Below is one example for each type of form, not for each criterion. The examples are to help you understand how to complete each form, regardless of the criterion.

The forms that are included are hyperlinked in the table of contents below.

Please note that these are examples only to help guide you in the type of information to include. For many reflections, your style may be different; for example, more narrative or more bulleted.

Note that unused forms (pages) are not included in this document. Please do the same with the final set of evidence forms you submit with your application.

**Criterion 1: Knowledge: Lifespan & Conditions**
- **Formal Learning**
- Independent Learning
- Mentee
- Publication – Peer-Reviewed

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

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

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

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

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

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

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

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

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

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

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

**Criterion 13: Accessing Networks & Resources**
- **Networking Case Study**
**Criterion 1—Knowledge: Lifespan & Conditions**

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

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

**Please identify the type of activity in which you participated:**
- ☐ AOTA CE: Participation in Self-Paced Clinical Course or CE Product from the list of AOTA offerings approved for this certification. *Completion of course will be verified by AOTA. Submission of additional documentation beyond this form not required.*  
- ☐ Non-AOTA CE: Attending workshops, seminars, lectures, or professional conferences with formal established objectives.  
- **X** Participation in post-professional academic coursework. *Attach unofficial transcript.*

1. **Activity information.**

<table>
<thead>
<tr>
<th>Activity Title</th>
<th>OT 123 Occupational Therapy Practice Seminar: Intrinsic and Occupational Factors</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider/Instructor</td>
<td>Joanne Smith, PhD, OTR/L and James Taylor, PhD, OTR/L</td>
</tr>
<tr>
<td>Activity Date(s)</td>
<td>September thru December 20XX</td>
</tr>
<tr>
<td>No. of Contact Hours</td>
<td>3 college credit hours, Contact hours: 3 class hours per week; 10-20 hours research and paper writing hours per week.</td>
</tr>
</tbody>
</table>

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

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>A)</td>
<td>This course was a seminar that focused on researching intrinsic factors related to the student’s individual area of practice.</td>
</tr>
<tr>
<td>B)</td>
<td>Understand the various diagnosis affecting the capacities and limitations of people who will be served by the student’s practice.</td>
</tr>
<tr>
<td>C)</td>
<td>Gain familiarity with key literature that underpins their area of practice.</td>
</tr>
<tr>
<td>D)</td>
<td></td>
</tr>
<tr>
<td>E)</td>
<td></td>
</tr>
</tbody>
</table>
3. Describe the relevance of the activity to your practice in gerontology. *(average word guideline – 200)*

This course was part of my doctorate degree curriculum and my focus of research and learning was on enhancing health and wellness in older adults in relationship to driving and community mobility. Each week we explored a key intrinsic area, independently thoroughly researched the area, directly applied the contents to our practice area (e.g., driving and community mobility in older adults), researched key assessments related to each area in relationship to our unique focus, and summarized our findings in weekly papers. The intrinsic areas explored and researched included the following:

- a. How an older adult’s occupational performance is affected by driving and community mobility
- b. How cognition changes with aging, various diagnoses associated with cognitive decline in older adults, and the impact on driving and community mobility
- c. The role of psychological factors and diagnosis in aging and the impact on driving and community mobility
- d. The physiological factors and related diseases/illness that impact older adults and the effect on driving and community mobility.
- e. Specific motor changes that occur with age and related diagnoses that impact older adults and driving and community mobility.
- f. The sensory changes (vision, tactile, olfactory) and various diagnoses that impact older adults and driving and community mobility.
- g. How spiritual factors can support Occupational Performance and any relationship to driving and community mobility and older adults.

This course was extremely relevant to my work with older adults and driving and community mobility has it provided me the evidence based background in the changes that can occur with aging and a more in depth knowledge related to the various diseases/illnesses older adults are confronted with which can impact both driving and community mobility.

4. Describe how the knowledge acquired from this activity “demonstrates acquisition of current knowledge of the effects of the interaction between lifespan issues and relevant conditions that impact occupational performance related to gerontology.” How did the activity influence the way you practice, or how did it affect your client outcomes? *(average word guideline – 200)*

This course had a strong impact on my work with driving and community mobility in older adults. I gained knowledge from evidenced based literature that I did not have – especially in normal changes that can occur as the result of aging as well as the many diseases/illnesses that can affect the various systems in relationship to driving/community mobility. For example, it is common as we age that our peripheral fields can significantly decrease, some parts of cognition and personality are more stable than others as we age, the role of cognition in reaction time, the role of exercise and activity in maintaining health, and of course, the importance of continued participation in activities and the community past the time of driving retirement.

The work within the course supported how some of the various changes that can occur with aging and/or disease can not only impact driving safety – but also community mobility. Thus, in my practice, I have become much more aware that once an older adult can no longer drive safely, it is often far from expected that he/she will be able to independently use community resources to remain mobile in the community. My recommendation meetings after the driving assessment now includes more time emphasizing the importance of remaining active past driving retirement as well as beginning to explore with family members the assistance an older adult may need in developing and using alternative forms of transportation. I have also began to explore working with social workers and case managers in ways to further provide assistance to older adults and families in these areas (i.e., not only the “typical transportation resources, but unique ways of putting weekly schedules together to include the older adults’ needs and desires).

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

Unofficial transcript included on page XX.
INDEPENDENT LEARNING
Table of Contents

Criterion 2 – Knowledge: Evaluation
Demonstrates acquisition of current knowledge of relevant evidence specific to evaluation in gerontology.

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

Please identify the type of independent learning activity in which you participated:

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

1. Why did you choose this activity?

☐ Clinical reference for specific population, program, or individual
☐ Invited peer review of scholarly work or publication (print or online)
☐ Preparation for poster or presentation
☐ Preparation for academic lecture
☐ Literature review for research project
☐ Preparation for serving as a mentor
☐ Other, please specify: __________________________________________________________

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

These references are for example purposes only. Applicants should ensure that independent learning reflects most current reference.


