARR, OTR/L**, is AOTA's Coding and Payment Policy Manager.

**HEATHER PARSONS, MSOT**, is AOTA's Vice President of Federal Affairs.



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# Occupational Therapy in Medicare’s Expanded Home Health Value-Based Purchasing Program

Jennifer Bogenrief

**O**n December 2, 2025, the Centers for Medicare and Medicaid Services (CMS) published its CY 2026 Home Health (HH) Prospective Payment System (PPS) final rule, effective January 1, 2026. In addition to payment policy and other quality provisions, CMS added three new Outcome Assessment and Information Set (OASIS)–based function measures to the expanded HH Value-Based Purchasing (VBP) Program that will help highlight occupational therapy contributions to patient outcomes:

- Improvement in Bathing (based on OASIS Item M1830)
- Improvement in Upper Body Dressing (based on OASIS Item M1810)
- Improvement in Lower Body Dressing (based on OASIS Item 1820)

Before proposing the addition of the measures, CMS convened a technical expert panel (TEP) to provide input regarding the needs of HH populations, quality concerns, and measure concepts for the expanded HH VBP. We were fortunate that two AOTA members—Trudy Mallinson, PhD, OTR/L, FACRM, FAOTA; and Tracy Mroz, PHD, OTR/L, FAOTA—served on the TEP, which met in 2023 and 2024. TEP members discussed a concern that the Discharge Function Score measure looks at functional status at discharge but does not include the ability to bathe and dress, which are

critically important for HH patients. TEP members agreed that bathing and dressing measures would be valuable, and supported CMS moving ahead as quickly as possible to add them to the expanded HH VBP using the existing M-based items while GG-based measures are being developed. CMS proposed the measures for the HH VBP in the CY 2026 HH PPS proposed rule that was published on June 30, 2025.

AOTA strongly supported the inclusion of bathing, upper body dressing, and lower body dressing as key functional measures within the expanded HH VBP. We emphasized in our written comments that bathing and dressing are fundamental components of daily living and serve as critical indicators of a patient’s independence and overall well-being. We explained that improvements in bathing and dressing help reduce the risk of falls, lower the likelihood of hospital readmission, decrease reliance on caregiver support, and empower patients to regain confidence and control in their daily routines.

The new function measures are meant to complement the Discharge Function Score measure and provide a more holistic picture of patients’ functional status. CMS stated that these measures would not create additional burden to HH agencies, as the data for these measures is already collected on OASIS assessments and used in other CMS models and programs.

## Conclusion

OTPs should review instructions and training for the OASIS items that comprise the bathing and dressing measures to ensure accurate completion of the OASIS. Be vocal about your role in helping your agency achieve quality outcomes. This is a great opportunity for occupational therapy to shine in home health! 📢

---

JENNIFER BOGENRIEF, JD, is AOTA’s Director of Regulatory Affairs.

## Resources

- CMS CY 2026 HH PPS Final rule: <https://bit.ly/4ksAuRP>
- CMS HH PPS Final Rule Fact Sheet: 2024 Expanded HH VBP Model TEP Summary Report: <https://bit.ly/30zRh9B>
- 2023 Expanded HH VBP Model TEP Summary Report: <https://bit.ly/3M6exLQ>
- Expanded HH VBP Model Web-Based Training: <https://bit.ly/4rAppQU>
- Expanded Home Health Value-Based Purchasing Model | CMS <https://bit.ly/4rIme9R>

# Inclusive Campus Supports for Neurodiverse Learners in Higher Education

**Zoey Zameito**

**A**s a neurodivergent individual, I had to learn how to advocate for myself to access accommodations for my academic success. I received accommodations in elementary, middle, and high school based on my parents' and teachers' advocacy for my learning needs. Throughout K–12, I used my accommodations less as I got older, believing I had “grown out of them.” When I began college as an undergraduate, I did not disclose my diagnosis due to the overwhelming process and potential judgment from peers, which discouraged me from seeking necessary accommodations. When I began my doctorate program in occupational therapy, the expectations and demands grew, and I quickly realized I needed to receive accommodations to get the most out of my education. During my

3 years of graduate school, I deepened my understanding of neurodiversity, and the systemic barriers neurodiverse learners may face in higher education, including ableism and the social pressure to mask identity. I started to view my accommodations as support needs based on learning systems that are not designed for me, rather than viewing them as personal learning weaknesses. These experiences inspired me to focus my capstone on neurodiversity advocacy in higher education.

Due to an increase in identified neurodiverse learners in society, there is a need for universities to increase support for current and future learners with varying processing needs (Evans et al., 2023). According to Hamilton & Petty (2023), achieving a sense of belonging within higher education may be a challenge for neurodiverse individuals. Many individuals hesitate to disclose their neurodiverse identity due to fear of marginalization (Hamilton & Petty, 2023). Additionally, occupational therapy practitioners (OTPs) have an opportunity to advocate for the needs of neurodiverse learners. School-based therapists can help K–12 learners use self-advocacy skills by ensuring an understanding of their processing needs and helping learners advocate for changes in the classroom to better support them (Kornblau & Robertson, 2021). Advocacy in higher education means creating community between individuals experiencing a mismatch between their learning styles and their classroom requirements. In my experiences, I found that support groups are an effective way to feel connected. In safe spaces, learners in higher education challenge peers' ideas that their extra needs make them less valuable than others. Advocacy includes equipping educators with knowledge about the learning and interaction needs of neurodivergent learners. Additionally,



cultural competence encourages both seasoned faculty and pre-professionals to adopt inclusive changes that better support diverse learners. Collaboration with disability services in higher education can also help students identify available supports and promote the use of accommodations as part of their daily routine on campus.

From both a personal and professional perspective, I have come to realize there is an opportunity for OTPs to expand their influence in higher education for the neurodiverse population. OTPs can help identify environmental and social barriers, advocate for inclusive policies, and implement interventions that promote participation and wellness (Kornblau & Robertson, 2021). Creating environments where neurodiverse learners can access needed support with-

out judgment is necessary to enhance occupational success. Overall, OTPs collaborating with faculty, disability services offices, and other student services on campus can help create a community where neurodiverse learners can thrive in higher education. 📍

ZOEY ZAMEITO, OTD, is a recent graduate of Monmouth University's Occupational Therapy Doctorate program. As a neurodivergent learner, her experiences throughout her OTD program deepened her understanding of systemic barriers in higher education. She is passionate about promoting access, participation, and wellness for neurodivergent learners, especially within the higher educational context.

### References

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### About Perspectives That Matter in OT

This monthly column is managed and curated by AOTA's DEI/JAB committee. It provides a platform for occupational therapy clinicians, educators, and students to share personal insights, professional experiences, and reflections related to diversity, equity, inclusion, justice, accessibility, and belonging (DEI/JAB) within the profession. Please send submissions to [dei@aota.org](mailto:dei@aota.org).



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# Individualized Care

## *Children and Families at the Center*

by Jennifer Lawson

In pediatric therapy, no two children share the same journey. Each child's story is shaped by unique strengths, challenges, family routines, priorities, and home and community environments. That is why individualized care that adapts to the child and family is essential. With best practice concepts related to medical necessity, dosage, goal writing, and the unique therapy journey for children with chronic, lifelong, or progressive conditions in mind, let's explore how practitioners turn the concepts behind individualized care into action.

### **The Foundation: Participation Matters Most**

The International Classification of Functioning, Disability & Health (ICF) model (World Health Organization [WHO], 2001) reminds us that health is about so much more than body structures and functions, health conditions, and diagnoses. True health for children is reflected in their ability to participate, play, learn, communicate, and join in family and community routines. The "F-Words in Childhood Disability" framework adds to this philosophy, emphasizing Function, Family, Friends, Fun, Fitness, and Future as guiding principles (Rosenbaum & Gorter, 2012).

When practitioners anchor their work in participation, goals become more than a checklist of developmental skills or test items.

Instead, therapy becomes about meaningful activities such as helping a child dress themselves in the morning, joining siblings in play, or communicating needs at mealtimes. These participation-based outcomes highlight why therapy is not only medically necessary but also deeply personal for children and families (Anaby et al., 2021; Crespo et al., 2013; Family-Guided Routines Based Intervention (FGRBI) & Caregiver Coaching, 2020; Laverdure & Beisbier, 2021; WHO, 2001).

