Fieldwork

Navigating Fieldwork’s Ethical Challenges
Reflective Writing in Level II Fieldwork To Promote Clinical Reasoning

PLUS
Pictorial History of AOTA
Evidence Perks
News, Capital Briefing, & More

CE ARTICLE
Secondary Prevention Related to Work: The Role of Occupational Therapy
As an occupational therapy fieldwork educator, your knowledge, supervision, and direction are critical to the success of your students and to the future of occupational therapy. AOTA is pleased to offer you the opportunity to advance your skills in this important area at an AOTA Fieldwork Educators Certificate Workshop!

**Here’s what you can expect to gain from this unique 2-day training for fieldwork educators and academic fieldwork coordinators—**

- Deeper understanding of your role as a fieldwork educator
- Effective strategies to integrate learning theories and supervision models
- Increased skills to provide high-quality fieldwork experiences
- Interaction with trainers through dialogue and reflections about fieldwork
- Engagement in four curricular modules: administration, education, supervision, and evaluation
- Analysis of strategies to support best practice in fieldwork education

**Earn 15 contact hours (1.5 AOTA CEUs/15 NBCOT PDUs).**

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For a list of available program workshops, go to [www.aota.org/FWECWorkshop](http://www.aota.org/FWECWorkshop).
Features

Navigating Fieldwork’s Ethical Challenges

Relevant Issues and Appropriate Resolution Techniques

Joanne Estes and Lea Cheynne Brandt outline how students can best respond to the many complex ethical challenges they may encounter during fieldwork placements.

Reflective Writing in Level II Fieldwork

A Tool To Promote Clinical Reasoning

Debra Hanson, Jody K. Larsen, and Sarah Nielsen discuss how journaling helps fieldwork students reflect on their knowledge, practice, and communications.

Special

In Honor of OT Month

History of The American Occupational Therapy Association, Inc.

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Send e-mail regarding editorial content to otppractice@aota.org.

Go to www.otpractice.org/currentissue to read OT Practice online.


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Back issues are available prepaid from AOTA’s Membership department for $16 each for AOTA members and $24.75 each for nonmembers (U.S. and Canada) while supplies last.
AOTA Updates

Autism Survey

OTA has developed a survey for occupational therapy practitioners working with children ages birth to 6 to learn more about their autism-specific screening and referral practices. The survey is a research project being promoted through a partnership with the Centers for Disease Control and Prevention (CDC), AOTA, the American Physical Therapy Association, and the American Speech-Language-Hearing Association, and relates to the CDC “Learn the Signs. Act Early” campaign.

To access the survey, please go to http://www.surveymonkey.com/s/aota. The deadline to complete the survey is June 1, 2011.

ACOTE Seeks New Accreditation Evaluators

The Accreditation Council for Occupational Therapy Education (ACOTE®) is once again seeking new members for the Roster of Accreditation Evaluators (RAE). RAE members evaluate compliance with ACOTE Standards for more than 350 occupational therapy and occupational therapy assistant educational programs, helping to ensure the competency of future occupational therapy practitioners.

The onsite evaluations and paper reviews conducted by RAE members provide ACOTE with the information necessary to make its accreditation decisions. Commenting on her experience as an accreditation evaluator, ACOTE member Dahlia Castillo, MS, OTR, stated: “As a practitioner, I find it fascinating to have a direct link to the education of future therapists. As a member of the RAE, I have had the privilege of meeting exceptional OT and OTA educators, clinicians, and students all over the country. Being a volunteer on the RAE is something I recommend to clinicians as an opportunity for professional growth and personal fulfillment that is beyond compare.”

For the positions to be filled in 2012, ACOTE is placing a strategic emphasis on recruiting a diverse pool of accreditation volunteers. Doctorally prepared OT practitioners and OTA educators are especially needed and are strongly encouraged to apply.

To qualify as an accreditor (RAE member), the applicant must:

- Be either an occupational therapist or occupational therapy assistant.
- Be a member in good standing with AOTA.
- Have at least 5 years of experience as an occupational therapy practitioner, including 3 years in education or fieldwork, occupational therapy administration, or another area of expertise.
- Not hold concurrent positions on any AOTA policymaking or decision-making body, including the Representative Assembly (Representative or Alternate), Board of Directors, Ethics Commission, or Commission on Education. In addition, RAE members may not hold a position in a credentialing capacity (e.g., National Board for Certification in Occupational Therapy [NBCOT] Executive Board member or Certification Examination Item Writer).

Selection Process

Applications will be accepted by the AOTA Accreditation Department until June 15, 2011. Members of the ACOTE Executive Committee, in collaboration with AOTA accreditation staff, will review all eligible applications, and the final list of applicants will be reviewed by members of ACOTE. After the selections are made, all applicants, whether selected or not, will be informed in writing of ACOTE’s decision by July 2011.

Duties and Responsibilities

All new members of the RAE will receive 2 1/2 days of training at the November 11 to November 13, 2011, Accreditation Evaluator Workshop to learn how to review and evaluate programs using the 2006 Standards. Newly trained evaluators will begin their first term of 3 1/2 years on January 1, 2012. RAE members are expected to participate in onsite accreditation evaluations as requested, complete paper reviews and peer evaluations as requested, and maintain communication with AOTA Accreditation staff and ACOTE. All expenses for onsite visits are fully reimbursable.

Application Process

If you or someone you know would be well suited for this exciting and important volunteer position, download the Educator or Practitioner Application for Membership from the Announcements & Newsletters section of the ACOTE Web site at www.acoteonline.org or request an application from AOTA Accreditation staff by e-mail at accred@aota.org or by phone at 301-652-6611, ext. 2914.

Applications should be completed and returned by e-mail to accred@aota.org or by mail to the ACOTE Accreditation Program, c/o AOTA, P.O. Box 31220, Bethesda, MD 20824-1220 no later than June 15, 2011.

Children’s Mental Health Awareness Day

Children’s Mental Health Awareness Day is May 3. An AOTA-sponsored virtual chat on pediatric issues will be held May 2, 2011, from 11:00 a.m. to noon EST, focusing on Children’s Mental Health Awareness Day and a new AOTA tip sheet on play. To access the call, go to www.talkshoe.com/tc/73733. For additional resources on children and mental health, go to Children and Youth in the Practitioners section of AOTA’s Web site, and click on Mental Health in the Browse by Topic section. To be considered as a member in AOTA’s volunteer school mental health workgroup, create a profile in COOL; www.aota.org/governance/leadership/volunteer/pediatric.aspx.
New Podcast: Universal Design

Listen to Vanessa Roberts, OTR/L, of VA Puget Sound Healthcare System in Seattle, Washington, and Michele Luther-Krug, COTA/L, SCADCM, CDRS, of Shepherd Center Driving Program in Atlanta, Georgia, discuss universal design—including accessibility, new research and technology, and how practitioners can get involved—at www.aota.org/consumers/consumers/podcasts.

Resources

Medicare Proposal on Accountable Care Organizations Released

The Centers for Medicare & Medicaid Services (CMS) has issued a proposed rule regarding Accountable Care Organizations (ACOs). Authorized by section 3022 of the Affordable Care Act (the health care reform law), ACOs are designed to create incentives for health care providers to work together to treat an individual patient across care settings. ACOs that lower health care costs while meeting performance standards on care quality will be eligible to receive financial incentives through the Medicare Shared Savings Program.

Under the lengthy proposed rule, providers participating in an ACO would work together to coordinate care as patients move among practitioners’ offices, hospitals, laboratories, and other settings, in an effort to streamline the process and eliminate duplication and errors. Patient and provider participation in an ACO is voluntary, and Medicare beneficiaries are expected to still be able to obtain their regular Medicare fee-for-service benefits, such as the annual wellness visit, from ACO providers.

For more on this, go to www.aota.org/news/advocacynews.

Connections

On March 31, 2011, Chris Metzler, AOTA’s chief public affairs officer, participated in a Professional Organizations Panel as part of the 2011 Army Medical Specialist Corps Iron Majors Week Conference in Arlington, Virginia. She discussed public policy issues that AOTA is addressing.

In addition, on March 23, 2011, Metzler and Karen Smith, OTR/L, CAS, practice associate with AOTA’s Approved Provider Program, attended a Centers for Disease Control and Prevention (CDC) meeting in Washington, D.C., on the Safe States Alliance, discussing priorities for the National Center for Injury Prevention and Control at CDC. AOTA’s work on Medicare polity related to falls was highlighted.

Practitioners in the News

Terri Nishimura, MA, OTR/L, was named a “Woman of the Year” in Los Angeles County by the Los Angeles County Board of Supervisors and the Commission for Women. Nishimura, one of the founding executive directors of the Pediatric Therapy Network, received the award for making a difference in the lives of women in Los Angeles County and bringing about social and economic change.

Heather Fisher, MS, OTR/L, received the 2011 Fieldwork Educator Award from AOTA.