Burns, Theressa. (2002). Cognitive Performance Test (CPT), Geriatric Research, Education and Clinical Center, MN VA Medical Center.


3. Date(s) of independent learning

1/2/XX, 3/5/XX, 4/2/XX, 5/7/XX, 6/4/XX, 7/2/XX, 8/6/XX, 9/3/XX, 10/1/XX, 11/5/XX, 12/3/XX

4. Time spent engaged in independent learning.

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

Approximately 33 hours.

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

As a solo practitioner, I felt the one way to ensure competency was to establish an ongoing connection and interaction with other OTs providing services to older adults with Parkinson’s disease. I also wanted to validate that the clinical decisions I make are based on the most current evidence. I felt that a journal club format would provide the opportunity for ongoing dialog with other practitioners and also provide an intellectually challenging and stimulating venue for appraising and keeping abreast of new developments in Parkinson’s. I chose to develop and lead a journal club because preparation for the monthly journal club meetings would challenge me and require that I critically examine articles to determine their relevance for discussion by the group.

The AOTA toolkit provided a format for critically appraising each article and guiding meaningful discussion during the meeting. The group chose evaluation as the first area of discussion because of the increasing Medicare emphasis on using standardized assessment to justify intervention and measure client outcomes. The group met monthly using an online platform that allowed members to see and interact with one another. We examined 11 articles over the period of 1 year that addressed various aspects of evaluation and reviewed well-established and new assessments.
6. Describe how the knowledge acquired from this activity “demonstrates acquisition of current knowledge of relevant evidence specific to evaluation in gerontology.” How did the activity influence the way you practice, or how did it affect your client outcomes? (average word guideline=200)

Participation in the journal club increased my knowledge of assessments available to me in practice. I learned about new assessments, such as the Physical Performance Test Protocol (article #11), to increase occupational performance testing. I also learned more about The Parkinson’s Activity Scale (article #10).

By critically appraising the research for each instrument, I gained a better understanding of its strengths and limitations relative to guiding development of the intervention plan. The knowledge I acquired helped me develop a more critical eye when selecting assessments and interpreting results, and I have more confidence in my selection of relevant and useful assessments to help me develop my intervention plans.

My increased understanding of what each test is measuring has improved my ability to document the results in a way that provides a stronger justification to physicians and other stakeholders for OT services, and I write more objective and measurable goals. This increased confidence has enabled me to speak with greater authority to physicians and other referral sources, and I have therefore noted increased referrals to my practice.
Criterion 4 – Knowledge: Systems

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

Guidelines

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

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

   Applicant, I.M (20XX). Effective compliance with Medicare guidelines and success in clinical education for occupational therapy and physical therapy students. Journal of XXXXX, xx(x), 447-456

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

   N/A

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

   This publication was chosen to represent my knowledge of Medicare reimbursement systems related to service delivery for geriatric clients in skilled nursing facilities. I chose this article since it represents a turning point in my career. I found myself caught up in the here and now provision of services to my clients in a nursing home setting. I was reacting to changes in Medicare regulations on service delivery by eliminating extracurricular activities, such as mentoring students, and focusing solely on providing direct care.

   During this period, a therapist on my team resigned and her position was difficult to fill because there is a shortage of OTs interested in working in geriatric rehabilitation in skilled nursing facilities. I realized that I was contributing to a potential long-term shortage of OTs for this population by not mentoring OT students. This publication reports on the outcomes of a training program I developed for therapists who work in nursing homes.

   The training reviewed the importance of mentoring students in geriatric rehabilitation, as well as reviewing new Medicare rules regarding students, concurrent therapy and group therapy. The training provided examples of how therapists could schedule their day given these rules within our facility to maximize time spent mentoring students while maintaining reasonable productivity standards.
Criterion 5—Evaluation: Uses Relevant Evidence

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

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

1. Age of Client | 79
Client Diagnosis(es) | Failure to Thrive; Osteoarthritis; s/p Amputated R index finger.
Setting for Evaluation | Nursing home where client has been a long-term resident for 7 years
Date of Video Recording | 1/22/XXXX

2. Provide a brief summary of the video content and how it demonstrates your use of "relevant evidence to establish an occupational profile with the client (person, organization, population) and assess the client’s occupational performance through a variety of measures, including standardized assessments, as appropriate." (average word guideline—200)

This video depicts an evaluation I conducted for a widowed 79 year-old female client with recent complaints of joint pain and decreased participation in self care and leisure activities. The video shows me using interview and observation to establish an occupational profile and to determine her perception of her functional status and ability to adapt to health and social changes.

During this initial intake evaluation, I conducted a standard facility interview. General demographics and client factors were gathered, as well as her perception of roles and satisfaction with those roles. I also used the Canadian Occupational Performance Measure (COPM) and the Occupational Case Analysis Interviewing and Rating Scale (OCAIRS). I chose the COPM because it is designed to be used across all disability groups and developmental levels, and it enables clients to identify and prioritize issues with their occupational performance. Because she was also diagnosed with failure to thrive, I decided to use the OCAIRS because it is designed for short-term psychiatric inpatients and it assists with the assessment of a client’s overall level of functioning.

Both tools assist clients with self-evaluation and can be used in developing intervention plans and goal setting.
3. After reviewing this video, describe the insights you gained, and reflect on how the analysis experience validated or supported change in your evaluation practice. (average word guideline–400)

My review of the video evaluating my client revealed:

1. My ability to develop a therapeutic environment occurred by establishing rapport, trust and comfort for the client. This allowed her to:
   - clearly identify problems in areas of occupation related to self-care, productivity, and leisure, including performing self-care tasks, leisure activities, and playing games with her grandchildren.
   - to be self-reflective, participate in goal setting, and participate in discharge planning.

2. I realized I could improve my therapeutic use of self by decreasing the number of times I asked the client “Is that OK with you?” Although ensuring the client is comfortable and consents to the evaluation, I felt that constantly asking “Is that OK with you?” was distracting and unnecessary.