### **Listening First: Caregiver Perspectives Drive Care**

Individualized care means leading with child and caregiver priorities, routines, hopes, and dreams, rather than with a list of missing skills and deficit areas. How practitioners communicate with caregivers makes all the difference. Asking the right questions is key. Instead of "What do you want from therapy?," a question that is often too broad while simultaneously limiting, practitioners are encouraged to use more meaningful open-ended questions (Destination Imagination Washington, n.d.; Conversation Starters, n.d.), such as:

- What is one thing that would make the biggest difference in your day?
- What part of the day feels most challenging right now, and why?
- Tell me about a typical day for you and your child.



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Questions like these shift the focus from deficits and diagnoses to lived experience, where caregivers are the experts, emphasizing the importance of relationship and collaboration from the start. These types of questions help to uncover priorities that shape therapy plans with caregivers as equal partners, enhancing engagement and ensuring that intervention supports unique daily needs (Rush et al., 2008).

## Medical Necessity With a Meaningful Lens

Individualized care is also about clinical responsibility. Therapy services must be justified as medically necessary, especially when billed through Medicaid or insurance. The following four guiding questions offer a practical framework for determining medical necessity.

- **Disorder?** Does assessment data show a disorder of body structure, function, or participation?
- **Medical Need/Risk?** Does the disorder create risks such as safety hazards, caregiver burden, or loss of independence?
- **Skilled Intervention?** Can only a trained practitioner (not a caregiver or community resource) address the issue effectively?
- **Readiness?** Is this the right time for the child and family to benefit from therapy?

Using this process to support adherence to clinical standards and best practice allows practitioners to balance the needs of families with the requirements of health plans, while also keeping the child and family at the center.

## Goals That Reflect Real Life

As therapists work to apply SMART (specific, measurable, achievable, relevant, time-bound) goal criteria, Ferro & Quinn (2020) note that goals often end up “over-engineered” (too complex or detailed, jargon-heavy, difficult to measure). Goals may also feel abstract and disconnected from family priorities. Approaching goal development with the following three components in mind ensures goals meet SMART criteria and are also meaningful and effective:

- **WHY**—Participation-based outcome: Why does this goal matter?

How does it reduce risk or increase independence?

- **HOW**—Measurable, meaningful activity: What functional daily activity is important to measure (e.g., walk from the front door to the car, instead of walk 10 feet)?
- **WHAT**—Body structure/function deficit: What underlying skill deficits or environmental needs are creating barriers?

When goals are created with these concepts in mind, objective data and functional updates within visit notes and re-evaluations become clearer,

goals and priorities (Bailes et al., 2008; Cramm, 2011; Enderby, 2012; Novak, 2012; Yoder et al., 2012).

This individualized care approach helps to prevent practitioner burnout, honors family routines, and supports children in experiencing life outside of therapy. It also builds caregiver confidence with solid integration of home programming and community resources. Research shows that when parents are empowered with strategies, outcomes improve and they are sometimes as effective as practitioners when given proper guidance (Law, et al, 2010; Roberts & Kaiser, 2011).

**"This individualized care approach helps to prevent practitioner burnout, honors family routines, and supports children in experiencing life outside of therapy."**

demonstrating both medical necessity and meaningful change. Caregivers see their child's growth reflected in everyday life—not just in test scores—which is especially important for children with chronic, lifelong, or progressive conditions. Health plan reviewers also notice and appreciate the value occupational therapy brings to these clients.

## The Therapy Journey: A Cycle or Continuum, Rather Than a Straight Line

The individualized care process recognizes that therapy is not always continuous. For children with chronic, lifelong, or progressive conditions, the journey often cycles through different phases. Throughout that journey, there are times where evaluation of medical necessity results in periods of direct intervention, times when frequency is low or consultative, periods of home or community transition to allow for generalization, as well as time for potential identification of new child and family

## Dosage That Fits the Child

How much therapy is the right amount? The answer depends on the child, family, and goals. Medicaid and professional guidelines provide general ranges, but individualized care means dosage must be matched to readiness, priorities, and medical necessity. Sometimes that means frequent, intensive sessions; other times, a consultative model with check-ins and coaching is the best fit (Douglas et al., 2020; FGRBI & Caregiver Coaching, 2020; Graham et al., 2015; King et al., 2019, 2023; Lorio et al., 2020; Meadan et al., 2020; Rush & Sheldon, 2005, 2011; Seruya et al., 2022).

The key is flexibility, adjusting therapy dosage not only to clinical need but also to what fits at any given time for each child and their caregivers.

## Beyond Requirements: Telling the Story

Individualized care is strengthened through strong documentation. Well-written notes don't just fulfill



compliance requirements; they tell the story of why therapy matters. By connecting participation-based outcomes with measurable activities and medical necessity, documentation validates the child's unique journey and communicates value to families, health plans, primary care physicians, and other professionals.

### Collaboration and Purpose

Individualized care is the heart of meaningful and effective pediatric therapy. It is about listening deeply, creating goals that matter, honoring natural cycles of therapy and life, and advocating for children and families. Whether working with a toddler learning to eat safely, a school-aged child gaining independence in self-care, or a teen preparing for adulthood, individualized care ensures that therapy is not just treatment. Commitment to individualized care leads to partnership, empowerment, and a meaningful, unique journey for each child and family. 🌱

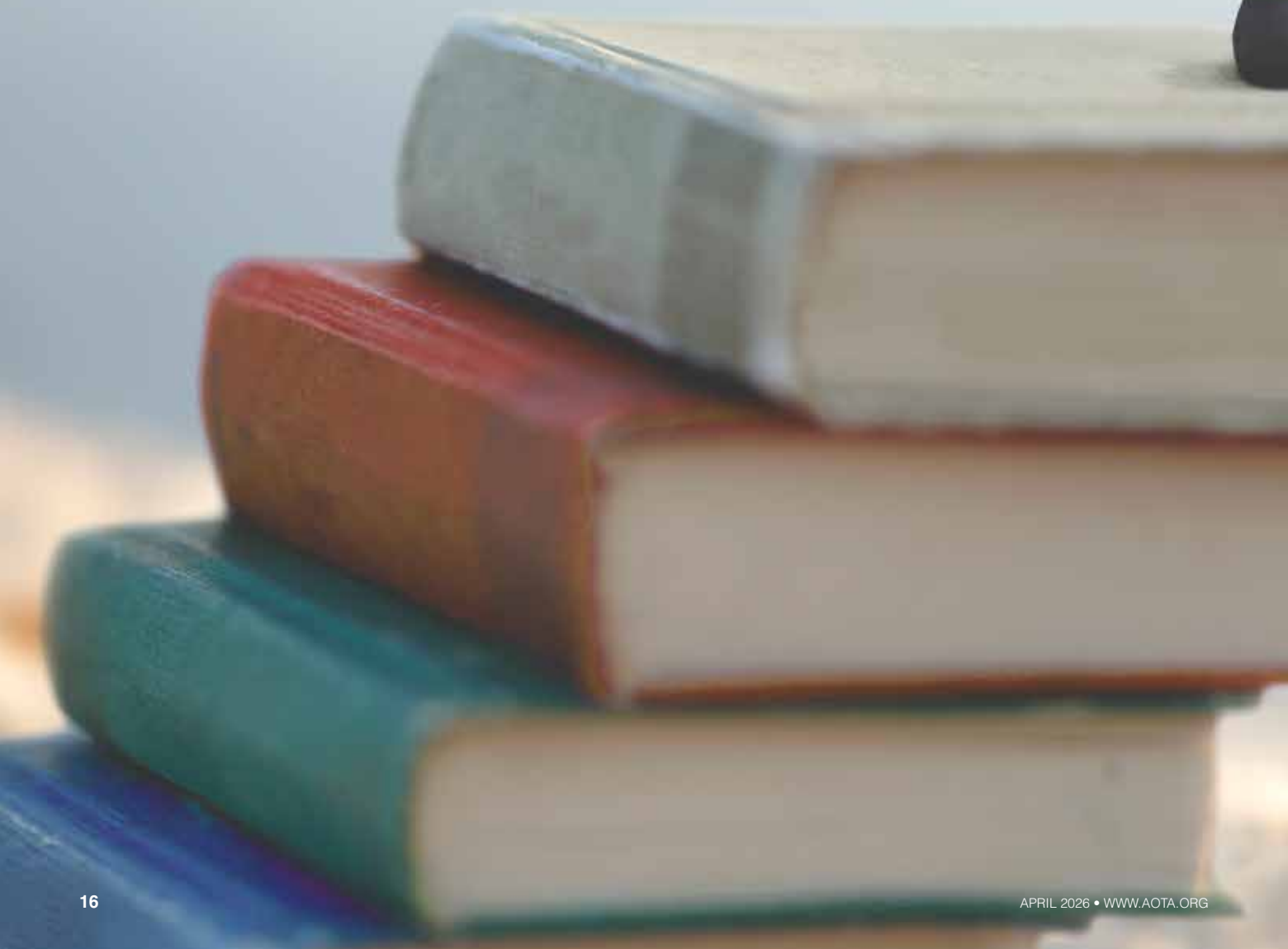
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# Multi-Tiered Advocacy for Occupational Therapy in Schools

by Rachel Kostelz and Joyce E. Rioux





Occupational therapy can transform students' ability to thrive in schools. Yet practitioners often report that the profession is misunderstood, narrowly applied, or constrained by systemic barriers. Practitioner frustration and student limitations stem from these challenges, commonly cited as

- limited understanding of occupational therapy's scope;
- referrals reduced to handwriting, fine motor, or sensory processing;
- misconceptions that services only apply under the Individuals with Disabilities Education Act IDEA of 2004 (IDEA);
- heavy caseloads that limit program development; and
- lack of leadership pathways.