B. Napier

This interactive book and CD-ROM provide students with an organizational tool that will help them make the transition smoothly and thrive during their fieldwork experience. This combination calendar–planner and self-organizer includes concepts from the Occupational Therapy Practice Framework: Domain and Process, 2nd Edition. Chapters feature successful personal, professional, and client strategies, as well as reflective forms to complete. $34 for Members, $49 for Nonmembers. Order #1253. http://store.aota.org/view/?SKU=1253

Clinical Supervision in Occupational Therapy: A Guide for Fieldwork and Practice (w/CD-ROM)

D. Costa

Addresses the research, theory, development, and training gaps in the occupational therapy knowledge base and provides a theoretical and philosophical framework that corrects myths about clinical supervision and forges a connection between the theory and practice of clinical education and supervision. $49 for Members, $69 for Nonmembers. Order #1238. http://store.aota.org/view/?SKU=1238

Clinical Environment in Occupational Therapy

L. Cheyney Brandt

Earn .1 AOTA CEU (1 NBCOT PDU/1 contact hour).

Exploring organizational ethics topics that may influence the ethical decision making of occupational therapy practitioners. Course material looks at ethical conflicts that may arise between the practitioner as an organizational employee and as an autonomous health care provider. $45 for Members, $65 for Nonmembers. Order #4841. http://store.aota.org/view/?SKU=4841

Ethics Topic—Moral Distress: Surviving Clinical Chaos

AOTA CeonCD™

L. Cheyney Brandt

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Explores how the complex nature of today’s health care environment may result in increased moral distress for occupational therapy practitioners as individuals. In addition to exploring the sources of moral distress, the course offers coping strategies for reducing negative outcomes associated with this rising phenomenon. $45 for Members, $65 for Nonmembers. Order #4840. http://store.aota.org/view/?SKU=4840

Buy Together and Save 15%!

Ethics Topic Set

$76.50 for members, $110.50 for nonmembers. Order #4840K. http://store.aota.org/view/?SKU=4840K

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Duquesne University. The student-nominated award recognizes an exceptional fieldwork educator who demonstrates commitment to high quality education of Duquesne University students and whose clinical practice exemplifies superior care to clients. Fisher is an occupational therapist at The Day School at The Children’s Institute in Pittsburgh, Pennsylvania.

Samia H. Rafeedie, OTD, OTR/L, assistant professor of clinical occupational therapy and occupational science at the University of Southern California, attended the Institute of Medicine’s meeting on cognitive rehabilitation therapy for traumatic brain injuries on March 16, 2011 in Irvine, California. Rafeedie, the co-chair of the Occupational Therapy Association of California’s Professional Development and Leadership Committee, commented on the importance of occupational therapy to help individuals engage in meaningful activities during the rehabilitation process.

Adam Simoes, an OT working in Aroostook County, Maine, was featured in the March 15, 2011, Bangor Daily News front page article “An Awesome Patient: Mars Hill Man Burned in Electrical Accident Battles Back to Health.”

In Memoriam

Joyce Slatky Collins, OTR, died February 26, 2011. A graduate of the Occupational Therapy Program at Mount Mary College in Milwaukee in 1948, Collins worked at Iowa State Hospital and South Dakota State Hospital before moving to North Augusta, South Carolina, in 1954. She set up several clinical programs in the Augusta area before joining the faculty of the Department of Neurology at the Medical College of Georgia. When educational programs in occupational therapy and physical therapy were established at the Medical College in 1970, Joyce taught in both.

She published articles on stroke rehabilitation and cerebral palsy, was a past president of the Georgia Occupational Therapy Association, and was named a Georgia Therapist of the Year. She ended her professional career as coordinator of therapies at Gracewood State School and Hospital in Augusta, Georgia.

Collins held board positions with United Cerebral Palsy, Epilepsy Association of Georgia, and the Muscular Dystrophy Association.

In addition to a 50-year career in occupational therapy, Collins was the mother of six children and an active community volunteer.

—Nancy Prendergast

Ted McKenna is the editor of OT Practice.

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During my 5 years representing AOTA before Congress, I have written many articles on many challenges on Capitol Hill. Issues change, but one issue always rears its head sometime in the fall, at the end of the calendar year: the Medicare Part B Outpatient Therapy Caps—or “the cap,” as it is affectionately known on the Hill and by most occupational therapists and occupational therapy assistants.

But this year something is different. The annual cap article is being written in April, early in the year, and the situation is urgent. Every year, Congress introduces a bipartisan therapy cap repeal bill, and it is used to raise the profile of the issue so that Congress acts to avoid the cap, usually by extending the current exceptions process for a year or two. The exceptions process ensures Medicare beneficiaries will be able to access the medically necessary rehabilitation services they need to live life to its fullest.

This year, however, it is not business as usual on Capitol Hill. There is no cap bill yet.

For better or worse, depending on your political perspective, the debate has been changed in Washington, and it has moved significantly to the “right,” or more conservative, fiscally conscious side. Tea Party candidates that ran on Republican tickets in November 2010 have swept into office and are working to hold the line on spending, to fulfill their campaign promises. The Republican majority has moved that way, too, and many Democrats are also being very conservative about spending. This considerable opposition to spending has placed action on the Medicare Part B Outpatient Therapy Caps in significant jeopardy.

No House or Senate Republican so far is willing to sponsor and take the lead on the legislation in the current 112th Congress. The major obstacle is the cost of repealing the cap or even of extending the exceptions process. Although cost issues must be considered, AOTA has always pursued and obtained bipartisan support because forestalling the cap helps Medicare beneficiaries.

Every year, if applied, the therapy cap would affect more than 640,000 Medicare beneficiaries. A whopping 15% of beneficiaries receiving therapy would hit the cap and be denied outpatient rehabilitation services. The cap is clearly a beneficiary issue, as rightly recognized by our partners at the Consortium for Citizens with Disabilities, the American Heart and Stroke Association, and the Parkinson’s Action Network, among others, and as evidenced by the Stop the Medicare Therapy Cap Facebook page, which has more than 4,300 “Likes”—clear evidence of the problem’s importance even in the digital world.

But underneath it all, the problem of the cap is also one of spending. Extending the exceptions process for 2012 is expected to cost roughly $900 million. And the cost of repeal, which by rule has to extend over a 10-year budget window, is estimated by the Congressional Budget Office to exceed $10 billion.

In this environment, many sympathetic members are reluctant to take up such a costly issue even though the cause is just and the consequences of inaction are dire. AOTA is also working to develop alternatives to the cap that would ensure only appropriate and necessary therapy is provided.

But it will not be enough to wait until the fall to begin our advocacy efforts in earnest. AOTA and our members must start now. In addition, it is critical that we enlist Medicare beneficiaries to advocate against the cap. Educate your patients, educate your family and colleagues, and educate your elected members of Congress. We must not fail.

Luckily, we have engendered a culture of advocacy within AOTA. We have built our annual Capitol Hill Day into a force that had roughly 400 participants last year, and we have created a track record of legislative activism and success. This year we will need to build on those achievements to face our most significant challenge of the past decade. Health reform has created enormous opportunities for the profession, but it has also stressed the health care financing system, particularly for Medicare and Medicaid.

In every crisis there is opportunity, and in this Congress, opportunities abound. Together, we can face these challenges and take advantage of opportunities. But this year, we need to start a little earlier and with a true sense of urgency, because it is not business as usual on Capitol Hill.

Tim Nanof is AOTA’s federal affairs manager.
Using Evidence in Practice
Experience From the Trenches

Marian Arbesman          Lizabeth Metzger          Deborah Lieberman

Providing best practice has always been at the forefront of occupational therapy. Since 1998, AOTA’s Evidence-Based Practice (EBP) project has incorporated this concept by developing and providing resources that enable occupational therapy practitioners to find and use research evidence that supports their practice. AOTA’s Centennial Vision has strengthened the goal of using evidence and provides a clear path for occupational therapy practitioners working with all individuals by emphasizing excellence in service that is informed by evidence.

We have long known that the use of evidence is growing. This latest Evidence Perks profiles two occupational therapists who have made incorporating evidence an important part of their practice. Anita Wyrick, OTD, OTR/L, and Maddie Maglio, MS, OTR/L, bring evidence into practice in different ways, but both imbue their work with passion, curiosity, and a desire to make sure their clients receive interventions that are client centered and informed by evidence.

Wyrick’s interest in EBP began before she entered her postprofessional master’s program at Virginia Commonwealth University (VCU) in 2000. As an occupational therapist working in the school system for 6 years, she was frustrated by not being able to get the information she needed for best practice, including providing the most up-to-date research possible to the families of children with whom she worked. Her studies at VCU introduced her to EBP, and she developed the skills she needed to search for evidence and analyze the research literature. As a result of her proficiency and confidence in research analysis, she reports that she became the “go to” person for teachers and administrators in her school district. She believes that presenting evidence brought credibility to her work and also resulted in better collaboration with coworkers, teachers, consumers, and administrators.

Wyrick’s capstone project for her OTD, also at VCU, brought her work on EBP to another level. Her project was to develop and teach an online course on EBP to occupational therapy practitioners working in school districts in her local area in Virginia. Since her recent retirement, she has also taught a course on EBP at VCU as well as half-day and 2-hour workshops at a variety of conferences, including AOTA and Virginia Occupational Therapy Association annual conferences.

Maddie Maglio credits her family’s interest in researching topics of importance as the spark for her involvement in EBP. As a student in the Master’s Program in Occupational Therapy at Boston University, as well as during her fieldwork in the EBP Project at AOTA, Maglio fine tuned her curiosity and ability to ask questions and challenge the status quo. She has continued using these skills during the 2 1/2 years she has worked as an occupational therapist at Spaulding Rehabilitation Hospital in Boston.