3. I was pleased to observe that I actively listened to the client and allowed her comments to guide the evaluation path. For example, when she mentioned that she had lost weight and was not able to re-gain it, instead of continuing with my planned assessment agenda, we briefly discussed what she thought was preventing her from being successful with her attempts at weight gain.

Due to these insights, I now pay closer attention to how I interact with my clients, and I am breaking the habit of verbally checking-in with clients too often. I have always appreciated the value of establishing a rapport with my clients, and watching the video reinforced the importance of this. Soliciting my client’s narrative of her rituals, routines, roles, and occupational adaptation enabled me to develop a client-centered treatment plan that addressed the whole client and not just her complaints about life. I believe watching the recording validated the importance of establishing the client’s occupational profile and helped me reevaluate how I present myself to my clients.
Mrs. Smith is a 72 year old married female with relatively good health up until November 20XX when she saw her family doctor, was diagnosed with an upper respiratory infection, and returned home with antibiotics. For the next week, the respiratory symptoms continued to worsen. She was admitted to the hospital by her physician to determine what was making her symptoms worse.

Once admitted she began to develop weakness and soreness in her biceps, thighs, and calves. She also noted shooting pains on her scalp and pain in her neck with paresthesias from her knees to her feet. Based on these symptoms, she was admitted to the ICU and diagnosed with Guillain-Barre Syndrome (GBS). Her symptoms continued to worsen, including 4 limb paralysis and weakness of the head and neck, incontinence, and need for a mechanical ventilator due to respiratory distress.

The day after being admitted to the ICU, Mrs. Smith was referred to me for an OT evaluation because of my expertise in the management of medically complex, older fragile adults.

I determined that Mrs. Smith was married and lived in a 1 level condominium with her husband. They are both retired university professors and had spent much of their retirement traveling until last year. The Smiths had multiple support systems, including family and friends. Prior to her admission Mrs. Smith enjoyed gardening, listening to music, and was active in senior center activities and church-related functions.

I completed an OT initial evaluation 2 days after her admission to the ICU. She was very weak in her all limbs and could only move her head from side-to-side. She was on a ventilator and dependent in all ADLs. She required a special bed for positioning and frequent positional changes for prevention of skin breakdown. Mrs. Smith also suffered from severe pain and increased sensitivity throughout her body.

Over the next few weeks, Mrs. Smith slowly began to regain some motor control and was weaned off the ventilator. She was transferred out of the ICU and made slow gains toward her OT goals over time. After a while, Mrs. Smith was able to operate a nursing call button by moving her head and sit up in a recliner for short periods of time. Having been weaned from the ventilator, she was able to take food by mouth in the form of a mechanical soft diet with assistance, and she begin to talk and express her needs. At the time of discharge to an acute care rehabilitation hospital, Mrs. Smith’s muscle strength in her shoulder girdle had improved to a grade of “poor,” she had no pressure sores, and was able to operate head/neck environmental controls for the nursing call button, radio and bed controls.
During Mrs. Smith’s ICU admission, I conducted an occupational performance interview that included the Canadian Occupational Performance Measure (COPM), Role Checklist (RC), and Occupational Self-Assessment (OSA). The initial goals I prioritized in collaboration with her and her husband were pain relief, anxiety reduction, prevention of contractures, and operating a nursing call button.

To promote her goal of having immediate access to the nursing staff, I provided and trained her in the use of a hands-free nursing call button operated by head rotation on day 1 of her ICU admission.

I used complementary and alternative approaches to pain management – including relaxation techniques, imagery, and sound acoustics – in order to reduce pain and support more active engagement in all therapies. I made a bed cradle to serve as a frame so that Mrs. Smith would not experience pain associated with the contact of the blanket or bed sheets on her skin. I recommended changes to the medical team concerning the timing of medication so that she would be more alert during therapy sessions, and I staggered therapy times to allow for ample rest times.

I noticed that PROM, positional changes in bed, and transfers out of bed (later) were not being performed consistently by all family members or across all nursing shifts. This became a priority, and I provided education and training for all family and nursing staff. I used patient-permitted photos to illustrate proper positioning, how to sit up in a recliner chair, how to operate the mechanical lift, and how and when to apply the hand orthotics. These helped considerably to support carryover of the Mrs. Smith’s goals and to reduce pain and anxiety associated with incorrect positioning.

When Mrs. Smith transitioned to a tracheotomy, I provided her with a mouth stick and instructed her on how to use a communication board. Ultimately the mouth stick was modified at her request so that she could express herself through painting. Room modifications were made to support engagement in occupational performance and social interaction by moving the clock to a visible location and turning her bed so that she could look out and see the nursing unit. The family was encouraged to post pictures of family members, and a favorite soothing photo was enlarged and posted on the ceiling to assist with anxiety management.

As she became more alert, she expressed a desire to spend time outside of her room and visit with her husband and family in the hospital garden. Transfer training became the next priority. I provided her with a loaner recliner wheelchair and high pressure relieving cushion, modified the chair to enhance comfort and used a pressure mapping system to illustrate the importance of correct positioning. Mrs. Smith’s transfers into a recliner wheelchair on the weekends were timed to coincide with her son’s visits. With the son’s presence during OT sessions – along with visits by other family members – she was willing to sit up longer, and these visits served as a powerful distraction for reducing anxiety and became a potent motivator for participation.