Insights from Rachel Kostelz's capstone experience with AOTA's Federal Lobbyist, Abe Saffer, underscore the need for advocacy to promote the value of occupational therapy in schools.

### Everyday Advocacy

Advocacy starts in daily practice, where every interaction shapes how occupational therapy is understood and valued.

### Understanding Policy

Understanding the policies guiding our work empowers practitioners to advocate effectively. Without this knowledge, others

may interpret policies in ways that narrow our scope.

IDEA identifies occupational therapy as a related service to help students with disabilities access and benefit from their education. According to the U.S. Department of Education ([DOE], 2006), occupational therapy includes

- improving, developing, or restoring impaired functions;
- enhancing the ability to perform tasks for independent functioning; and
- preventing further impairment through early intervention.

In schools, *function* refers to a student's ability to participate in meaningful roles, interact with peers, and engage in learning experiences, not isolated skills (Laverdure & Seruya, 2024). The word *preventing* highlights the importance of proactive support that removes barriers before they disrupt learning, allowing practitioners to advocate for early interventions that benefit all students.

The Every Student Succeeds Act of 2015 builds on IDEA by recognizing occupational therapy practitioners as Specialized Instructional Support Personnel. Such recognition reinforces our role as partners in broader efforts to emphasize prevention, mental wellness, and barrier reduction. This designation also equips practitioners to advocate for inclusive programming, influence initiatives, and highlight their contributions to student engagement and achievement.

**Reflection:** *Do I fully understand the laws and policies that guide my work?*

### Participation-Focused Language

Participation-focused language highlights how occupational therapy supports student access, engagement, and inclusion by shifting attention from isolated skills to what students can do—learning, interacting, and joining activities (Frolek Clark & Polichino, 2021). This approach is key in multi-tiered systems of support, where practitioners contribute at individual, group, classroom, and school-wide levels (Lynch et al., 2023). Aligning our language with education's mission demonstrates how expertise in development, health, and occupation translates into strategies that drive student success.

Participation-focused language begins with everyday word choices in reports, meetings, and conversations. For example, saying a student has *handwriting difficulties* narrows our role to a single skill, while focusing on *written expression* emphasizes participation in meaningful occupations. Similarly, reframing *sensory needs* in terms of *social-emotional learning* and *inclusive environments* highlights how our services support student engagement and the conditions that enable it. The language we use shapes expectations, fosters belonging, and expands opportunities for all learners to participate fully.

**Reflection:** *Do my words frame student engagement and what makes engagement possible?*

## Occupation-Centered Practice

Occupational therapy adds distinct value in schools by supporting students' participation in meaningful routines and activities (Cahill & Beisbier, 2020). Sustaining this occupation-centered focus requires attention to personal, contextual, and occupational relevance (Jewell et al., 2022).

Building on these essentials, the Occupation-Centered Intervention Assessment (OCIA; Jewell et al., 2022), provides a reflective structure for analyzing and guiding interventions. Its effectiveness relies on occupation-based evaluations that capture authentic participation in school routines, ensuring interventions support meaningful engagement rather than isolated skills. For example, written communication services might consider:

- **Evaluation:** Combine occupation-based assessments with performance analysis during classroom writing and review of writing samples across a school day.
- **Professional Reflection:** Consider whether interventions preserve personal, contextual, and occupational relevance.
  - *Personal:* Ensure that writing supports a classroom project the student values.
  - *Contextual:* Embed strategies into classroom routines, like journal writing or project-based tasks.
  - *Occupational:* Maintain a focus on writing as functional communication rather than just mechanics.
- **Intervention Planning:** Prioritize support for written communication across classroom activities using tools, accommodations, or co-teaching to help students produce work and meet academic expectations.
- **Collaboration:** Partner with teachers, support staff, and families to embed strategies into routines, using shared language to show how adaptations, task modifications, and scaffolding support meaningful participation. Active collaboration helps shape classroom practices and school-wide approaches that foster inclusion and engagement in written communication.
- **Advocacy:** Promote system-wide practices, programs, and policies that support engagement for all

students in written communication and literacy.

**Reflection:** *Am I ensuring my practice stays occupation-centered?*

## Strategic Advocacy

Advocacy grows when practitioners influence programs, partnerships, and service models across school communities.

## Service Models

Service structures shape both perceptions of our role and our ability to meet student and school needs (American Occupational Therapy Association [AOTA], 2025). Many schools still use caseload models, basing staffing on student numbers and limiting proactive, system-level work.

Workload models recognize the full scope of occupational therapy, including direct services and indirect proactive, preventative work such as training, observations, environmental modifications, team participation, data collection, and systems-level initiatives (AOTA, 2025). Such services extend beyond individualized education programs (IEPs), advancing equity, building educator capacity, and fostering inclusive learning environments.

Workload-based staffing positions occupational therapy as essential to student success across all tiers of support. This model supports collaboration, Universal Design for Learning leadership, and early barrier reduction, reinforcing occupational therapy's value at individual and systemic levels.

**Reflection:** *How am I influencing decisions to align staffing with student needs and outcomes?*

## Responding to Societal Shifts

IDEA's 50th anniversary in 2025 marked a pivotal moment for occupational therapy advocacy. Before its enactment, students with disabilities were excluded or segregated (Sandoval Gomez & McKee, 2020). Today, access is not enough; students deserve meaningful participation and belonging. Occupational therapy, with its focus on function, environments, and participation, is well positioned to advocate for inclusive practices.

An Ohio district's prevention-and-wellness initiative, led by

occupational therapy practitioners (Pfirman et al., 2023), implemented an MTSS mental health model with universal Tier 1, 2, and 3 supports. Intervention hours spent were increased fivefold; students remained in school 85% of the time during behavior escalations, and 80% of screened students received timely care. This demonstrates how program-level advocacy expands access, participation, and student success.

When a district launched an initiative to create "think spaces" in classrooms, an occupational therapist saw an opportunity (Thomas, 2025). She advocated for joining the initiative, highlighting how to strengthen student engagement in designing and using the spaces. This ensured the spaces were meaningful opportunities to learn, not just places to go. By leading the co-creation process, setting up stations so students could trial self-awareness and regulation techniques, and integrating reflection into daily routines, she aligned the initiative with district goals and student needs. This strategic advocacy elevated occupational therapy's visibility, strengthened staff collaboration, and embedded practices that fostered emotional literacy, community, and purpose.

**Reflection:** *How am I partnering with the school community to influence programs and elevate occupational therapy's impact?*

## Systems Advocacy

Systems-level advocacy maximizes impact, empowering practitioners to influence policy, anticipate change, and keep participation and equity central.

## The Big Picture

The educational landscape is constantly evolving. State priorities shift with leadership changes, while federal guidance responds to emerging societal needs. Federal funds make up only 8% of school revenue, leaving most resources at the state and local levels (Saffer, 2025a). As funding tightens nationwide, schools may face difficult choices, yet this also creates opportunities for practitioners to elevate the value of their work. Staying alert to policy changes and aligning services with key priorities positions practitioners as essential voices in shaping education.

Continuous engagement means monitoring the educational environment, including:

- District mission statements, strategic plans, and performance reports (DOE, 2024)
- State and federal policy updates, bills, and budgets (National Center for Education Statistics, 2024; DOE, 2025)
- Societal trends in mental health, school safety, and inclusion
- National and state occupational therapy associations for early insights and advocacy support.

**Reflection:** *How am I staying informed about changes in education, funding, and policy priorities?*

### At the Policy Table

Occupational therapy must have a unified voice in policy discussions. Practitioners can offer solutions grounded in expertise and aligned with system goals; advocacy is most powerful when coordinated through state and national associations. Engaging collectively at school, district, state, and federal levels helps shape policies on tiered supports, school mental health, and equity, ensuring inclusive learning environments for all students.