Although finding time to look for evidence has been challenging, Maglio reports that she makes it a priority, as she feels that it is crucial to providing best practice. Taking a monthly course on research and statistics through the Clinical Scholars Program at Spaulding has helped her hone her evidence skills and provided her with the confidence to think about partnering with others in clinical research projects that will result in evidence for practice.

Although both Maglio and Wyrick mentioned that it does take time and energy to find and use evidence, they also said that partnering with others to share ideas facilitates the process. Both spoke of the value of journal clubs for sharing up-to-date information on evidence and strengthening critical appraisal skills. As a newer practitioner, Maglio spoke not only of the importance of having a supervisor who supports her interest in evidence, but also of her good fortune of having partnered with others in clinical research projects that will result in evidence for practice.

Anita Wyrick, OTD, OTR/L, and Maddie Maglio, MS, OTR/L, show that with some time, effort, practice, and help from peers, it is possible to provide evidence-based, client-centered, and up-to-date care for consumers.

Evidence Perks continues on page 15.
Fieldwork is an important, challenging component of occupational therapy education. Intended to provide students an opportunity to apply theoretical knowledge in authentic practice settings; develop advocacy, leadership, and managerial skills; and develop a professional identity, fieldwork requires dynamic interaction between three stakeholders: the academic institution, the clinical facility/supervisor, and the student. Adherence to high ethical standards during all phases of the fieldwork experience is expected of these stakeholders. However, occupational therapy and occupational therapy assistant fieldwork students negotiate unique ethical issues, have particular ethical responsibilities, and need to effectively deal with ethical tensions. The Occupational Therapy Code of Ethics and Ethics Standards (2010) (Code and Ethics Standards) provides guidance for students as they navigate ethical challenges during fieldwork placements.

Empirical literature about ethical issues encountered by students in fieldwork is sparse. However, two studies have explored this area from the perspectives of occupational therapy and physical therapy students. Findings of these studies indicate that students frequently encounter ethical issues during their fieldwork experiences and that these issues affect their learning. Ethical issues particularly relevant to fieldwork students include conflicting values, systemic constraints, conflict between didactic education and clinical practice, witnessing unethical behavior, failing to speak up, and disclosing student disability.

EXAMINING RELEVANT ISSUES

Conflicting values. Fieldwork students may observe and/or experience instances of conflicting values. Conflict can occur between students/practitioners and recipients of service; team members from different disciplines; and students and supervisors. Tension around discharge issues is particularly noteworthy in differences of opinion among team members or between clinicians and recipients. In particular, opinions often differ as to the most appropriate discharge destination. Students also need to be aware of their own values, especially when their values conflict with clients’ values. For example, a student's value system may prioritize personal independence over interdependence valued by his or her client. Students need to recognize their ethical responsibility to operate from a client-centered perspective and respect clients’ values and wishes. Indeed, the Code and Ethics Standards’ Principle 4F (Social Justice)
Self-reflection; seeking assistance from trusted, more experienced professionals; and accessing AOTA ethics resources will assist students in developing skills that promote ethical practice

guides occupational therapy personnel to provide services that reflect an understanding of how services can be affected by a variety of factors that contribute to the uniqueness of clients, including, but not limited to, age, ethnicity, race, culture, sexual orientation, gender, or gender identity.

Systemic constraints. Academic fieldwork coordinators and fieldwork educators acknowledge that changes in health care delivery practices and reimbursement, along with cost-containment strategies, have resulted in challenges to maintaining quality client care. These challenges are often linked to the pressure to do more with less. Practitioners are experiencing increasingly high productivity expectations and increased time spent in documentation and administrative duties. Students may also be affected by these changes in the form of resource and systemic constraints (e.g., lack of time for intervention or team communication, staff shortages, large caseloads, dual accountability to client and agency). Of particular concern may be a lack of resources (e.g., appropriate assessment tools, access to research to inform evidence-based practice), creating a barrier to implementing best practice techniques learned in school.

Conflict between didactic coursework and clinical practice. This raises another potential source of ethical tension for students—when fieldwork site practice conflicts with theory or practice techniques taught in the academic portion of the student’s education. Accreditation Council for Occupational Therapy Education Standards for all three levels of education—doctoral degree-level for the occupational therapist, master’s degree-level for the occupational therapist, and educational program for the occupational therapy assistant—mandate that students be assigned to fieldwork sites that are consistent with academic program curriculum design. The reality may be that due to the shortage of fieldwork sites, students may be placed at facilities that have a less-than-ideal match with academic curriculum design.

Witnessing unethical behavior. Students may also experience ethical tension upon observing behaviors by other health care providers that are contrary to ethical standards learned in school. These behaviors could include showing disrespectful attitudes toward clients; talking about clients and the power differential that accompanies this status.

Failure to speak up. Students may feel conflicted between speaking up and staying silent in situations requiring that they advocate for clients (e.g., confronting observances of unethical behavior by others) or when they disagree with their supervisors. Contributing to this conflict could be the inherent power imbalance between student and supervisor or between other health care provider relationships. The power imbalance may lead to fieldwork students feeling vulnerable or lacking confidence due to their relative inexperience. Although advocating for clients is an ethical responsibility, students may experience discomfort due to the conflict that client advocacy can produce within team relationships. Students may fail to speak up when their opinions differ from those of their supervisors because the students feel subordinate. Further complicating the relationship is the fact that supervisors grade, and ultimately pass or fail, students. Ethical tensions may arise when students are asked to perform an intervention technique that they do not feel confident performing, that they were taught is outside of the usual scope of occupational therapy practice, or that is emerging and thus lacking in recognized standards. Students may hesitate to speak up in these situations due to a perceived fear that
doing so could jeopardize their passing status. However, doing so in each of these circumstances protects the well-being of the recipient and is consistent with the Code and Ethics Standards.

**Disclosure disability.** A final issue that could create ethical tension for a student is his or her decision to disclose a nonevident disability. Statutory laws such as the Americans with Disabilities Act of 1990 (ADA), the Americans with Disabilities Amendments of 2008, the Health Information Portability and Accountability Act of 1996, and the Family Education Right to Privacy Act of 1974 have confidentiality requirements prohibiting academic programs from divulging a student’s disability status to a fieldwork site without the student’s permission. A student with a qualified (but nonevident) disability must therefore decide whether or not to divulge this information. Despite federal statutes that protect the student against discrimination related to disability status, a student may hesitate to share information about a disability due to fear of fieldwork supervisor bias. A student who chooses not to divulge this information must understand that he or she cannot be given accommodations for which he or she is otherwise eligible under the ADA. Furthermore, a student with a disability who chooses not to disclose it has an ethical duty to ensure that he or she can provide safe and effective client intervention without accommodations.

**Professional Behavior**

Students have an ethical responsibility to uphold high standards of professional behavior. Several principles of the Code and Ethics Standards are noteworthy here. According to Principle 1N (Beneficence), students should promote and practice occupational therapy “on the basis of current knowledge and research” (p. 153). Students can accomplish this by bringing to the facility current information from the academic portion of their education, perhaps in the form of in-service presentations. This is a noteworthy benefit of fieldwork sites having fieldwork students.

Another particularly pertinent issue is related to maintaining confidentiality and privacy. Principles 3G and 3H (Autonomy and Confidentiality) direct occupational therapy personnel to ensure that client confidentiality and the right to privacy are respected unless the client is in danger of imminent harm or exhibits behavior that personnel are mandated by law or other regulations to report without consent. Confidentiality requirements apply to all communication, including “verbal, written, electronic, augmentative, and nonverbal” (p. 155). Principle 7B (Fidelity) upholds these same privacy and confidentiality requirements with information about colleagues, including fieldwork supervisors and other health care provider team members. Students should be particularly careful to maintain confidentiality when reporting information as required by their academic program (e.g., during debriefing sessions, written assignments, or online blogging).

In addition to adhering to privacy and confidentiality requirements, Principle 6B (Veracity) directs occupational therapy personnel to “Refrain from using or participating in the use of any form of communication that contains false, fraudulent, deceptive, misleading, or unfair statements or claims” (p. 158). Students should respect this principle when communicating about service recipients, their fieldwork supervisor, other occupational therapy personnel, other health care provider team members, and other facility employees. One area where students should be especially cognizant of the need to adhere to confidentiality and other professional boundary require-
ments is participating in social networking sites. Postings that students perceive as “normal” within their social group may be deemed unprofessional, unethical, or illegal by fieldwork facilities or potential employers. In fact, health care students have been expelled from programs due to inappropriate postings related to patient care on social networking sites.

**RESOLUTION TECHNIQUES**

Fieldwork students face and must effectively negotiate a number of ethical tensions. Indeed, according to Principles 5D and 7C (respectively), students have an ethical responsibility to “Be familiar with established policies and procedures for handling concerns about the Code and Ethics Standards” (p. 157) and to “Take adequate measures to discourage prevent, expose, and correct any breaches of the Code and Ethics Standards” (p. 158). Applying a systematic method to resolve ethical issues can lead to effective and satisfactory solutions. Often, one is faced with an ethical dilemma that cannot be resolved to the absolute satisfaction of all stakeholders. The goal with these and other ethical issues is to reach consensus. Consensus occurs when all parties agree to a resolution that they can live with (i.e., that does not compromise their integrity).