Based on Mrs. Smith’s priorities, realistic and achievable goals were set and ultimately met. These goals were revised weekly. At discharge, Mrs. Smith was able to pursue more roles she highly valued according to the RC. Her COPM and OSA scores both showed improvement, reflecting increased engagement in valued and meaningful life pursuits. Mrs. Smith was ultimately able to be discharged to a rehabilitation facility closer to her home, family, and friends to continue her recovery.
**Criterion 7—Intervention: Design & Implementation**

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

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

1. **Dates of mentoring relationship**
   
   Twice per week for 1 hour (January 4 – March 18, 20XX) for a total of 14 hours:
   
   - January 04, 20XX (1.0 hour)
   - January 11, 20XX (1.0 hour)
   - January 14, 20XX (1.0 hour)
   - January 18, 20XX (1.0 hour)
   - January 25, 20XX (1.0 hour)
   - January 31, 20XX (1.0 hour)
   - February 05, 20XX (1.0 hour)
   - February 17, 20XX (1.0 hour)
   - February 24, 20XX (1.0 hour)
   - February 28, 20XX (1.0 hour)
   - March 04, 20XX (1.0 hour)
   - March 12, 20XX (1.0 hour)
   - March 18, 20XX (1.0 hour)

2. Approximately how many hours did this represent in total? 14 hours

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

   - **A)** To design 3 effective low vision treatment interventions that are client-centered in the older adult population.
   - **B)** To implement and assess 2 low vision treatment interventions that are client-centered and contextually-relevant interventions in the older adult population.
   - **C)**

4. **Mentor** | Jane Doe, MS, OTR/L

   **Position/Role of Mentor** | Staff occupational therapist in Assisted Living Facility (ALF) for 10 yrs. Jane was committed to this partnership to enhance my clinical reasoning and clinical performance skills in low vision with the older adult population.

   **Workplace of Mentor** | ALF

   **Contact Information for Mentor (email or phone number)** | JaneDoe@email.com
5. State why the mentor was selected to help you meet the goals identified above relative to the criterion specified. *(average word guideline–50)*

As an experienced OT, she brings knowledge and an enhanced clinical set to the older adult population. Jane Doe has attended several continuing education courses that focus on developing effective and client-centered interventions in the SNF and is recognized in our region as a low vision expert. I was new to the ALF setting and wanted to increase my skills in low vision interventions.

6. Briefly describe how the skills acquired from this mentoring activity influenced your service delivery with clients, specific to your ability to "design and implement gerontology interventions that are client-centered, contextually relevant, and evidence-based to facilitate optimal occupational engagement." *(average word guideline–350)*

Through this mentoring experience, I learned how to analyze and implement low vision interventions that are client-centered, contextually-relevant, and evidenced-based to facilitate true optimal occupational engagement for the older adult population. Clients participating in an enhanced skilled intervention that is evidenced-based and contextually-relevant impact occupational engagement and facilitate positive outcome achievement.

Mrs. Smith is someone for whom I provided services with the support of my mentor. Examples of client-centered, contextually-relevant, and evidenced-based interventions that I learned and provided include:

- This client expressed concerns with matching her clothing, seeing small items to complete needle point projects, and seeing the buttons on the microwave during meal time. Due to these concerns, the client began decreasing her occupational engagement in social activities in the ALF and stopped wearing clothing with buttons.

  Jane oversaw my use of a number of low vision assessments to evaluate Mrs. Smith’s impairments, including: Vis Tech Cards, Lea Contrast Sensitivity Chart, The National Eye Institute 25-Item, AMPS.

- I learned to provide specific sequencing steps with Mrs. Smith to safely use a table top microwave to prepare her noon meal, and tried various working surface distances to achieve best visual acuity for table top detailed task work and reading.

- I learned to modify the client’s environment with contrast tape, contrast background, lighting, and elevation of work surface in her ALF apartment.

- The mentor provided me with information concerning a number of low vision resources, and I provided Mrs. Smith with the AOTA fact sheet “Occupational Therapy Services for Persons with Visual impairment” to increase her and her family’s understanding of the role of OT in low vision in the ALF setting.

I discovered the importance of applying advanced knowledge that is evidenced-based in the focus of low vision practice.

Throughout this mentoring experience, I learned about specific low vision treatments that are provided in the client’s own environment to facilitate optimal occupational engagement.
PROGRAM DEVELOPMENT

Criterion 8 - Intervention: Wellness & Prevention

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

Guidelines

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

1. Dates of program development. April 1st 20XX through June 12th 20XX

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

   The purpose of the Members Only Program is to maintain and/or improve functional levels of nursing home residents through meaningful activity. I developed this program at ABC nursing home to provide long-term residents with a 3-day a week club where they engaged in group activities that are physically and cognitively stimulating and meaningful. Residents discharged from rehab services are invited to join this club. OTs and PTs tailor exercise programs to club activities prior to discharge, and restorative nurses and activity staff carry out resident-specific plans in the club setting.

3. Describe how this program development activity, including description of resources used, demonstrates your ability to “provide gerontology intervention that incorporates wellness and prevention for clients (persons, organizations, populations) to optimize present and future occupational engagement.” (average word guideline–500)

   As the OT at ABC nursing home, I noticed that when residents were discharged from OT services and became long-term residents of the facility, many of them returned to visit the OT department and requested to partake in therapy.

   I consulted with the activity director concerning attendance of these residents during already scheduled afternoon activities, and she reported that participation was inconsistent. I interviewed 5 residents who often spent time in the OT department, and they stated that they liked to come to the department since it felt more like a club or somewhere they belonged.

   My observations of the residents, along with subsequent interviews with the activity director and other residents helped me identify a need for an activity that would provide meaningful occupation and a sense of belonging for residents. The activity director and I met several times over a period of 2 weeks and decided to create a club that met 3 times a week at 2:00pm in the activity room. The club has a schedule of group activities and required membership to attend. The activities director created posters to advertise the club, application forms and membership badges. The equipment used for club activities was already owned by the facility.

   Membership is open to former rehab clients and all nursing home residents. Once an application to join the club is received, the resident is referred to OT for an evaluation of their current ability to engage in specific club activities designed to improve or maintain occupational performance. If necessary, the resident receives OT during club meetings to modify the environment and/or train the activities staff in assisting the resident in physical activities or how to modify an activity based on the resident’s cognitive abilities.

   The club has been very successful. Currently, 54% of the residents are club members and carry membership cards with them. Since club inception, the incidents of decline in late loss ADLs have decreased and there is a noticeable increase in the number of residents socializing in common areas during non-club times.