For example, when a state passed legislation to create a committee tasked with developing workload recommendations, an occupational therapist proactively asked to participate in the early planning process. This led to an invitation to join a focus group and to invite other practitioners to contribute (J. Rioux, personal communication, August 14, 2025). An active role in the state occupational therapy association and government affairs involvement enabled her to respond quickly and engage effectively. Early engagement ensures occupational therapy perspectives are included from the start.

Across the country, practitioners influence policy by partnering with Departments of Education to develop practice guidelines, ensure Medicaid compliance, and represent the profession. Associations such as the Occupational Therapy Association of California, lead legislative efforts (AB 1009) to recognize occupational therapy leadership in schools. Practitioners also hold

elected positions from local councils to state legislatures and Congress, bringing occupational therapy expertise to policy decisions across education, health, and community systems. State and national organizations, including AOTA, support practitioners by tracking policies, providing resources, and connecting networks, while communities of practice offer spaces to share strategies, discuss policy, and build professional support.

**Reflection:** *What steps am I taking to influence education policy and ensure occupational therapy is represented?*

### Membership Matters

AOTA shapes federal policy by uniting occupational therapy practitioners nationwide. Working with state associations, AOTA strengthens advocacy to protect the profession and those we serve. A recent example is the withdrawal of 17 states from a lawsuit seeking to declare Section 504 unconstitutional (Saffer, 2025b), which would have threatened protections for students with disabilities. This outcome resulted from coordinated efforts that mobilized state associations, shared updates, supported messaging through AOTA's Legislative Action Center, and included AOTA staff office hours to address concerns. Together, these actions demonstrate AOTA's ongoing ability to drive effective federal advocacy and safeguard the profession's future.

**Reflection:** *How will I invest in occupational therapy's future?*

### Conclusion

Advocacy is central to school occupational therapy. Through daily choices and system-level engagement, we strengthen the profession and open doors for every student. Lasting impact comes when we commit to consistent, informed advocacy. 🗣️

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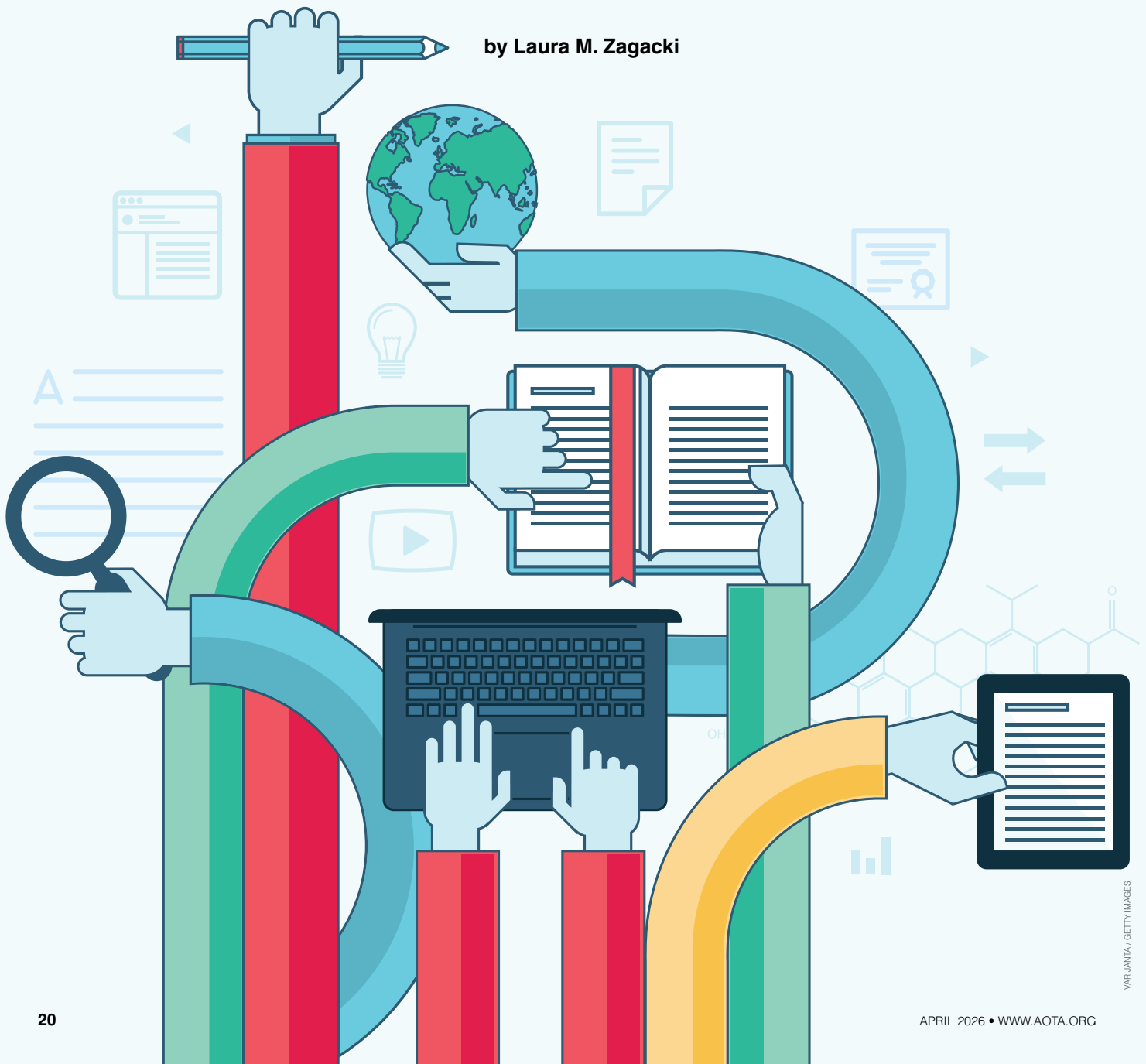
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# USING PROJECT-BASED LEARNING

for Students to Understand the Occupational Therapy Process

by Laura M. Zagacki



**S**triving for occupational therapy students (OTs) to comprehend the components of the therapeutic process of occupational therapy is a significant aim in higher education. The occupational therapy process is dynamic and has been operationally defined in the *Occupational Therapy Practice Framework: Domain and Process (OTPF-4*; American Occupational Therapy Association [AOTA], 2020): evaluation, intervention, and outcomes. Although the therapeutic process between a practitioner and client is dynamic and reflective (AOTA, 2020), teaching the components of the therapeutic process can be accessible to students when explored in and out of the traditional classroom setting. Helping students develop understanding and competency in applying the therapeutic process will make them better practitioners to support their clients' occupational participation. Teaching components of the therapeutic process also complies with the standards set by the Accreditation Council for Occupational Therapy Education (2023). Thus, identifying teaching methods to support OTs knowledge and skills of the therapeutic process is valuable.

Effective teaching methods engage students in clinical reasoning and opportunities for application. Project-based learning is notably an effective method for teaching and is "defined as using authentic, real-world projects, based on a highly motivating and engaging question, task, or problem, to teach students academic content in the context of working cooperatively to solve the problem" (Bender, 2012, p. 16). The real-world issue offers a genuine learning experience that students may encounter in their clinical practice. The authentic experience defines project-based learning and increases student motivation as they address an existing problem rather than a supposed one (Bender, 2012).

Project-based learning increases student motivation in learning and can contribute to student personal growth in life skills: time management, communication, critical thinking, self-direction, personal responsibility, problem-solving, creativity, collaboration, and work ethic (Wurdinger, 2016). When offered to OTs, project-based learning can facilitate learning meaningful life skills they will use when interacting with future clients and colleagues, and in daily life. Bender's components of project-based learning include 1) an anchor, 2) collaborative teamwork, 3) a driving question, 4) feedback and revision, 5) inquiry and

ability and watched a video of those who were interviewed about their experiences of living with their sibling who had a disability. A collaborative discussion followed, where students posed questions and comments to one another and the professor in a group setting, to increase their understanding

The next step in project-based learning is to develop a driving question. Bender notes that student choice is integral for active student participation (2012), and the driving question was developed through collaboration between the students and the professor to increase student motivation and engagement. The

## **"WHEN OFFERED TO OTSS, PROJECT-BASED LEARNING CAN FACILITATE LEARNING MEANINGFUL LIFE SKILLS THEY WILL USE WHEN INTERACTING WITH FUTURE CLIENTS AND COLLEAGUES, AND IN DAILY LIFE. "**

innovation, 6) opportunities for reflection, 7) a process of investigation, 8) a publicly presented product, and 9) student voice/choice (2012). Project-based learning components are embedded within student experiences as they are features of this instructional method. What follows is a case-based explanation of how project-based learning was implemented by a professor to teach OTs the occupational therapy process. This project was completed over the course of three semesters with eight OTs. To introduce a topic, students are given a complex task to solve (i.e., a project anchor). The anchor given to the OTs was *occupational therapists addressing needs of siblings in families when one child has autism*. As an introduction, students read articles about the needs of siblings who have a brother or sister with a dis-

driving question was, "What does the occupational therapy process look like when working with a child with autism and their sibling without a disability?" Students collaborated to develop a series of tasks to problem-solve and address the question or a process of investigation, as outlined in Table 1. Reflection is part of the process throughout the learning steps.