Morris has developed a model that promotes systematic and critical reflection on an ethical issue or problem so that one can have a firm foundation on which to make a decision or come to a consensus. This model is especially helpful in dissecting complex ethical issues and breaking them down into manageable parts in order to more easily come to a resolution. Working through the steps of the model may seem time consuming and not helpful for situations that require on-the-spot decisions. However, in those instances, one can reflect through the steps of the model after having made a more immediate decision. The reflection can then be applied to future situations calling for immediate ethical action.

An adaptation of Morris’ model is as follows.

1. Define the dilemma: Identify all of the key stakeholders (i.e., people or organizations involved in or impacted by the situation), state the known facts of the situation, determine what additional information is needed, and define the specific issue or problem to be resolved.
2. Identify two to three potential solutions.
3. Analyze each potential solution: Identify the scope of consequences or impact for each. One should consider the ethical (i.e., adherence to or violation of the Code and Ethics Standards), legal, social, and personal ramifications for each potential solution.
4. Select a course of action. Determine which course of action you can best do, defend, and live with based on its potential ramifications or consequences.
5. Implement the chosen course of action.
6. Reflect on the process and outcome after implementation. Ask yourself such questions as, “Do I believe I made the right decision?” and “Would I do the same thing given a similar situation in the future?” If reflecting on the process and outcome leads you to believe that you could have taken a more appropriate or effective action, it is important that you learn from the situation and apply this learning toward positive self-development.

**CONCLUSIONS**

Occupational therapy fieldwork students face many challenges as they navigate the process of transitioning from student to practitioner. One challenge is to effectively negotiate ethical situations, some of which are unique to the role of fieldwork student. Strong academic preparation provides students with the tools to deal with and resolve ethical issues they will face.

However, knowing the process of ethical resolution and applying it in real-life situations are two different things. Similarly, identifying the ethical course of action and taking this action are two different things. It takes a strong sense of personal integrity and commitment to being an ethical person to effectively analyze and take action in these challenging situations. Self-reflection; seeking assistance from trusted, more experienced professionals; and accessing AOTA ethics resources will assist students in developing skills that promote ethical practice.

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**References**


continued on page 15
Traditionally, Level II fieldwork has been approached from the perspective of the apprenticeship model, in which the supervisor’s expertise is transferred to the student who learns to “do as I do.” Students are viewed as passive recipients of known information, and outcomes are measured in regard to proficiency in technical skills. This approach is helpful for developing procedural reasoning, to understand the diagnosis and treatment techniques from the perspective of known categories or methodologies. It does not, however, promote interactive or conditional reasoning, in which therapists consider multiple variables affecting the intervention process and weigh the soundness of their decisions.

The supervisor who views student learning from a constructivist perspective appreciates that learning happens when students “own” the experience for themselves. Within the constructivist approach, students are encouraged to take an active role in their learning and a critical, reflective attitude toward existing practice and procedures.

The development of conditional and interactive reasoning skills is enhanced as students develop and test hypotheses, compare and contrast options, and contemplate “what if” scenarios.
As students discover and take responsibility for constructing their own knowledge, they are able to engage in self-authorship, or the ability to define their own beliefs, identity, and relationships. In contrast to accepting the status quo, self-authorship involves objective consideration of the variables affecting each situation and changes that might be made to positively impact therapy outcomes. Indeed, the Accreditation Council for Occupational Therapy Education Accreditation Standards mandate that the Level II fieldwork experience be “designed to promote clinical reasoning and reflective practice, to transmit the values and beliefs that enable ethical practice, and to develop professionalism and competence in career responsibilities” (p. 661).7

**JOURNALING AS REFLECTION**

The purpose of this article is to illustrate a constructivist learning approach in which clinical reasoning skills are developed through reflective writing paired with discussion. The education literature describes various methods used to promote reflective professional practice, including the use of journals, feedback, peer group discussion, free writing, and portfolios.8–10 Journaling as a tool to promote reflective learning helps students bridge the gaps between theory, academic knowledge, and practice, allowing them to analyze a situation, gain insights, and dialogue with educators.11–16

Students value reflective practices that combine writing about day-to-day experiences with the opportunity for discussion and feedback, and they identify as “good supervisors” those individuals who ask questions that allow opportunities to challenge assumptions and analyze situations independently.17 But students do express concerns about journaling, including the time commitment required and whether the purpose, goals, and objectives of journaling are clearly delineated.11,18 Boud suggested that three elements be present in productive reflective journaling: (1) returning to the experience by describing what occurred, (2) attending to feelings about the incident that inhibit or enhance further reflection, and (3) re-evaluating the experience by relating new information and examining relationships between new and old ideas.8

Reflective learning through journaling may take several forms. Journaling may consist of free writing about experiences, selecting a critical incident each week to reflect upon, or selecting specific topics based on the student’s needs.8,9 Although some students prefer structured journaling, others feel restricted by stringent criteria.11 This suggests the need to balance between free journaling and guided reflective writing. The following case examples illustrate different approaches to reflective journaling.

**CASE EXAMPLE: MARK**

Throughout his Level II adult lifespan fieldwork experience, Mark completes a weekly written Clinical Reasoning Exercise (CRE). Prior to completing his first CRE, Mark’s fieldwork educator explains to him that even when

<table>
<thead>
<tr>
<th>Intervention that was effective</th>
<th>Intervention that was not as effective</th>
</tr>
</thead>
<tbody>
<tr>
<td>2. What was effective? I was able to figure out the correct scoring and explain my rationale for the score I selected.</td>
<td>2. What was effective? The food was cooked and the client completed many of the tasks independently.</td>
</tr>
<tr>
<td>3. What was not as effective? I needed reminders to look at the next level and the previous level before selecting the score.</td>
<td>3. What was not as effective? I felt like I was in the way a lot of the time. I would normally just jump in and help, but I wasn’t sure what to do or how much to help him.</td>
</tr>
<tr>
<td>4. What would you do differently next time? Take more time to thoroughly read the options and not get so anxious to come up with an answer.</td>
<td>4. What would you do differently next time? Before the group session, ask the group leader what I could do to help; ask the client what type of help he wants/needs.</td>
</tr>
</tbody>
</table>

The structured format is short and relatively quick to complete, but it encourages the students to take time to critically analyze their own thoughts, ideas, and approaches to client care.
Jane’s Fieldwork Review Meeting

Jane and her fieldwork educator review her journal and together identify a pattern of frustration for Jane. Jane’s journal details several intervention sessions with children who are difficult to motivate and engage. She tells her fieldwork educator she is unsure of what to do. Jane’s fieldwork educator asks if she has considered theories or models that might help her look at motivational factors. Jane says she has thought about behavioral and cognitive–behavioral models, and the Model of Human Occupation, but she is not sure which to select. Together, Jane and her fieldwork educator agree that her weekly goal will be to select a different strategy to use in each intervention session, based on one of the identified models she reviews.

To facilitate this process, a journaling assignment that includes Boud’s three elements is developed. Jane is asked to describe what she did based on each model; attend to how she felt about it; and reevaluate the effectiveness, considering what she might use again or change in the future.

At her next weekly review meeting, Jane’s journal describes the different theoretical approaches she used and how effective she found the strategies to be in the interventions. When asked by her fieldwork educator whether there are theoretical approaches she believed were most appropriate in certain situations, Jane is not as confident. This conversation leads to setting her next weekly objective to compare and contrast the three models and determine how effective they are with two children she is seeing. This prompts Jane to engage in more research about the models and to try additional strategies in her practice, followed by reflective journaling to assist in the process.

an intervention is effective, there are always alternate approaches to consider. She also states that when an intervention is not fully effective, there is always some aspect of the intervention that is effective. The purpose of this CRE is to reflect on the experience and learn from it.

To complete the CRE, Mark selects and reflects on two interventions that he has implemented over the previous week—one he thought was effective, the other not so much. Using Boud’s three elements of reflection—of returning to the experience, attending to feelings, and re-evaluating the experience—Mark mentally revisits the experiences after the pressure to perform has passed. He writes a brief description of the two interventions, identifies what was effective and what was not as effective in each intervention, and what he would do differently next time (see Table 1 on p. 12). By reflecting on both his positive and negative reactions to the interventions, Mark looks at his performance more objectively and identifies his own strengths as well as opportunities for growth related to the specific type of intervention. Through this process, Mark increases his own sense of mastery. By identifying what he would do differently next time, Mark re-evaluates the intervention process, solves problems independently, and plans for future therapy sessions.

Mark submits his written CRE to his fieldwork educator 24 hours before the scheduled weekly supervisory meeting. The educator reviews Mark’s reflections and prepares her feedback. During the meeting, Mark shares his weekly reflection and identifies what was effective and ineffective. She also logs questions for her fieldwork educator. As did Mark, Jane submits her journal to her fieldwork educator 24 hours prior to her weekly supervision meeting, with the educator then reviewing the journal to understand Jane’s strengths and weaknesses. At each meeting, they review Jane’s journal together, along with the facility’s weekly fieldwork objectives. The journal helps Jane and the educator identify what facility fieldwork objectives are being met and where problem areas exist. Jane’s progress is recorded on her weekly fieldwork review form and new weekly objectives are set.