   We found that creating an engaging environment with an added layer of ownership and belonging increased resident engagement in social and meaningful activities. I – and other staff members – believe this increased engagement has resulted in improved functional capacity and participation in social interactions.
Criterion 9–Outcomes

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

Guidelines

- Refers to an activity implemented in a program, department, facility, or organization.
- Should not include any form of standard client documentation (e.g., evaluation summary, discharge plan) or identification of client name(s) or facility information.

1. Type of Program/Service Being Evaluated  | Chronic pain outpatient geriatric rehabilitation program.
---|---
Date(s) of Evaluation  | Three years between July 1, 20XX to June 30, 20XX

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

I evaluated services delivered in a 17-day interdisciplinary outpatient geriatric pain rehabilitation program. The goal of the program is to assist older adults (average age 71) who have chronic dependence on prescription and over the counter analgesics return to improved activity patterns relative to self-care and productive and leisure activities, and to eliminate pain behaviors. A cognitive-behavioral model was the basis for treatment and incorporated OT, physical therapy, biofeedback, relaxation training, stress management, wellness instruction (e.g., sleep hygiene, healthy diet), chemical health education, and pain management training (e.g., activity moderation, elimination of pain behaviors).

Starting in July I began using the Canadian Occupational Performance Measure (COPM) with each participant at both program entry and discharge. OTs administered the COPM to obtain each client’s perceived performance and satisfaction in activities that were important to them. During treatment, the OTs addressed occupational performance by assisting in lifestyle modifications, recommending task adaptations, and educating participants in managing pain through engagement in meaningful occupations. The OT intervention combined group and one-on-one discussion and education with hands-on practice of daily activities. Participants were able to demonstrate both verbal and physical understanding of concepts and techniques through active participation. OTs also used biofeedback as a tool to assist participants in learning how to perform relaxation techniques as a means to manage pain.
3. Identify methods or tools used for the program/service evaluation. *(average word guideline–200)*

Comparison of initial and discharge scores from Canadian Occupational Performance Measure (COPM) for all older adult participants who completed the program.

4. Summarize evaluation findings. *(average word guideline–200)*

Data from 1,212 older adult (68% female; 32% male) participants over a 3-year period was evaluated from July 20XX to June 20XX. Positive benefits of the program were clearly illustrated in changes to the older adults’ functioning, specifically in performance and satisfaction of activities identified as important to them. At admission, the average performance score on the COPM was 3.45 and the average satisfaction score was 2.2. At discharge, the average performance score rose to 7.03 and satisfaction also rose to an average of 6.84.

When analyzing the data in regard to gender differences, males scored significantly higher in satisfaction at admission, and females scored significantly higher in performance and satisfaction upon discharge. At admission, the average male satisfaction score was 2.4 and 2.2 for females. At discharge, scores rose to 6.7 and 8.39 respectively. Females and males did not differ in a statistically significant manner in performance upon admission. At admission, the average male performance score was 3.56 and 3.44 for females. At discharge, scores rose to 6.78 and 7.15 respectively.

Finally, data analysis for outcomes for the 5 most prevalent diagnoses – including fibromyalgia, low back pain, generalized limb pain, abdominal pain, and headache – indicated that changes in performance and satisfaction, from admission to discharge, were statistically significant based on diagnosis. For the most prevalent diagnostic groups, admission scores rose to a range of 6.62 to 7.42. Performance ranged from 3.29 to 3.62, and at discharge these scores rose to a range of 6.91 to 7.41. Satisfaction scores at admission ranged from 2.09 to 2.44 and at discharge had risen to a range of 6.62 to 7.42.

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

Through a formal evaluation of this program, we were able to validate a number of approaches that had been established. We considered that, although programming is primarily provided in a group setting, individual one-on-one sessions might be geared to older adult participants more specifically based on gender and diagnosis in order to provide greater individualization and potentially improved outcomes, since heterogeneous client populations did not always respond equally. This is something we continue to explore.

6. Summarize how this program evaluation demonstrates your ability to "evaluate effectiveness of services delivered, either for caseload or programs, in order to validate service delivery and make changes as appropriate to maximize outcomes related to gerontology.” *(average word guideline–300)*

I feel that this service delivery evaluation of a geriatric chronic pain program, that uses a cognitive-behavioral approach rather than a curative and interventional approach, illustrates my ability to evaluate the effectiveness of services delivered. As this is an interdisciplinary pain program, outcomes could not specifically be linked to OT alone. However, through use of the COPM, we were able to validate that this interdisciplinary pain rehabilitation program (that incorporated OT interventions), improved both older adult participants’ performance and satisfaction in activities that were important to them and enabled their return to occupations they reported to be more satisfying.
Criterion 9–Outcomes
Evaluates effectiveness of services delivered, either for caseload or programs, in order to validate service delivery and make changes as appropriate to maximize outcomes related to gerontology.

What type of research was conducted? Please choose 1.

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

1. Title of research conducted.
   - **The Efficacy of an Allen-Cognitive Approach in Nursing Homes**

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

Citation:
- Not included for this example, but should be included if activity is used for application.

3. Role of applicant in the research. *(average word guideline–25)*
   - **Sole researcher**
4. Purpose and rationale of the research. (average word guideline–250)

I work in nursing homes with geriatric clients who have cognitive deficits, and I have used the Allen-cognitive assessments and tools for identifying cognitive levels and for training caregivers on the resident’s remaining abilities. I found the Allen tools to be very beneficial but wondered if there were better tools available. I reviewed the literature to find information on the efficacy of programs for this population and found no quantitative research on the effectiveness of any specific rehabilitation-driven dementia care programs in nursing homes. The paucity of information in the literature motivated me to conduct a study to examine the efficacy of an Allen-cognitive approach to the care of nursing home residents with dementia or other cognitive deficits. The study examined whether or not there was a relationship between implementation of an Allen-cognitive approach to nursing home care and the number of quality indicators recorded by the nursing home for residents with cognitive deficits.