Each task was carried out in sequential order to support students' understanding of the question and the occupational therapy process. The TPBA was selected as an evaluative measure due to its ecological and play-based assessment of developmental domains. The TPBA provides observation guidelines that were used by the OTs to record play behaviors that the child with autism and their sibling exhibited, and

students assessed the performance skills related to play. The SRS-2 was selected as a measure of the social skills of both the child with and without autism. This assessed the social ability of each child and allowed the OTSs to gather information about the social interaction skills of each sibling.

Two families, who each had one child with autism and had an interest in helping their children play together, were invited to the university where the OTSs implemented the occupational therapy therapeutic process with their children under the supervision of a licensed occupational therapist. An occupational profile of each family unit and each child was developed to understand their occupational strengths and needs. Each family unit consisted of a mother, father, and two children. The personal factors and interests of each child are described in Table 2.

Each sibling pair was observed by six OTSs for an hour-long free-play session in a child-friendly sensory gym equipped with developmentally appropriate toys. During this observation, the OTSs completed the TPBA to gather informa-

tion about each child's play skills and interactions.

The TPBA assessment of Brian and Bailey revealed Brian's strengths in memory and verbal communication; and areas of concern in motor planning, non-verbal communication, problem solving, and restricted play interests. His sister, Bailey, had strengths in fine motor skills, verbal communication, and problem-solving skills; and areas of concern in emotional self-expression, and making eye contact. In the second family, the OTS found Trey's strengths to be his verbal communication, occasional eye contact, and memory; and concerns in impulsivity, self-control during activity transitions, and restricted play interests. Trey's sister, Ella, had strengths in fine motor skills, verbal and non-verbal communication, emotional expression, and problem-solving; and a concern in her attention span.

A parent completed an SRS-2 for each child. This information was gathered to help the OTS understand each child's social abilities related to social participation and social interaction skills. Scores above 59 reflect a significant concern in social ability. Both children with autism,

Brian and Trey, scored in the significant range of social impairment on the SRS-2 for their total score and all subscales. Bailey scored in the significant range in motivation and restricted and repetitive behaviors, but her total score was in the range of typical development. Ella, Trey's sister, had scores in the range of typical development.

After the evaluative information was gathered, the OTSs reflected on the findings and engaged in collaborative discussion to synthesize the information. Students identified and shared supports and barriers to occupational participation in sibling play and social participation. The impact of each child's performance related to joint play, contexts, and environmental supports were discussed.

The OTSs noticed that the siblings Brian and Bailey preferred to play independently. Because of this, the OTSs reasoned together that the intervention plan should target social participation between them with parent support. The intervention plan focused on helping Brian and Bailey improve their understanding of play activities and expectations and to problem-solve during activities, creating

**Table 1. Project-Based Learning and Corresponding Actions**

Learning Step	Students' Actions
Identify relevant topics to help understand the question	<ul style="list-style-type: none"> <li>● Topics included:               <ul style="list-style-type: none"> <li>○ needs of siblings of children who have autism</li> <li>○ occupations that siblings participate in together</li> <li>○ autism and participatory factors</li> </ul> </li> </ul>
Search for information related to the question	<ul style="list-style-type: none"> <li>● Completed a literature review of needs of the siblings of children who have autism, occupations of play and social participation, and participation challenges of children with autism</li> <li>● Identified relevant assessments of play and social participation</li> </ul>
Synthesize data that was collected	<ul style="list-style-type: none"> <li>● Determined that occupational therapy can support siblings in play participation when one child has autism</li> <li>● Selected non-standardized and standardized assessments: Transdisciplinary Play-Based Assessment, 2nd ed. (TPBA; Linder, 2008) and Social Responsiveness Scale, 2nd ed. (SRS-2; Constantino, 2012)</li> </ul>
Collaborative decision-making on how to move forward in applying the occupational therapy process	<ul style="list-style-type: none"> <li>● Recruited two families who have a child with autism and one without</li> <li>● Evaluated occupational participation of sibling pairs from parent interview and using the TPBA and SRS-2</li> <li>● Planned interventions for joint participation in play</li> <li>● Developed home activity program for each family, and implemented interventions with each family</li> </ul>
Develop a product that allows students to communicate their work to others	<ul style="list-style-type: none"> <li>● Home activity program given to each family</li> <li>● Presentation at collegiate scholarship day</li> <li>● Presentation at occupational therapy conference</li> </ul>

**Table 2. The Recipients of Occupational Therapy**

Child With ASD	Brian	Trey
Age	10	4.5
Gender	Male	Male
Diagnosis	Autism spectrum disorder	Autism spectrum disorder
Comorbidities	Anxiety, ADHD-Hyperactive	None
Interests	Horror movies, video games	Books, deep sea creatures
Sibling	Bailey	Ella
Age	9	7
Gender	Female	Female
Medical Diagnosis	Anxiety, ADHD	None
Interests	Anime, drawing	Gymnastics, axolotls

*Note.* Pseudonyms used for all children

opportunities for them to play together by embedding activities into daily routines, increasing communication, and regulating the social emotional skills needed to express their feelings.

In the second family, the OTSs reasoned together that the intervention plan for Trey, Ella, and their parents target social participation and emotional regulation. The intervention plan focused on helping Trey and Ella improve their time spent in sibling play, use teamwork to support interactions, plan for transitions between activities, and create opportunities for the siblings to play together by embedding activities in daily routines, increasing communication, and managing levels of arousal and stress.

## Conclusion

Through a collaborative discussion of occupational therapy approaches, students appraised the *OTPF-4* definitions of each approach and made decisions about which approach and strategies would match the children's performance needs. The OTSs engaged in decision-making to write a home activity program that detailed each focus area and strategies to help the family.

The final step of project-based learning is to deliver a product that allows students to communicate their work to others. In this case, the OTSs delivered a product in three ways.

- One student met with each family to review the home activity program and implemented some of the strategies with the family.
- The OTSs prepared and presented a slideshow to their peers, faculty

members, and family members during an on-campus scholarship day.

- The OTSs co-wrote a proposal for and presented a poster at the AOTA INSPIRE Annual Conference.

During the 3-semester-long project-based learning experience, the OTSs valued the discussion and collaboration: "I liked that we had discussed in class what we will be changing." They practiced skills in communicating with each other and problem solving throughout the project. These life skills are a product of project-based learning (Wurdinger, 2016). Several students said that it was engaging to progress through the steps. Student A noted, "I thought it was exciting to see our project come to life," and student B added, "I am excited to begin to see all of our work come together toward our final product." Providing a real-life occupational therapy question to address gave the OTSs opportunities to practice clinical reasoning, communicate with recipients of occupational therapy services (children and families), develop creative strategies to facilitate social participation between siblings, and apply the steps of the occupational therapy process with a real family. Student C reflected on her observational skills during the experience: "I noticed a lot about the sibling relationship through observing their play!" Several students reflected on the environment's influence on sibling play and discussed environmental modifications to support the children's occupations. The students also saw how the real-life experience differed from

their assumptions, and this experience elicited further clinical reasoning or *wondering* as student B called it. Student C commented on the play observation, saying, "It wasn't what we expected, but I am glad to have had the opportunity." The experience provided opportunities for problem-solving and creativity to adjust their thinking and actions—valued skills in working as a practitioner in the field. Project-based learning in occupational therapy is an effective teaching method that can help students learn about the occupational therapy process and practice meaningful life skills. 📌

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# Evidence-Based Sensory Resource for New School-Based OTPs

## Program Development and Evaluation

**Amy Leatherman Cowell**  
**Barbara Demchick**

**E**ducation is a fundamental childhood occupation, and difficulties in sensory processing can present challenges for children to be successful in the learning environment. Sensory-based interventions (SBI) are widely used in school-based occupational therapy when working with students identified with sensory processing needs following evaluation. Thompson-Hodgetts and Magill-Evans (2018) found that 98% of the pediatric occupational therapy practitioners surveyed who work with children with autism spectrum disorder have used sensory-based strategies with their students. With sensory-based strategies often being utilized with the pediatric population, it is imperative that occupational

therapy practitioners (OTPs) have access to current, robust research to facilitate evidence-based practice (EBP).