CASE EXAMPLE: JANE

On her early lifespan Level II fieldwork, Jane is asked to use weekly journaling as a means to improve critical reasoning skills and promote student-centered learning. Initially, Jane journals about each intervention session, identifying what were effective and ineffective strategies. She also logs questions for her fieldwork educator. As did Mark, Jane submits her journal to her fieldwork educator 24 hours prior to her weekly supervision meeting, with the educator then reviewing the journal to understand Jane’s strengths and weaknesses. At each meeting, they review Jane’s journal together, along with the facility’s weekly fieldwork objectives. The journal helps Jane and the educator identify what facility fieldwork objectives are being met and where problem areas exist. Jane’s progress is recorded on her weekly fieldwork review form and new weekly objectives are set.
The journaling process, Jane reflects critically on her work and forms new approaches to intervention from week to week. This record of critical reflection has the added benefit of charting the progression of Jane's critical reasoning. For an example of this growth, see “Jane’s Fieldwork Review Meeting” on p. 13.

When asked at the close of her fieldwork how she felt about the journaling process, Jane says it improved her observation skills. “Now when I’m in a session, I find I can think through the critical reflection process and adapt on the go, which I couldn’t do before,” she says. The journaling facilitated open communication with her fieldwork educator about her learning, Jane says, and it gave Jane time to think and read before discussing complex issues with the educator. Jane cautions that journaling is time consuming and recommended students schedule time each day to journal. She says she at first worried about how long the journal should be, but that staying focused on her weekly objectives made her worry less about wasting time writing down unnecessary details.

Jane’s fieldwork educator says journaling enables her to better understand students’ learning and critical thinking processes. One of the biggest benefits is being able to identify when students are having difficulty applying what has been discussed throughout the week. Journaling also helps facilitate an open dialogue with her students, the educator says, and it contributes to a student-centered learning environment in which students take more responsibility for their own learning and for setting weekly objectives. That approach relates directly to what the educator says is the most important goal of fieldwork: to produce students who are reflective practitioners.

**SUMMARY**

Both cases examples illustrate how reflective writing can improve critical reasoning over the course of the Level II fieldwork experience. The structured format is short and relatively quick to complete, but it encourages the students to take time to critically analyze their own thoughts, ideas, and approaches to client care. Initially, students who are novices in thinking reflectively about their experiences may report that a treatment session was “perfect” or “terrible” and leave it at that. But with practice and weekly conversations with the fieldwork educator, students learn to carefully consider the details that influence the therapeutic outcome. It is often easier for the student to reflect on another therapist’s approach rather than his or her own approach. Although this may be helpful later in the learning experience, it is important for students to “own” their observations and construct treatment plans reflecting their own clinical reasoning process rather than mimicking the work of others. This is easily corrected after the first week, but it highlights the need for educators to define expectations. By using the same framework throughout the fieldwork, students become familiar with the process and learn to look for and reflect on meaningful experiences.

In both examples, the written reflection is a record of learning, demonstrating growth in the students’ level of mastery over time. A written record of critical reflection substantiates that students are prepared for entry-level practice. When the students’ attention is directed to focused areas of practice, they become aware of their own repertoire of knowledge and skills in combination with present circumstances. This results in improved observation skills and the ability to apply theoretical concepts to practice situations. By practicing reflective skills under the mentorship of the fieldwork educator, occupational therapy students are prepared for the lifelong learning that will be foundational to their professional career.

**Occupational Therapy Fieldwork Survival Guide: A Student Planner, 2nd Edition**

**Clinical Supervision in Occupational Therapy: A Guide for Fieldwork and Practice (w/CD-ROM)**

**The Essential Guide to Occupational Therapy Fieldwork Education: Resources for Today’s Educators and Practitioners (w/CD-ROM)**

**CONNECTIONS**

Discuss this and other articles on the OT Practice Magazine public forum at http://www.OTConnections.org.

References


Debra Hanson, PhD, OTR/L, is the academic fieldwork coordinator at the University of North Dakota, which has campuses in Grand Forks, North Dakota; and Casper, Wyoming. Hanson has more than 20 years of experience working with fieldwork educators and students. She is the academic fieldwork coordinator representative for AOTA's Commission on Education.

Sarah Nielsen, MMGT, OTR/L, works for the Trinity Health Child Adolescent Partial Hospitalization Program serving children ages 5 to 17. Nielsen has 10 years of experience with Level I and Level II fieldwork students. She is also an adjunct faculty member at the University of North Dakota.

Jody K. Larson, MS, OTR/L is lead occupational therapist at the North Dakota State Hospital. Larson has 28 years of experience working with Level I and Level II occupational therapy students and is an adjunct faculty member at the North Dakota State College of Science.

Using Evidence in Practice continued from page 6

a more experienced mentor who is as passionate about research as she is. Discussions with the whole team also give her the opportunity to learn about evidence from others and to share the research findings she has discovered.

Maglio and Wyrick report that it is crucial to have a toolkit of resources available to overcome the most frequently reported barriers to using evidence: lack of time and the lack of knowledge of available resources. Both mentioned using online resources such as PubMed (www.ncbi.nlm.nih.gov/pubmed); Google Scholar (http://scholar.google.com); AOTA Evidence-Based Practice Resources (www.aota.org/ebp), including the EBP Resource Directory; and OTseeker (www.otseeker.com) as first steps when looking for evidence. They also noted the importance of turning to more knowledgeable and experienced clinicians as valuable guides for finding evidence, and said that Evidence-Based Rehabilitation: A Guide to Practice is a great book for finding resources for EBP.

As evidence becomes increasingly available for occupational therapy, practitioners appreciate hearing about examples of others who are committed to incorporating the findings from research into practice. Wyrick and Maglio show that with some time, effort, practice, and help from peers, it is possible to provide evidence-based, client-centered, and up-to-date care for consumers.

Reference


Marian Arbesman, PhD, OTR/L, is president of Arbesman Ideas in Williamsville, New York, and an adjunct assistant professor in the Department of Rehabilitation Science at the State University of New York at Buffalo. She has served as a consultant with AOTA's Evidence-Based Practice Project since 1999.

Lizbeth Metzger is a Level II fieldwork student from Boston University. At AOTA, she is working on the Evidence-Based Practice Project and with the Federal Affairs Department.

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Navigating Fieldwork's Ethical Challenges continued from page 10


History of the American Occupational Therapy Association, Inc.

In honor of Occupational Therapy Month, OT Practice this year presents highlights from the history of the American Occupational Therapy Association, from its founding in 1917 to the great contributions its members provide today to the occupational therapy profession.

1917
National Society for the Promotion of Occupational Therapy, Inc. (NSPOT) founded as professional association. First Annual NSPOT Meeting held in New York City, with 6 in attendance.

1921
Board of Management and House of Delegates governance structure established.

1922
First professional journal, Archives of Occupational Therapy, published.

1923
NSPOT renamed The American Occupational Therapy Association, Inc. (AOTA).

1925
Earliest AOTA educational standards announced.

1930
AOTA and the American Medical Association Council on Medical Education and Hospitals (AMA–CMEH) affiliated to accredit occupational therapy programs.

1935
AOTA and AMA–CMEH published “Essentials of An Acceptable School of Occupational Therapy,” and four schools accredited.

1939
Opening issue of Occupational Therapy News published.
1947
Winifred Kahmann became the first occupational therapy professional elected as AOTA president.

American Journal of Occupational Therapy (AJOT) launched as official journal.

First edition of Occupational Therapy textbook by Helen S. Willard and Clare S. Spackman released.

1950
First AOTA Award of Merit presented in honor of significant contributions to the profession.

1952
AOTA became official member of the World Federation of Occupational Therapists (WFOT).

1955
First Eleanor Clarke Slagle Lecture awarded. The Lecture became the foundation for documenting the advancement of occupational therapy.

1958
First Essentials and Guidelines for an Approved Educational Program for Occupational Therapy Assistant adopted.

1963
Occupational Therapy Assistant (OTA) membership category created.

1964
The American Occupational Therapy Foundation (AOTF) incorporated.

1965
Governance bodies renamed as Executive Board and Delegate Assembly.

1966
American Student Committee of the Occupational Therapy Association (ASCOTA) organized.

1968
First professional lobbyist retained for federal advocacy.

1972
AOTA National Office relocated from New York City to Rockville, Maryland.
History of the American Occupational Therapy Association, Inc.

1973
AOTA Roster of Fellows established to recognize contributions to the profession.

1975
OTA Award of Excellence created to honor OTAs. Florida and New York became first states to enact occupational therapy licensure laws.

1976
AOTA policymaking body Delegate Assembly renamed Representative Assembly.

1977
First national certification examination administered to OTAs.
Committee of State Association Presidents (CSAP) instituted.
Original Occupational Therapy Code of Ethics adopted.
First Special Interest Sections created—Developmental Disabilities, Gerontology, Mental Health, Physical Disabilities, and Sensory Integration.

1978
AOTA Roster of Honor established to recognize contributions by occupational therapy assistants.
American Occupational Therapy Political Action Committee (AOTPAC) established.

1981
First issue of AOTF's Occupational Therapy Journal of Research (OTJR) published.

1986
AOTA became a voluntary membership organization and created American Occupational Therapy Certification Board (AOTCB) to administer certification exam.

1987
OT Week periodical published as new benefit to members.

1990
AOTA and AOTF governing boards established Presidents’ Commendation in Honor of Wilma L. West Award for outstanding leaders.

1991
First Terry Brittell OTA/OT Partnership Award presented in acknowledgment of professional alliance.

1993
First “Capitol Hill Day” held to involve members in grassroots advocacy.

1994
AOTA moved to new headquarters in Bethesda, Maryland.
The AOTA Accreditation Committee renamed Accreditation Council for Occupational Therapy Education (ACOTE®) and became an operational accrediting agency independent of AMA.