5. Describe how this research demonstrates your ability to “evaluate effectiveness of services delivered, either for caseload or programs, in order to validate service delivery and make changes as appropriate to maximize outcomes related to gerontology.” (average word guideline–400)

This study used quantitative data to validate the effectiveness of the Allen-cognitive approach to care in a nursing home. The study found two statistically significant positive relationships between implementation of an Allen-cognitive approach and the number of quality indicators for nursing home residents with cognitive deficits. First, for the entire study cohort, there was a statistically-significant positive relationship between the implementation of the Allen-cognitive approach and the number of quality indicators for behavioral symptoms affecting others (t(30) = 2.75, p < .05). Also, for subjects with eight (average of 2.67) or more total quality indicators in the pre-Allen-cognitive approach period, there was a statistically significant decrease in the total number of quality indicators after the implementation of the Allen-cognitive approach (t(22) = 2.23, p < .05).

Each quality indicator represents an area of care for nursing home residents. Quality indicators do not provide definitive measurements of nursing home care but do identify functional problems and are used by the state for monitoring nursing home quality and to track trends in nursing home care. A reduction in the number of quality indicators in a nursing home is associated with improvement in resident care and a decrease in the burden of care for caregivers.

The results of this study provided me with data to share with interdisciplinary team members to support our use of the Allen-cognitive approach. Based on the results of this study, I was asked by the nursing home company I work for to mentor OTs in other facilities within the company on the use of the Allen-cognitive tools in nursing homes. I am currently creating a training program for all nursing home staff on the most effective techniques for interacting with geriatric residents at the different Allen-cognitive levels.
HOLISTIC PRACTICE CASE STUDY

Criterion 10—Holistic Practice

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

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

2. Date(s) case study represents. May 3 – May 29, 20XX

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

Clara is an 82 year old widow, 3 weeks s/p hip fracture, who underwent an open reduction and internal fixation (ORIF) at a nearby hospital. She tripped in a parking lot while out to dinner with friends. Subsequently, I treated her when she was sent to our skilled nursing facility for rehabilitation. Clara spent several weeks in rehabilitation learning to complete her basic activities of daily living (ADLs) while maintaining a partial weight bearing (PWB) status on her right lower extremity. She became proficient at her functional mobility skills using a wheeled walker within the facility. She deals with significant pain in that leg and a decreased ability to reach her feet for clothing management and dressing skills.

Clara is being considered for discharge to her home as soon as she is independent with a walker. I identified that Clara lived alone in a one-story single family home. Also noteworthy is Clara’s past history of macular degeneration that was considered a contributing factor to her fall. Clara expressed concerns over her inability to drive due to her failing eyesight and current PWB status on her right (driving) leg when she returns home. I educated her on driving cessation options and alternative community resources. She also expressed concerns over her fear of falling again when accessing the community. Clara confided she feels a keen sense of loss since her husband passed away 6 months ago.

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

Clara cared for an ailing husband for the last 5 years, who died from cancer at home only 6 months ago. She is having a difficult time reconnecting with friends and old leisure activities. She acquired some bathing durable medical equipment (DME) while caring for her husband, but is not sure what happened to it. She had been driving in the community to go to church, pick up groceries, and to go to doctor appointments. Clara has some macular degeneration (dry) in 1 eye that appears to be getting worse. I identified the following barriers to her returning home alone:

1) depression over the recent loss of her husband,
2) fear of falling again,
3) failing eyesight and the effect on her ability to safely complete BADLs and IADLs,
4) inability to resume social activities,
5) pain in PWB RLE,
6) need for DME to assist with safe bathing activity,
7) Inability to access the community for IADLs.
This case is a good example of how I holistically address my work with clients. While she was referred for physical needs, it became clear that there were social and emotional needs impacting her overall performance. Due to my experience and community contacts, I was able to impact total client needs in the following manner:

**Physical:**
Since mobility is temporarily impaired, I arranged for her to take advantage of Meals-on-Wheels until she can decide to have her groceries delivered or make other arrangements. Her medications are also being delivered from her local pharmacy.

Clara has been referred to a free local medical equipment exchange program through her church to acquire the recommended bathroom items. She was able to demonstrate safe bathing technique using a bath bench and grab bars. She was also recommended to use a raised toilet seat to help maintain PWB status and reduce pain levels with sit to stand while toileting.

Home health occupational therapy was requested to assist with safe installation of bathroom DME equipment, carry-over of WB status during ADL and IADL completion, fall prevention strategies and home safety issues.

**Social:**
I recognized that driving would be impacted by her macular degeneration and PWB status on the RLE, and provided her with information and costs on medical-based driving programs in her area. I counseled her about possible driving cessation and community options for community mobility so she could still engage with friends.

Clara was referred to Social Services to address community access, as well as the potential for moving to an assisted living facility (ALF).

**Emotional:**
I addressed her depression by using the Geriatric Depression Scale and referred her to a grief counselor with the opportunity to join a support group. I encouraged Clara to contact her church members again. She used to enjoy attending a quilting group that met weekly. I suggested that they may have some tasks that she could do from home until she can rejoin the group. Her church has a home companion program as well, that will keep her connected until she can resume more normal attendance.
Criterion 11—Ethical Practice: Fiscal & Regulatory

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

Guidelines

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

Ethical Scenarios

Scenario #4

Scenario #5

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

Scenario #6

1. To which scenario are you responding? 5

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

   - Beneficence
   - Nonmaleficence
   - Autonomy, Confidentiality
   - Social Justice
   - Procedural Justice
   - Veracity
   - Fidelity
3. Describe how you would apply the ethical principles identified above to guide you toward a resolution for the concern noted. (average word guideline—500)

The therapist has an ethical obligation to be proficient in the administration of the updated edition of the test, and use the most current scoring tables when reporting results.

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

D. Avoid the inappropriate use of outdated or obsolete tests/assessments or data obtained from such test in making intervention decisions or recommendations.

G. Take responsible steps (e.g., continuing education, training) and use careful judgment to ensure their own competence.