Watt and colleagues (2023) explored the effect of SBIs on behavior and the impact of intervention on classroom engagement through a scoping review. After examining 19 studies, they found that students who cannot self-regulate through managing their own behavior struggle to perform in the classroom. SBIs that promote self-regulation can aid students in engaging in multiple occupations within the school context, including play, social communications with peers, and task completion through cultivating fine motor skills and attention in the classroom. SBIs should be highly personalized due to the individualistic nature of sensory processing, which creates challenges to the generalizability of studies into their efficacy.

When entering school-based practice, OTPs are expected to be experts within this realm of special education related services, ready to provide evidence-based recommendations to assist children with self-regulation and attention within the classroom environment. Charles and Glennon (2020) found that only 52% of 284 surveyed OTPs learned about SBI through a college course, whereas 64% learned through continuing education classes and 60% learned through occupational therapy journals. It can be inferred, therefore, that many OTPs learn about SBI through their own self-initiated learning after graduation from occupational therapy school. In fact, Thompson-Hodgetts and Magill-Evans (2018) discovered that OTs with fewer than 5 years of experience recommend SBI for fewer students.

New OTPs to school-based practice may express a less robust knowledge base and awareness of evidence-based



sensory strategies that are appropriate for the school environment than more experienced practitioners. Providing a resource to bridge this knowledge gap is imperative for providing effective sensory strategies to facilitate self-regulation and participation in classroom tasks. Improved behavioral regulation and participation in the classroom are beneficial for children, teachers, and the overall learning milieu. Although many practitioners seek out continuing education courses and professional journal articles to supplement their knowledge of EBP, providing a resource that defines evidence-based sensory strategies will increase the efficiency of gathering this information to utilize within the school environment.

### Program Description

Although SBIs are widely used in school-based occupational therapy when working with students with sensory processing needs, many new school-based OTPs, including some in the first author's school system, express lack of familiarity with them. The need for an efficient resource tool is apparent. Our specific aims were to:

- Provide a resource tool for new occupational therapists (OTs) to facilitate the use of evidence-based SBIs with students.
- Improve new OTs' knowledge, competence, and confidence with SBI recommendation and facilitation.
- Through the use of evidence-based SBIs, facilitate students' improved participation and self-regulation in their school occupations.

We developed an evidence-based resource tool for new school-based OTs and collected pre- and post-intervention survey data via a web-based, self-completion questionnaire, regarding participants' response to using the resource and their confidence with facilitating evidence based SBI. The pre-intervention survey was completed by six school-based OTs with 5 years or fewer of school-based experience, working in elementary, middle, and high schools. We gathered data on their current use of SBIs, and their knowledge, confidence, and competence levels with providing recommendations and facilitating SBIs in the school setting.

Figure 1. Example of Page From Online Sensory Resource

Improved Seat Time for the Movement Seeking Student

Desired behavior: Increased seat time

Problem: Vestibular seeking

A student with Vestibular Seeking may:

- rock, wobble, or squirm when seated
- seek opportunities to be upside down
- constantly move around, running, jumping, spinning, climbing, or rocking
- take physical risks like climbing on furniture, jumping from unsafe heights, or tipping chairs back
- engage in fast, impulsive, or unintentionally rough movements while playing
- have trouble concentrating while sitting or being unable to sit still for short periods

Provide with correctly sized therapy ball for seating—individually fitted to a diameter that the child can sit comfortably with their feet flat on the floor with knees and hips flexed at 90°. Have child use as a seat for up to 10 minutes during a difficult time of day for to seat behavior. (Schilling & Schwartz, 2004)

Slow linear (back and forth) swinging for 5 minutes before instruction (Van Rie & Heflin, 2009)

Rapidly bouncing an exercise ball for 5 minutes before instruction (Van Rie & Heflin, 2009)

Jumping on trampoline for up to 5 minutes before instruction (Borewell & Stein, 1998)

Figure 2. Sample Data Sheet

Targeted outcome behavior:	<input type="text"/>	If other, specify:		<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Sensory based intervention:	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
	Baseline Data			Intervention Data			
Date of observation:	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
How many times did behavior occur:	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Duration of behavior:	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

The evidence-based resource tool was established through a web-based platform and disseminated to the participants via email. This resource included evidence-based sensory intervention recommendations based on a student's specific sensory needs, with sensory needs and recommendations broken down by vision, hearing, proprioception, interoception, and vestibular senses, paired with corresponding behaviors seen in the school environment. Evidence-based strategies were provided for particular sensory needs and behaviors, with instructions for their use. Examples of strategies include noise attenuating headphones and sound absorbing wall

material to increase attention in the student who is auditory over-reactive; chewing gum or eating a crunchy snack, doing yoga, and jumping on a trampoline to increase seat time for the student who is proprioceptive seeking; using calm colors, decreasing clutter, and providing a refuge space to improve visual attention in the student who is visually over reactive; and therapy ball seating, slow linear swinging, rapidly bouncing an exercise ball, and jumping on a trampoline to increase seat time in the student who is vestibular seeking (see Figure 1). A link to a data sheet was posted at the bottom of each page of the resource (see Figure 2), so participants could systematically

evaluate a child's response to the SBI. A link to the Motivation Assessment Scale was included in the resource, to assist participants in identifying particular behaviors as sensory based. The Motivation Assessment Scale and Motivation Assessment Scale II are rating scales that are designed to assist in identifying the motivation behind a challenging behavior in individuals with developmental disabilities (Texas Education Agency, n.d.).

### Program Outcomes

The post-intervention survey collected after 8 weeks addressed the OTs' response to using the resource, as well as their knowledge, confidence, and competence levels with providing recommendations and facilitating SBIs after utilizing the resource tool. Four OTs with 2 to 5 years of experience completed the post-intervention survey. The participants identified the resource as somewhat helpful in identifying SBIs, as well as the included interventions being somewhat effective in assisting students with their sensory needs. The participants responded that the resource was very straight-forward, clearly identifying the desired behavior, problem, and solution; it contained simple visuals and easy to read language rather than paragraphs; and addressed the primary behaviors related to learning readiness. One participant noted that continued needs include the "lack of ability to provide the intervention in a comprehensive school setting (e.g. significant need for proprioceptive and vestibular input, therefore there would be too much instructional time missed, significant sensitivity to many triggers which cannot be altogether eliminated in a school setting)." Suggestions for improving the resource included: providing more guidance or suggestions about how to implement and monitor each SBI; expanding the resource to include other needs relative to school-based occupational therapy, suggesting which intervention to trial first; and adding a link for teachers to educate them on sensory needs. Barri-

ers to effective provision of SBIs in the school setting were identified as staff inconsistency, few funds for buying materials, and significant student sensory needs that require excessive time out of class.

### Implications for Occupational Therapy

Post intervention data identified the continued need for an effective resource for new school-based OTPs. The expansion of the resource to include more sensory profiles, as well as a link to a teacher presentation on student sensory needs, would be beneficial for meeting the identified needs of these therapists, and development is underway. One of the four therapists who completed the post-intervention survey, who has 3 years of experience in school-based practice, identified increased feelings of competence in recommending SBIs, which suggests that the resource may be effective in increasing knowledge, competence, and confidence of its users. This tool appears to be most effective for therapists with 3 years of experience or less; however, continued data collection is to be conducted.

### Conclusion

Entry-level occupational therapy education includes minimal content on SBI, despite it being a leading area of practice and research in the profession (Schaaf et al., 2015). Although the literature has reported that teachers value collaboration with OTs (Benson et al., 2016), most OTPs have little information to guide them in determining student sensory needs, teacher training needs for student sensory-based behaviors in the classroom, and development of training programs using teacher-preferred methods. The development of a resource for OTPs to utilize for facilitating evidence-based SBI can further be used as a training and consultation tool within the scope of consultation with teachers in the school environment. 🌀

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# Benched by Anxiety

## Rethinking Coaching, Confidence, and Childhood Potential

**Sean Weir**

**T**his article addresses a call for understanding anxiety in youth sports from the perspective of an occupational therapist, academic researcher, and parent.