Ensuring accessibility for the wheelchair user was a top occupational therapy priority in 1972, as shown by Diane Haglund, OTR.

In 1994, AOTA moved to its new building at 4720 Montgomery Lane in Bethesda, MD.

First “Hill Day” was held in 1993 and brought members to Washington, DC, to lobby on behalf of the profession.

First AOTA/AOTF Presidents’ Commendation in Honor of Wilma L. West Award was awarded to Wilma L. West in 1990.

AOTPAC founded in 1978.

The Occupational Therapy Journal of Research began publication in 1981.
History of the American Occupational Therapy Association, Inc.

1995
AOTA launched OT Practice magazine to provide clinical practice information.

1997
AOTA Web site with url www.AOTA.org established as occupational therapy online resource.

1998
First voting OTA representative elected to AOTA Executive Board.

1999
Publication of OT Week ceased and its content was integrated into OT Practice.

Resolution J, “Movement To Required Postbaccalaureate Level of Education,” adopted by Representative Assembly.

2001
AOTA Board of Directors approved “Affiliation Principles for AOTA and State Associations.”

2002
AOTA Press established as Association’s publishing group.

2006
Centennial Vision launched to reach goals for the profession by AOTA’s 100th anniversary in 2017.

New AOTA Board Certification and Specialty Certification programs launched.

2007
Accreditation standards that require entry into the profession as an occupational therapist at the master’s level or above were implemented.

The first annual AOTA/NBCOT National Student Conclave held for occupational therapy students.

2008
OT Connections social-networking site activated.

2009
Professional brand “Occupational Therapy: Living Life To Its Fullest™” inaugurated in support of the Centennial Vision.

2010
AJOT launched as electronic journal.

OT practitioners in the military provide intervention to wounded warriors all over the world, including Iraq and Afghanistan.

OT Practice launched in 1995.


Centennial Vision finalized in 2006.

OT Connections launched in 2008.

AJOT Online launched in 2010.

More than 560 students attended first AOTA/NBCOT National Student Conclave held in Pittsburgh in November 2007.

Brand launched in 2009.
Blogs as Learning Tools
http://otconnections.aota.org/forums/t8740.aspx

Lisa Gonzalez Posted:
Tue, Jan 4 2011 4:33 AM
I am exploring the use of blogs as a learning tool in an OTA curriculum for psychosocial class instead of creating a student journal on BB. I see a lot of OT/OTA blogs now and several indicating blogs, etc. are new professional learning tools. I would love any information on how to set up a reflective assignment and grading criteria using blogs for this class.

David M. Merlo replied on Wed, Jan 5 2011 4:30 AM
I teach in an OTA program and have my students create personal Web sites as a way to explore their own volition, occupations, values, interests. I then engage my students in a service-learning project where they teach children at a community center to develop their own Web sites as a means of teaching technical literacy, exploring volition, goals, and culture. You can learn more about the project at www.web-kids.org.

sambrookj replied on Thu, Jan 6 2011 11:42 PM
I have also integrated a blog into the psychosocial interventions course I teach. The focus is on advocacy and emerging opportunities for OT practice, with an emphasis on psychosocial well being. The students blogged about various events they attended, like Hill Day, and posed questions to peers about possibilities for OT intervention. I also need to refine my rubric. It worked well but was labor intensive to monitor and grade with a class of 45.

Robyn Otty replied on Thu, Jan 13 2011 6:35 PM
Depending on the flavor of the class/assignment, you can instruct a blog page where the students participate in each other’s forums and postings. So if the class assignment pertains to an ethics dilemma, the student can construct an ethics page and post polls and or topics for peers to contribute content.... The only piece I would recommend when using a non-university-based 3rd party site is give students parameters of postings and allow the students to remove the site after the course has ended.

For more of this discussion and to view other posts, go to www.OTConnections.org. New user? Click on “User’s Guide” in the upper right hand corner of the Web page.

SOCIAL MEDIA SPOTLIGHT
www.aota.org/twitter

Happy Occupational Therapy Month! How are you celebrating & promoting OT Month? Get some tips here: http://ht.ly/4sS5Q #OTMonth <http://twitter.com/search?q=%23OTMonth> 4 Apr


Talk one on one with an AOTA Board member in your classroom! Learn more & Schedule a Boardroom to Classroom session http://ht.ly/4eTDz 16 Mar
Evaluating Psychological and Social Concerns in Physical Disability Settings

Kathy Kannenberg

Q I am an occupational therapist working in an acute care rehabilitation facility. Many of my clients seem to have psychological and social issues that make it challenging to engage them in treatment. I am not sure how to evaluate these issues, especially when time is very limited.

A Evaluating psychological and social factors that limit or support engagement in desired occupations is critical to include in all practice settings and with all clients. However, time constraints, productivity standards, and the everyday realities of practice can make it difficult to do so and cause psychological and social factors to be overlooked during evaluations that primarily address physical client factors.

Clients experience a wide variety of emotional responses when adjusting to hospitalization, illness, and injury. Changes in daily routines, habits, and roles; loss of function; and feelings of anxiety or other emotions all affect the client’s ability to be involved in treatment and achieve occupational goals. Clients may also have comorbid psychiatric conditions such as schizophrenia, depression, or anxiety, leading to symptoms that interfere with treatment.

Understanding the client’s history and life context is the key to understanding the strengths and personal supports the person has that positively affect treatment outcomes. Supportive factors may include positive self-concept, a history of resilience, adaptive coping skills, self-efficacy, and a personal social support system.

Gathering this information may seem overwhelming and time consuming, but evaluating psychological and social factors can be routinely incorporated into the evaluation and continued during treatment interventions. The first step is to perform a comprehensive chart review that includes information related to psychosocial factors such as relevant comorbid diagnosis or medications that might affect treatment (e.g., history of anxiety, medications for depression, addiction). Reviewing the social worker’s and other team members’ notes can provide a wealth of information about social factors affecting treatment outcomes. Finding out if the person has supportive friends and family, is working or unemployed, or has resisted treatment or had difficult interactions with nursing staff can help the therapist respond empathically to emotions, build a therapeutic relationship, and set meaningful and realistic goals.

The next step of the evaluation process is to initiate an occupational profile to identify the client’s occupational history, patterns of daily living, interests, values, needs, concerns, and priorities for occupational performance. Creating an occupational profile helps the occupational therapist understand what is important and meaningful to the client as well as reveals past experiences and interests that may indicate the client’s strengths and limitations. Creating an occupational profile supports a client-centered focus, facilitates client involvement, and guides more efficient interventions.

The final step in evaluating psychosocial factors is to use empathy and active listening skills when interacting with the client, both verbally and nonverbally. Observing daily changes in affect or behavior provides a wealth of valuable clinical information about what is going on inside the person that will ultimately affect treatment outcomes (e.g., client looks sad, is apathetic about treatment, seems unable to manage anxiety or pain, or is starting to talk about fears and concerns for recovery). Social abilities can be observed by noting the person’s ability to initiate and maintain relationships with staff and communicate needs and feelings.

Gathering information on psychological and social factors is not based on the amount of time spent with the client but on a planned and thoughtful approach that we as practitioners use to facilitate setting mutual goals and identifying client strengths that support moving the client toward achieving occupational performance goals.

Kathleen Kannenberg, MA, OTR/L, CCM, is a clinical specialist in occupational therapy (psychiatry) at Harborview Medical Center in Seattle, Washington. She is a member of AOTA’s Commission on Practice.
To advertise your upcoming event, contact the OT Practice advertising department at 800-877-1383, 301-652-6611, or optracads@aota.org. Listings are $55 each for 1–10 lines, $150 for 11–15 lines, per event. Multiple listings may be eligible for discount. Please call for details. Listings in the Calendar section do not signify AOTA endorsement of content, unless otherwise specified.

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### May

**Jacksonville, FL** May 21–22

Evaluative & Intervention for Visual Processing Deficits in Adult Acquired Brain Injury Part I. Faculty: Mary Warren, OTR, SCLV, FAOTA. This updated course has the latest evidence-based research. Participants learn a practical, functional, reimbursable approach to evaluation, intervention, and documentation of visual processing deficits in adult with acquired brain injury from CVA and TBI. Topics include hemianopsia, visual neglect, eye movement disorders, and reduced acuity. Also Portland, OR, September 9–10 and West Haverstraw, NY, Octo-ber 29–30, 2011. Contact: www.visabilities.com or (888) 752-4364, Fax (205) 823-6657.

**San Diego, CA** June 4–14

Lymphedema Management. Certification courses in Complete Decongestive Therapy (135 hours). Lymphedema Management Seminars (31 hours). Coursework includes anatomy, physiology, and pathology of the lymphatic system, basic and advanced techniques of MLD, and bandaging for primary-secondary UE and LE lymphedema (incl. pediatric care) and other conditions. Insurance and billing issues, certification for compression-garment fitting included. Certification course meets LANA requirements. Also in Minneapolis, MN, July 9–19. AOTA Approved Provider. For more information and additional class dates/locations or to order a free brochure, please call 800-863-5935 or log on to www.acols.com.