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

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

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

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

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

The therapist needs to learn the updated test administration and scoring procedures. She can engage in self-study, and practice the new procedures with colleagues or typically developing children until she feels competent. If support from colleagues is not available, the therapist should pursue a formal professional development activity or a mentor who can support this learning.
### Criterion 12—Advocating for Change

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

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

1. Date(s) case study represents. **April – September 20XX**

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

   I provide OT services to older adults at a day center centrally located in town. Clients who attend this center are older adults receiving Medicaid services, and they normally use city-funded transportation services provided by community transportation systems (CTS). The CTS provides scheduled pickups and drops off clients near the center. The center provides occupational, physical, and speech therapy services, in addition to other leisure and social activities. The original location of the bus stop nearest the center was not accessible for non-ambulatory clients.

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

   I quickly realized that several clients who are non-ambulatory often have difficulty accessing the center because of the bus stop location. I decided it was imperative to advocate for a change in the location of the bus stop in order to provide an accessible entrance for all participants. At that time, we had 2 clients who were unable to utilize the bus transportation system because of the current drop off location, and these clients relied on their caregivers to bring them to OT services. Often the caregiver was working and the clients would miss their scheduled session. I decided to write to the city council members to request funding to change the location of the bus stop and to approve the construction of a ramp.

   I started a petition to collect signatures to support our need for a change in location of the bus stop and for constructing a new ramp. I organized an open house so that local community and business leaders could visit our day center to help increase their understanding of the value of our services. I also spoke at one of our local council meetings to vocalize the need for the change.

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

   As a result of my advocacy, the location of the bus stop was moved and a ramp was added in front of the center. This provides each client with the opportunity to attend our center at their leisure and not have to rely on others for support, thereby enabling clients to be more consistent in participating in OT sessions and in improving their social participation.
As OT practitioners, we must advocate for the required services for our older adult populations. Through advocacy and communication, I was able to receive funding for the construction of a ramp and change the location of the bus stop at our day center. This funding provided an opportunity for older adults, who are non-ambulatory, to utilize the city transportation system and attend our center. Many clients were forced to rely on their caregivers or family members for transportation to the center and were often unable to make it to their OT session or social activity. Through a specifically focused advocacy and goal, I was able to be a change agent for the population that we serve and increase access to services at the center.

Our day center promotes optimal engagement with an activity program designed for each client. When clients are unable to attend, they lose an opportunity to engage in desired activities, such as bingo, sewing, cooking, cleaning, and the book club. Providing easy access to our services enables older adults within our community to maintain relationships and support with other members. Participation in this program enables clients to maintain their highest level of function and to utilize a strong support staff.

I understand the value of the day center to the older adult population, thus I should continue my quest for advocacy and communicate the importance of access to our services within our community. I will continue to speak to our city councilmen, board members, congressional leaders, and the people of our town to help maintain transportation as it currently stands. It is my hope that based upon the current path; we will begin to change or influence policy or programs that promote health and occupational engagement for older adults.
## Criterion 12–Advocating for Change

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

### Guidelines

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

### Type of advocacy activity:

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

### Description of Activity Table

<table>
<thead>
<tr>
<th>Description of Activity</th>
<th>Target Audience</th>
<th>Date(s)</th>
<th>No. of Hours Involved</th>
</tr>
</thead>
<tbody>
<tr>
<td>Organizer of community event (health fair)</td>
<td>Older adults living in the community</td>
<td>02/12/XX</td>
<td>8</td>
</tr>
<tr>
<td>Lobbying to/education for policy makers</td>
<td>Congressional leaders of AnyState</td>
<td>09/19/XX</td>
<td>12 hrs. (includes preparation of materials, meeting, and follow up)</td>
</tr>
</tbody>
</table>
2. Applicant’s objectives for advocating for change. List no more than 3.

A) To speak with congressional leaders during the AOTA Hill Day in Washington, D.C., demonstrate political activism for the older adult population and present data supporting the role of OT in falls risk management.

B) To increase knowledge and awareness of Medicare Part B Caps among older adults and the role of occupational therapy in falls reduction.

C) 

3. Discuss the results, outcomes, or progress toward change affected by this advocacy effort that demonstrates how you “advance access to services or influences policies or programs that promote the health and occupational engagement of clients (persons, organizations, populations) in the gerontology practice area.” (average word guideline–350)

I used the local community health fair as an opportunity to increase the understanding by older adults of the Medicare Part B Cap, its impact on health care services that impact them, and to collect signatures in anticipation of a meeting I had planned with congressional leaders.

During the fair, seniors were invited to participate in a screen to identify falls risk indicators (with provided consent). The data, which I would later share with congressional leaders, demonstrated that 40% of older adults age 75 and older had a risk for falls or high fear of falling. This demonstrated the potential need and importance of OT services with the older adult population, and I was able to collect 50 signatures to support this position. The participants received copies of the screening information and were encouraged to share it with their general practitioner or gerontologist.

I attended the AOTA 20XX Hill Day in Washington, D.C. on September 19, 20XX with more than 400 politically active occupational therapy practitioners from around the US. Individually, I met with congressional leaders of AnyState and discussed OT legislative priorities that included: eliminating the Medicare Outpatient Therapy Cap, including OT as part of the health care solution, and the role of OT services in the older adult population. I shared the falls risk data I collected during the health fair and presented the 50 signatures.

During the meeting I had a positive response by congressional leaders, and several requested that additional information be provided to their staff for follow up. I sent follow-up letters to both congressional leaders from AnyState monthly for a period of 6 months, and was ultimately invited to serve on a newly created Falls Risk Panel for the state. As a result of this advocacy effort, I increased awareness of the value and importance of occupational therapy services for the older adult population.
**Criterion 12—Advocating for Change**

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

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

1. **Name of organization**
   - Falls Free Coalition (FFC)

2. **Dates of service**
   - FFC: Ongoing for 3 years since January 10, 20XX. Face-to-face meeting 5 times per year.