As both an OTP and academic researcher, I have studied the neurobiology of stress, human performance, and occupational engagement. However, nothing could have prepared me for the anguish of watching my own son be consumed by anxiety. His anxiety was not simply an internal condition, but a response that was amplified by external voices of authority. Recently, his coach told him he was not trusted on the floor because of his anxiety. This statement was not a neutral observation; it was a projection of negative self-worth that pierced his developing identity. Witnessing the light in his eyes dim and

his belief in himself fracture compels me to ask: When will we stand up? When will we collectively reject stigmatizing practices in youth sports and instead cultivate environments where children are nurtured and supported?

Anxiety is not a personal weakness, but a neurobiological response rooted in the brain. The frontal lobe, particularly the prefrontal cortex, plays a central role in higher-order executive functions, including emotional regulation, problem-solving, and decision-making (Arnsten, 2009). During optimal conditions, the prefrontal cortex moderates amygdala activation, dampening excessive fear responses. However, when people, especially children, experience stress, rejection, or criticism, the balance between the prefrontal cortex and amygdala is disrupted, leading to heightened anxiety (McEwen & Morrison, 2013). In young athletes, whose brains are still developing, this vulnerability is particularly pronounced. Comments from coaches that undermine confidence can activate the amygdala in ways that override rational processing and trigger the body's survival instincts.

Anxiety is further characterized by the activation of the fight, flight, or freeze response, mediated by the sympathetic nervous system. This physiological process prepares the body to confront or escape perceived threats through increased heart rate, shallow breathing, and muscle tension (Chand & Marwaha, 2022). Although adaptive in the presence of real danger, this response becomes maladaptive in performance settings. When children are told they are untrustworthy due to anxiety, their brain interprets the remark as social rejection, which activates neural pathways associated with physical pain (Eisenberger, 2012). This compromises their ability to engage cognitively and emotionally in sport, redirecting attention away from



learning, skill execution, and teamwork. Such states reinforce a cycle in which anxiety impairs performance, and poor performance reinforces further anxiety (Beesdo et al., 2009).

From an occupational therapy perspective, sports are not just recreational pursuits but meaningful occupations that support social participation, self-identity, and developmental growth (AOTA, 2020). Negative experiences in these contexts can create occupational imbalance and even occupational deprivation. Stigmatizing comments, such as those my son endured, often result in avoidance behaviors, decreased participation, and withdrawal from both athletic and social opportunities. This cycle not only diminishes immediate performance but also undermines long-term resilience and self-esteem (Fraser-Thomas et al., 2008). In contrast, research demonstrates that supportive coaching, which emphasizes encouragement and growth, fosters resilience, grit, and sustained engagement in valued occupations (Côté & Gilbert, 2009). Occupational justice, which emphasizes the right to meaningful participation free from stigma, highlights how damaging exclusionary or critical practices can be to children's developmental trajectories (Wilcock & Townsend, 2019).

To address this challenge, OTPs can play a critical role in implementing a community-based model of practice in school districts. Such a model positions coaches not merely as sport instructors but as key developmental figures. The model begins with education, where coaches receive structured workshops on child development, trauma-informed practices, and the neuroscience of anxiety. These trainings, facilitated by OTPs and other allied health professionals, help coaches understand the profound impact their words and behaviors have on children's neurological and emotional states (Substance Abuse and Mental Health Services Administration, 2014). Strength-based coaching is the second pillar, reframing athletes' experiences around potential rather than deficits. By recognizing effort, creativity, and

persistence, coaches can reinforce adaptive coping and resilience (O'Brien & Kuhaneck, 2020). A third element is embedding safe and supportive environments in athletic programming, ensuring that inclusion, positive reinforcement, and belonging are consistently prioritized. Such strategies have been linked to better psychosocial outcomes and improved athletic performance (World Health Organization [WHO], 2020). Lastly, sustainable partnerships between occupational therapy programs and school districts institutionalize accountability and reflective practice, ensuring that the psychosocial dimensions of sports participation are valued alongside physical skills.

Significantly, this model benefits not only children experiencing anxiety but also the broader youth sports culture. By fostering encouragement, safety, and growth, sports environments align with global recommendations for promoting healthy participation in physical activity (WHO, 2020). Beyond physical outcomes, these environments support mental health, social connection, and lifelong engagement in leisure and play, which are central to human occupation.

As professionals, educators, and parents, we must advocate for systemic change in youth sports. Coaches occupy positions of immense influence on children's identities and developmental pathways. They must be equipped with strategies that align with developmental science, trauma-informed care, and occupational justice. Anxiety should not be stigmatized but understood as a natural human response requiring compassion and support. Occupational therapy has historically championed inclusion, dignity, and the right to meaningful participation. These principles are urgently needed in youth sports.

## Conclusion

We must stand up for children like my son, whose potential should be nurtured rather than constrained by the projections of others. When will we stand up? The answer must be: *now*. 🗣️

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# Supporting Community Reintegration After Burn Injuries

**Ellie Bute**  
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**Hannah Oldenburg**

**M**ore than 30% of burn survivors report experiencing long-term psychosocial challenges after their injury (Rosenberg et al., 2018; Shokre et al., 2024), including managing social relationships and participating in meaningful activities (Capell et al., 2025). During hospitalization, survivors report symptoms including nightmares and disrupted sleep, post-traumatic stress from their incident, anxiety, depression, hopelessness, and changes in self-identity (Fauerbach et al., 2011; Rosenberg et al., 2018). Burn centers, including the one at Regions Hospital (Regions) in Minnesota, provide comprehensive support systems to address patients' psychosocial needs throughout their hospitalization. However, patients enter a new phase of recovery as they leave the hospital, and this com-

munity reintegration process brings new challenges. As burn survivors return to the community, they must manage their recovery process while adjusting to changes in their sense of self. Occupational therapy practitioners (OTPs) are well-equipped to support these transitions, as they focus holistically on occupational participation, routines, and relationships. Practitioners can support survivors by helping them build confidence, establish new routines, and reconnect with their sense of self outside of the hospital setting.

## Social Adjustment

Occupational therapy supports the health and well-being of populations, enabling them to engage in their desired occupations. The *Occupational Therapy Practice Framework: Domain and Process (OTPF-4;* American Occupational Therapy Association [AOTA], 2020) defines health as “a state of complete physical, mental, and social well-being, and not merely the absence of disease or infirmity” (AOTA, 2020, p. 5). OTPs provide support for various occupations, including social participation, which includes any activity that involves interacting with other individuals, such as family members, friends, intimate partners, and community members (AOTA, 2020).

For burn survivors, both physical and psychological factors can affect social participation levels. Changes in body image and self-esteem can contribute to a fear of being judged by others, which may lead to increased isolation. Physical changes such as fatigue, pain, itch, sensitivity to touch, and skin tightness may exacerbate these concerns and affect how an individual pursues social opportunities. Symptoms of anxiety and depression are common in burn survivors, which may decrease motivation or desire to spend time with friends, family members, or romantic partners (Shokre et al., 2024).



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**Figure 1. Interventions to Address Social Participation and Routine Building**

**Create** a fatigue management program to support engagement in meaningful occupations throughout the day that include social participation.

**Restore** a sense of identity through engaging in meaningful occupations and roles that may be new or re-established.

**Train** on coping strategies to manage anxiety during social interactions and contexts, including stress management techniques, problem-solving, and cognitive reframing.

**Establish** routines to incorporate new health management occupations, such as home exercise programming, scar management, and orthotic care and maintenance.

**Advocate** with survivors to establish meaningful social participation goals for themselves.

**Educate** on the purpose of engaging in creative activities, such as art or writing, to process emotions and engage in self-reflection.

In addition to personal factors, burn survivors may experience losses that create further barriers to social participation. These may include having to relocate after losing their home in a fire, or the injury or death of friends or family members involved in the burn event. Job loss or increased financial strain after hospitalization may affect access to social events or activities. Additionally, an inability to drive, whether due to pain medications or physical limitations, can affect an individual's independence and ability to connect with loved ones after they leave the hospital.

OTPs can help address barriers to social engagement by identifying the underlying reasons for one's social isolation. This may include self-perception, fear of judgment or rejection from others, mental health challenges, or concerns about having little or no social support (Rosenburg et al., 2018). As practitioners gain insight into these contributing factors, they can tailor their interventions to their patients' specific needs. Practitioners can refer individuals struggling to cope with their experiences to peer support groups, which provide opportunities for survivors to process emotions and connect with others who have lived through similar experiences. OTPs also support individuals with appearance-re-

lated anxiety through the development of coping skills, cognitive reframing practices, and gradual exposure to their changed physical appearance.