### June

**Texas Tour** June, 2011

Integrating Yoga Into Your Work with Kids. Jene- ney/Magnetics presents a holistic approach to using yoga activities to improve motor, self-regulation, social-emotional, and cognitive skills. Course approved by TOTA and TSHA. For more information, visit www.yoga-yingo.com, e-mail jeannette@yoga-yingo.com, or call 480-635-7199.

**Orlando, FL** Jul. 12–15

Take the Wheel: A Driver Education/Training Workshop for the Therapist, STOP-LEARN-GO! A hands-on workshop for the therapist that de-sires to transition into the in-vehicle work of a com-prehensive driver evaluation. This unique workshop will provide the advanced knowledge and practice in the skills that are important for on-road work. All skills practiced safely in a training vehicle with ex-perienced driver rehab therapists. Topics include setting up the evaluation car, structuring the in-car time, planning driving routes, and practicing the physical, visual and cognitive skills needed by a therapist in the evaluation car to control the route, the car, and the client. Instructors: Susan Pierce, OTR/L, SCDCM, CD/RS, Carol Blackburn, OTR/L, CDRS, Mary Ellen Keith, OTA, CDRS. Only 12 spac-es available! Visit us at booth 1022 at the AOTA Annual Conference and Expo. Contact Adaptive Mobility Services, Inc. at (407) 426-6820 or visit us at www.adaptivemobility.com.

### August

**Jacksonville, FL** Aug. 13–16

AED Annual Conference and Exhibits. Professionals specializing in the field of Driver Rehabilitation meet annually for continuing education through workshops, seminars, and hands-on learning. Earn contact hours for CDRS renewal and advance your career in the field of driver rehabilitation. Contact AED of 866-672-9466. Visit our Web site at www.aed.net.

### September

**Portland, OR** Sept. 10–11

Evaluative & Intervention for Visual Processing Deficits in Adult Acquired Brain Injury Part I. Faculty: Mary Warren MS, OTR/L, SCLV, FAOTA. This updated course has the latest evidence-based research. Participants learn a practical, functional, reimbursable approach to evaluation, intervention and documentation of visual processing deficits in adult with acquired brain injury from CVA and TBI. Topics include hemianopsia, visual neglect, eye movement disorders, and reduced acuity. Also in West Haverstraw, NY, Sept. 29–30. Contact: www.visabilities.com or (888) 752-4364, Fax (205) 823-6657.

### Ongoing

**Internet & 2 Day On-site Training**

Ongoing

Become an Accessibility and Home Modifications Consultant. Instructor: Shoshanna Shamborg, OTR/L, MS, with over 22 years of private practice experience specializing in design/build services, specialized products, home safety, environmental modifications, assistive technology, and ADA con-sulting. Start a private practice or add to existing services. Extensive manual + 2 Day on-site training options nationwide (currently in Baltimore, MD and Phoenix, AZ). AOTA Approved Provider of CE + NBCCOT CE Registry. Registration, brochures, + calendar for current dates/locations at www. AOTSS.com. Contact Abilities OT Services, info@ aotss.com or 410-358-7269. Group and COMBO discounts. SEMINAR SPONSORSHIP AVAILABLE.

**Online Course**

Ongoing

OT Intervention for the Patient With Low Vision. This online course is designed to provide occupa-tional therapists with the appropriate skills to screen, evaluate, and develop a comprehensive treatment plan for treating the older adult and people with diabetes who have a visual impairment. Participants of this course will be able to implement low vision prin-ciples into treatment strategies for immediate ap-plication with successful outcomes in patient care.

Included in the course will be instruction for using remaining vision, low vision devices, compensatory techniques, environmental modifications, develop-ment of a network of resources, and effective document-ation for skills for reimbursement. Instructor: Rhonda Landry, OTR, SCLV, CDE. Six contact hours. Only $100. Contact Vision Quest at 409-363-3960. Visit www.visionquestcon.com.tw to see pending locations for live seminars.

**Video Seminars Online**

**Unlimited CEUs**

All the Continuing Education Hours You Want for Only $177. For one low price of $177, you can have unlimited access to over 640 hours of clinical continuing education—over 90 CEU seminars and programs. Take as many courses as you want for one full year for only $177. Purchase before May 1, 2011, to get this low price of $177. Starting May 1, the price will be $199. Approved for AOTA, IACET, BOC CEUs. Meets NBCTOT criteria for PDUs. Take advantage of this special offer while it lasts! www. clinicians-view.com. 575-526-0012.

### October

**AOTA Self-Paced Clinical Course Ongoing NEW!**

OCCUPATIONAL THERAPY AND HOME MODIFICATION: PROMOTING SAFETY AND SUPPORTING PARTICIPATION. Edited by Margaret Christenson, MPH, OTR/L, FAOTA, and Carla Chase, EdD, OTR/L, CAPS. This new SPCC consists of text, exam, and a CD-ROM of hundreds of photographic and video resources that provide education on home modification for occupational therapy professionals. Occupational therapists who work with either adults or children will find an overview of evaluation and intervention, detailed descriptions of assessment tools, and guidelines for client-centered problem solving and occupation-based outcomes. Earn 2 AOTA CEUs (20 NBCTOT PDUs/20 contact hours). Order #3029. AOTA Members: $370, Nonmembers: $470. http://store.aota.org/view/?SKU=3029.

**AOTA Self-Paced Clinical Course Ongoing NEW!**

MENTAL HEALTH PROMOTION, PREVENTION, AND INTERVENTION WITH CHILDREN AND YOUTHS: A GUIDING FRAMEWORK FOR OCCUPATIONAL THERAPY. Edited by Susan Bazyk, PhD, OTR/L, FAOTA. This important new SPCC provides a framework on the role of occ-UPATIONAL THERAPY in mental health interventions for occupational therapists. Includes content from several standards of practice, and evidence as they apply to mental health practice, including theories, stan-dards and guidelines. Includes a network of resources, and effective documentation options nationwide (currently in Baltimore, MD and Phoenix, AZ). AOTA Approved Provider of CE + NBCCOT CE Registry. Registration, brochures, + calendar for current dates/locations at www. AOTSS.com. Contact Abilities OT Services, info@ aotss.com or 410-358-7269. Group and COMBO discounts. SEMINAR SPONSORSHIPS AVAILABLE. 575-526-0012.

For one low price of $177, you can have unlimited access to over 640 hours of clinical continuing education—over 90 CEU seminars and programs. Take as many courses as you want for one full year for only $177. Purchase before May 1, 2011, to get this low price of $177. Starting May 1, the price will be $199. Approved for AOTA, IACET, BOC CEUs. Meets NBCTOT criteria for PDUs. Take advantage of this special offer while it lasts! www. clinicians-view.com. 575-526-0012.

AOTA Self-Paced Clinical Course Ongoing Early Childhood: Occupational Therapy Services for Children Born to Five. Edited by Barbara E. Chandler, PhD, OTR/L, FAOTA. This course is an enlightening journey through occupational therapy with children at the earliest stage of their lives. Ex-plores the driving force of federal legislation in oc-cupational therapy practice and how practitioners can facilitate and develop children’s occupation. Offers an enlightening journey through occupational therapy practice and how practitioners can facilitate and develop children’s occupation. Offers a long-standing expertise in transitioning early child-hood development into occupational engagement in natural environments. Earn 2 AOTA CEUs (20 NB-CROT PDUs/20 contact hours). Order #3026. AOTA Members: $370, Nonmembers: $470. http://store.aota.org/view/?SKU=3026.

AOTA Self-Paced Clinical Course Ongoing Occupational Therapy in Mental Health: Considerations for Advanced Practice. Edited by Marian Kavanagh Scheinholtz, MS, OTR/L. A comprehen-sive discussion of recent advances and trends in mental health practice, including theories, stan-dards of practice, and evidence as they apply to occupational therapy. Includes content from several federal and non-government entities. Earn 2 AOTA...
This year’s conference was more informative than ever and Quinnipiac was proud to contribute. If you missed it, our OT faculty gave presentations in the following areas:
- Academic & Fieldwork Education
- Children & Youth
- Rehabilitation, Disability & Participation
- Productive Aging
- Professional Issues
- Mental Health

Quinnipiac’s School of Health Sciences proudly offers an online post-professional master’s degree in occupational therapy via Quinnipiac University Online. This unique program enables occupational therapy professionals to advance their knowledge of emerging research, leadership, critical thinking and entrepreneurial concepts of occupational therapy.

This is an unprecedented opportunity for practicing occupational therapists to learn from our superior faculty and continue with a quality education — without interrupting their careers. Our post-professional master’s degree can be completed in five semesters in an online format with a one day on-campus requirement. The program’s pace affords a steady accumulation of skills that can be applied immediately to the workplace.

Practioners develop leadership skills so they can:
- Build on experience
- Refine clinical skills in specialized practice
- Participate in research

The curriculum, faculty and online learning environment enable students to attain advanced skills that are in high demand today and will continue to be valued in the future. With a smart, intuitive interface, engineered by an award-winning team of professionals, our online program is convenient and flexible.