3. **Approximate number of hours of service**
   - FFC 45 hours

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

   I volunteered and have been a board member of my state OT association for more than 20 years. In addition, I have worked exclusively with older adults since 1991 in service settings of hospital based Acute Rehab units, skilled nursing facilities (SNF/LTC), specialty hospitals and more recently, in home health (HH). My decision to work with older adults has sparked my passion for learning and becoming more involved in fall risk and prevention education for the geriatric population. In mid 20XX, I requested to be a liaison (committee member) from our state association board to our state’s Falls Free Coalition (FFC) for fall prevention.
5. Describe how this leadership activity helped you to "advance access to services or influences policies or programs that promote the health and occupational engagement of clients (persons, organizations, populations) in the gerontology practice area." (average word guideline – 400)

<table>
<thead>
<tr>
<th>The FFC consists of representatives from several state agencies, state universities, allied health professions, local agencies on aging, and state-wide district representatives. The current roster includes 46 members. The coalition began with the state AARP, and was supported by the Department of Health and Senior Services (DHSS). The FFC invited key stakeholders to a long-term strategic planning and visioning process that occurred in early March 20XX. This meeting began the state development plan. FFC now has a website and a liaison from the DHSS to monitor it. We developed a governing structure, a membership form, a template for developing local fall awareness days, an educational podcast, and several reproducible resources for community education. The coalition has five sub-committees: Executive Leadership; Best Practices; Public Awareness and Advocacy; Healthcare Provider Education/Professional Affairs; and Data and Evaluation.</th>
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I have personally been involved in the following committee activities:

- 2 annual reviews of the strategic plan that supports the coalition.
- Reviewed assessments used to identify falls risk (e.g., Functional Reach, Get up and Go) for the Best Practices committee.
- Development of annual “Senior Falls Prevention Day” and tracking tool.
- Implementation of “Steady As You Go Program” that has 3 components: public education, exercise programs sponsored by senior centers, and special events with Area Agency on Aging networks.
- Setting state goals for tracking cost reductions in unintentional falls hospitalizations.
- Increasing awareness of possible fall risks, such as medication management, balance, and vision changes.

As a result of my involvement, I have made these changes in my own practice:

- Educate co-workers on the “Fall Prevention” handout.
- Educate students, professional organizations and co-workers on the FFC website and resources.
- Support of annual Fall Awareness Day activities.

This example demonstrates how I have been involved with 1) increasing statewide awareness about the issue of falls and 2) increasing stakeholders’ education concerning prevention and safety. As a result of this work, I have produced a best-practices handout that I use with all of my home health clients discussing falls risk and prevention. Both my volunteer efforts, as well as those that I have implemented in my own practice, focus on the promotion of health and occupational engagement of clients in the gerontology practice area.
**Criterion 13—Accessing Networks & Resources**

**Negotiates the service delivery system to establish networks and collaborate with team members, referral sources, or stakeholders to support clients’ occupational engagement.**

**Guidelines**
- The networking case study should reflect an understanding of the system in which you work and an ability to access resources outside of your routine work group and referral pathways.
- The networking case study should **not** include any form of standard client documentation (e.g., evaluation summary, discharge plan).

1. Date(s) case study represents. **February – April 20XX**

2. Identify the problem(s) that interfered with the client’s (person, organization, population) occupational engagement. *(average word guideline–100)*

   A 65 year old male with a diagnosis of C7 spinal cord injury was 6 months post-injury and was continuing to gain independence with ADLs and IADLS. One of his primary OT goals was to develop a strategy and sufficient strength to perform upper extremity dressing with setup from his power wheelchair. After months of working in a skilled therapy setting with me, he learned to use the grab bar in the clinic restroom to pull his trunk forward, allowing room for the back of his shirt and jacket to fall down behind him. However, the patient and I realized that he would not have access to this grab bar unless he was in our clinic restroom, which created a problem for his independence in other settings.

3. Identify the key networks or resources you established or accessed to address the problem. *(average word guideline–100)*

   My first attempt in addressing the limitation of dressing outside the clinic restroom was to contact the seating and positioning representative to see if an extension could be added to this client’s wheelchair to simulate the grab bar function. Unfortunately, this was not available, but I continued to search for additional local wheelchair and engineer companies to help design a wheelchair modification.

   In performing this search, I discovered that the local university’s engineering program offered design consultations with students and professors. This was an ideal match since an engineering design course was already in place to offer designs to help solve problems for people with disabilities. I took the initiative to participate in the upcoming quarter’s course that allowed my client and me to work with engineers over a 12 week period, designing a lever-based arm rest extension that ultimately serves as a grab bar and provides upper extremity dressing independence for my client.
This case demonstrates my determination in pursuing multiple sources to help solve a client’s occupational performance problem. As an OT, I am accustomed to thinking creatively for solving problems that interfere with my clients’ independence. In this case, my initial thought was to take advantage of our advanced seating and positioning local vendor in order to design a potential adaptation for this client’s wheelchair. When this option was unsuccessful, I decided to research options in the area for private wheelchair companies that could design a unique armrest for this client. While I did find several private companies that were willing to perform this work, it was cost-prohibitive to the client. Alternatively, I came across a more promising and affordable solution at the local university.

I contacted the engineering department chairman seeking information on the EDC, or Engineering Design Course. I submitted a request outlining my client’s problem, how it impacted his independence, and provided brainstorming solutions that I had considered up to that point. I made myself available to meet with engineering students over a 12 week period. I prepared a detailed formal presentation for the class of 50 students, sharing information on spinal cord injury and the associated impact on occupational performance.

The patient and I assessed designs created by the engineering students during our skilled dressing interventions and provided the students with feedback during weekly consultations. These skilled trials with the client supported his occupational engagement in both ADL and IADL since the bar was also used by the client to help perform pressure relief and improve overall sitting tolerance.

My collaboration with the client, the engineering students, and professional engineers resulted in a final design featuring a lever-based armrest extension for the client that can go with him wherever he performs upper extremity dressing.

In summary, this case is a strong example of developing new networks with team members and other professionals to support this client’s occupational engagement. Since my initial experience, I have further strengthened this relationship by using the EDC as a networking source for more than 10 other clients.