As burn survivors begin to cope with their new reality, OTPs may gradually expose them to social experiences, using strategies to build confidence in discussing their injuries, coping with anxiety during social interactions, setting boundaries, and advocating for their needs by creating social scripts or role-playing through different scenarios. Practitioners at Regions Hospital, a Level 1 Trauma Center in St. Paul, Minnesota, begin addressing social participation during hospitalization to prepare for discharge. They educate patients on scripts to use for managing stares or comments from strangers. They also scaffold exposure to social environments with trips to the hospital gift shop or cafeteria to practice these strategies in relatively safe environments (those with controls and support) before leaving the hospital. Additionally, OTPs encourage survivors to initiate and plan activities to support their engagement with peers, such as going to the movies or cooking a meal for others. Participating in these meaningful activities can help survivors reconnect with their sense of self, supporting their overall engagement in social relationships. These

practices can help survivors reduce social avoidance tendencies, which often lead to higher rates of depression and lower body image (Rosenburg et al., 2018).

Burn survivors may also face barriers within intimate partner relationships following hospitalization. OTPs support patients with their sexual and romantic relationships by addressing areas of concern, including training on positioning techniques to reduce discomfort in areas of increased sensitivity and to avoid shearing recently healed skin. OTPs also educate on fatigue management and desensitization strategies to support participation in physical activities, such as energy conservation techniques and exposure to different textures or clothing materials. Additionally, practitioners collaborate with survivors and their partners to explore activities to promote the intimacy and emotional connection associated with sexual activity but scaffolded in a manner that is comfortable for each individual.

### **Establishing New Routines**

Another domain of occupational therapy practice involves supporting performance patterns to help shape and reinforce a person's occupational identity. Routines are a specific type of performance pattern, and these are often disrupted as burn survivors discharge from the hospital and navigate transitions to the community. Routines are described as the "established sequences of occupations or activities that provide structure for daily life; they can also promote or damage health" (AOTA, 2020, p. 12). Patients discharging from the hospital must establish routines that align with new roles and responsibilities to optimize recovery. These responsibilities may include caring for their wounds, managing scars, engaging in home exercise programs (HEP), attending follow-up appointments, and returning to work and leisure activities. Survivors often have to navigate these new routines while still fulfilling the responsibilities of their previous roles. For example, a single parent who was injured may now have to return to caring for their child(ren) and managing house-

hold tasks without any support, while continuing to manage their recovery process. Throughout hospitalization, OTPs at Regions educate patients on how they can best manage their recoveries, emphasizing HEP routines to support their reintegration process. See Figure 1 for additional intervention approaches used by OTPs in burn rehabilitation settings. However, some individuals may not be able to return to previous roles as quickly as desired. Some may face difficulties returning to work or school, or they may require additional support to complete self-care activities. Challenges during reintegration may result in feelings of grief due to the loss of previous abilities or roles. This grief may be especially present when an individual loses the ability to participate in something that at one time defined them, affecting their sense of occupational identity.

### Case Example

Mateo is a 28-year-old Mexican-American male who sustained 27% total body surface area full and deep partial thickness burns affecting his bilateral upper extremities (circumferential), chest, anterior neck, and face. He is married, a father of one, and works as a barber. Throughout hospitalization, Mateo experienced serial surgical procedures, eventually resulting in split-thickness autografting to all affected sites. Mateo transitioned home after 55 days in the hospital. He presented for outpatient occupational therapy sessions at Regions with high levels of fatigue and hypertrophic scar formation. He also reported feeling anxious about how others would respond when they see him. Throughout his transition to the community, Mateo has faced challenges with returning to caregiver activities, work tasks, and social interaction.

During outpatient therapy, practitioners trained Mateo on ADLs and home management skills to reduce his wife's caregiver burden and help protect their marital relationship. With training on HEP throughout hospitalization, OTPs also discussed how stretching and exercises have been implemented into daily

### Resources to Support Adjustment and Recovery

- American Burn Association (<https://ameriburn.org/>)
- Burns—Journal of the International Society for Burn Injuries
- Journal of Burn Care & Research
- Model Systems Knowledge Translation Center (MSKTC) (<https://msktc.org/>)
- Phoenix Society for Burn Survivors (<https://www.phoenix-society.org/>)

routines. Additionally, OTPs facilitated strength and endurance programs, as well as fine motor coordination activities, to support Mateo with work and child-rearing tasks. OTPs also educated him on skin precautions so he could perform his roles without causing pain or injury to his fragile and sensitive new skin.

To prepare Mateo for work and social engagement outside of the hospital and home environments, practitioners exposed Mateo to his new skin through touch and mirror use. Throughout this gradual exposure, OTPs provided education and reassurance regarding the skin healing process and changes in pigmentation and sensitivity over time. OTPs also supported his emotional processing of these physical changes. They provided scripts and educated him on cognitive reframing techniques to use when discussing his burn event with strangers and loved ones, with a goal of improving stress management within social contexts.

### Conclusion

Returning to everyday habits and routines can be difficult for burn survivors, especially reintegration to social participation, such as work, family engagement, and sexual intimacy. Social participation is a key occupation that occupational therapy can address throughout each phase of burn recovery. As survivors adjust to life outside of the hospital, OTPs can help re-establish meaningful roles and routines, fostering a sense of occupational identity and supporting long-term recovery. 📌

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**Everyday Ethics: Core Knowledge for Occupational Therapy Practitioners and Educators, 4th Edition** by Deborah Yarett Slater, OT, MSOT, FAOTA. This important CE course provides an overview of key ethical theories, the Occupational Therapy Code of Ethics and Standards of Conduct, a Framework for Ethical Decision Making with case analysis and the role and function of agencies which regulate the occupational therapy profession. Earn .2 AOTA CEUs (2.5 NBCOT PDUs/2 Contact Hours). Order #OL4953



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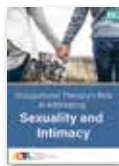
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**Occupational Therapy in the Inpatient Rehabilitation Setting for Patients with COVID-19** by Melissa R Brottman, OTD, OTR/L, CPAM, et al. This course highlights effective interventions and assessments and will help you to understand the importance of a team approach to rehabilitation, how to start a COVID program, and various special considerations for patients continuing to recover from this disease. Earn: .15 AOTA CEU (1.88 NBCOT PDUs/1.5 Contact Hours). Order #OL8309.



**Occupational Therapy's Role in Trauma-Informed Schools** by Sharon M. McCloskey, EdD, MBA, OT/L, CTP; Meghan Suman, OTD, OTR/L, BCP, SCSS. The purpose of this course is to familiarize you with the typical response to trauma in the brain, and sequelae of experiences and behaviors that can occur when the thinking brain is deactivated, and the emotion brain takes the lead in response to future perceived threats. Also discussed is the need to address trauma through the inclusion of trauma-informed approaches within the school

and school system. Earn .1 AOTA CEU (1 contact hour; 1.25 NBCOT PDU) Order #OL8376.



**Assistive Technology, Universal Design for Learning, and School-Based Practice** by Pamela Stephenson, OTD, OTR/L, BCP, FAOTA; Mindy Garfinkel, OTD, OTR/L, ATP. This course provides a foundational understanding and definition of assistive technology and universal design for learning. Information on how these can be embedded into school-based practice is also provided. In addition, the course outlines the role of legislation in supporting the use of technology in school contexts. Earn .15 AOTA CEUs (1.5 contact hours/1.88 NBCOT PDUs). Order #OL8408.



**AOTA Fieldwork Ethics, Second Edition** by Deborah Yarett Slater, MS, OT/L, FAOTA. For most of us, there will come a time in our professional career when we will either work alongside or supervise fieldwork students.

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**Performing a Home Health Start of Care Bundle.** by Karen Vance, OTR/L and Carol Siebert, OTD, OT/L, FAOTA. This course bundle will provide you with important information needed during the start of care process. Topics covered include the importance of starting care for OTs; changing the perception of occupational therapy in the home care community; changes to legislation; and the medication reconciliation process—in addition to others. Individuals completing the series including three 'Essentials' courses are eligible to receive the AOTA Performing a Home Health Start of Care micro credential and digital badge. Please see the Performing a Home Health Start of Care digital badge page for more information about requirements for obtaining the micro credentials. Earn .85 CEUs (8.5 NBCOT PDUs/10.5 Contact Hours). Order #OL8334. Total Bundle Credit: AOTA Members: \$189.65, Nonmembers: \$259.65. <http://store.aota.org> 0622



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