AOTA Self-Paced Clinical Course Ongoing
Dysphagia Care and Related Feeding Concerns for Adults, 2nd Edition. Edited by Wendy Avery, MS, OTR, PR/所提供的 occupational therapists at both entry and intermediate levels with an up-to-date resource in dysphagia care, written from an occupational therapy perspective. Earn 1.5 AOTA CEUs (15 NBCOT PDUs/15 contact hours). Order #3029, AOTA Members: $285, Nonmembers: $385. http://store.aota.org/view/?SKU=3028

AOTA Self-Paced Clinical Course Ongoing
Collaborating for Student Success: A Guide for School-Based Occupational Therapy, Edited by Barbara Hanft, MA, OTR, FAOTA, and Jayne Shepheard, MS, OTR, FAOTA. Engages school-based occupational therapists in collaborative practice with education teams. Identifies the process of initiating and sustaining changes in practice and influencing families/education personnel to engage in collaboration with occupational therapists. Perfect for learning to use professional knowledge and interpersonal skills to blend hands-on services with education teams and system supports for families, educators, and the school system at large. Earn 2 AOTA CEUs (20 NBCOT PDUs/20 contact hours). Order #3023, AOTA Members: $470. http://store.aota.org/view/?SKU=3023

AOTA Self-Paced Clinical Course Ongoing
Strategies to Advance Gerontology Excellence: Promoting Best Practice in Occupational Therapy. Edited by Susan Coppola, MS, OTR/L, BCG, FAOTA; Sharon J. Elliott, MS, OTR/L, BCG, FAOTA; and Pamela E. Toto, MS, OTR, BCG, FAOTA. Foreword by: Wendy Wustman, PhD, FAOTA. Excellent resource for gerontology practitioners today to help sharpen skills and prepare for the spiraling demand among older adults for occupational therapy services. Special features include core best practice methodology with older adults, approaches to and prevention of occupational problems, health conditions that affect participation, and practice in cross-cutting and emerging areas. Earn 3 AOTA CEUs (30 NBCOT PDUs/30 contact hours). Order #3024, AOTA Members: $490. Nonmembers: $590. http://store.aota.org/view/?SKU=3024

AOTA Self-Paced Clinical Course Ongoing

AOTA Self-Paced Clinical Course Ongoing
Neurorehabilitation Self-Paced Clinical Course Series. Series Senior Editor: Gordon Muir Giles, PhD, DipCOT, OTR/L, FAOTA. This series includes 4 components—the Core SPCC and 3 Diagnosis-Specific SPCCs. The Core SPCC is highly recommended as a prerequisite for the Diagnosis-Specific courses. Each of the Diagnosis-Specific SPCCs is based on a case study model supported by key concepts presented in the Core. Core SPCC: Core Concepts in Neurorehabilitation: Earn .7 AOTA CEU (7 NBCOT PDUs/7 contact hours). Order #3019, AOTA Members: $130, Nonmembers: $184. http://store.aota.org/view/?SKU=3019

AOTA Diagnosis-Specific SPCCs: Neurorehabilitation for Dementia-Related Diseases (Order #3022 http://store.aota.org/view/?SKU=3022, Neurorehabilitation for Traumatic Brain Injury (Order #3020 http://store.aota.org/view/?SKU=3020). Order #3021, AOTA Members: $185, Nonmembers: $263. Call or shop online to purchase the Core and/or 1 or more Diagnosis-Specific SPCCs together for significant savings!

AOTA CEnoCD™ Ongoing
NEW! Certified Nursing Facilities 101. Christine Kroll, MS, OTR and Nancy Richman, OTR/L, FAOTA. This self-paced course is designed to enable nursing facility practitioners to better manage practice within skilled nursing facility settings. It addresses the importance of documentation, requirements for different payers, significance of managing productivity, understanding critical thinking, and understanding the legal practice standards. Earn .3 AOTA CEU (3 NBCOT PDUs/3 contact hours). Order #4843, AOTA Members: $108, Nonmembers: $154. http://store.aota.org/view/?SKU=4843

ADED Approved AOTA CEnoCD™ Ongoing
NEW! Determining Capacity to Drive for Individuals With Dementia Using Ethical and Professional Reasoning: The Responsibility of All Occupational Therapists. Linda A. Hunt, PhD, OTR/L, FAOTA. Emphasizes the role of occupational therapy in the evidence-based evaluation process and focuses on the required professional reasoning and ethics for making final recommendations about the capacity for older adults with dementia to drive or not. Provides the Multifactor Older Driver Evaluation (MODE) and the Multifactor Older Driver Education (MODE) as general practice and driving specialist occupational therapy practitioners who work with older driver clients with dementia. Earn .2 AOTA CEU (2 NBCOT PDUs/2 contact hours). Order #4842, AOTA Members: $68, Nonmembers: $97. http://store.aota.org/view/?SKU=4842

ADED Approved AOTA CEnoCD™ Ongoing
Creating Successful Transitions to Community Mobility Independence for Adolescents: Addressing the Needs of Students With Cognitive, Social and Behavioral Limitations. Miriam Monahan, MS, OTR, CDRS, CDI, and Kimberly Patten, OTR/L, AMP. Addresses the critical issue of community mobility skill development for youth with diagnoses that challenge cognitive and social skills, such as autism spectrum and attention deficit disorder. Community mobility is vast in that it includes mass transportation, pedestrian travel, and driving, and is essential for engaging in vocational, social, and educational opportunities. The course is appropriate for occupational therapy practitioners practicing in educational settings and in driver rehabilitation. Earn .7 AOTA CEU (7 NBCOT PDUs/7 contact hours). Order #4833, AOTA Members: $175, Nonmembers: $250. http://store.aota.org/view/?SKU=4833

ADED Approved AOTA CEnoCD™ Ongoing
Driving Assessment and Training Techniques: Addressing the Needs of Students With Cognitive and Social Limitations Behind the Wheel. Miriam Monahan, MS, OTR, CDRS, CDI. Occupational therapy practitioners in the driver rehabilitation area are challenged by students with Asperger’s syndrome, nonverbal learning disabilities, autism, traumatic brain injury, attention deficit disorders, and lower IQ scores. This new course is highly visual and creative in addressing critical issues related to driving assessment and training. Course highlights include skills deficits related to these diagnoses, methods and tools that address driving skills (including video review), assessment techniques to determine the readiness to drive, and intervention techniques for...
developing specific social and executive function skills necessary for driving tasks. Earn 1 AOTA CEU (1 NBCOT PDUs/1 contact hours). Order #4840, AOTA Members: $45, Nonmembers: $65. http://store.aota.org/view/?SKU=4840

AOTA CEonCD™ Ongoing CEonCD Manuals on Human Occupation Screen Tool (MOHOST): Theory, Content, and Purpose. Gary Keilhoffer, DrPH, OTR/L, FAOTA; Lisa Castle, MBA, OTR/L; Supriya Sen, OTR/L; and Sarah Skinner, MEd, OTR/L. Occupation-focused practice and top-down assessment make occupational therapy unique when assessing and documenting client services. Unfortunately, therapists often turn to quicker impairment-oriented or performance-based assessments. The MOHOST occupation-focused assessment tool is comprehensive and easy-to-administer with a wide range of clients at different functional levels. This new course teaches you how to use a variety of information from observation, interview, chart review, and proxy reports to complete the MOHOST tool. Earn 4 AOTA CEUs (4 NBCOT PDUs/4 contact hours). Order # 4838, AOTA Members: $125, Nonmembers: $180. http://store.aota.org/view/?SKU=4838


AOTA CEonCD™ Ongoing Sensory Processing Concepts and Applications in Practice. Winnie Dunn, PhD, OTR, FAOTA. Examines the core concepts of sensory processing based on Dunn’s Model of Sensory Processing. The course explores the similarities and differences between this approach and other sensory based approaches, examines how to implement the occupational therapy process, and reviews evidence to determine how to create best practice assessment and intervention methods. Case studies and applications within school-based practice, and knowledge and practice issues on the horizon are discussed. Earn .2 AOTA CEUs (2 NBCOT PDUs/2 contact hours). Order #4836, AOTA Members: $68, Nonmembers: $97. http://store.aota.org/view/?SKU=4836

AOTA CEonCD™ Ongoing Ethics Topics—Organizational Ethics: Occupational Therapy Practice in a Complex Health Environment. Lea Cheyney Brandt, OTD, MA, OTR/L, and Member-at-Large, AOTA Ethics Commission. Explores organizational ethics issues that may influence the ethical decision making of occupational therapy practitioners. Participants will be introduced to ethical strategies that will assist in ad-dressing situations in which occupational therapy practitioners may be pressured by an organization’s administration to provide services that are in conflict with their personal or professional code of ethics. Earn 1 AOTA CEU (1 NBCOT PDUs/1 contact hours). Order #4841, AOTA Members: $45, Nonmembers: $65. http://store.aota.org/view/?SKU=4841


AOTA CEonCD™ Ongoing Occupation-Focused Intervention Strategies for Clients With Fibromyalgia and Fatiguing Conditions, Renee R. Taylor, PhD. Presents a number of evidence-based strategies for managing fibromyalgia and other fatiguing conditions, such as chronic fatigue syndrome. Learners will become familiar with interdisciplinary treatment approaches and how to work best with other professionals treating these syndromes. Earn .2 AOTA CEU (2 NBCOT PDUs/2 contact hours). Order #4839, AOTA Members: $68, Nonmembers: $97. http://store.aota.org/view/?SKU=4839

AOTA CEonCD™ Ongoing Pain, Fear, and Avoidance: Therapeutic Use of Self With Difficult Occupational Therapy Populations, Renee R. Taylor, PhD. Examines strategies for managing client pain, fear, and avoidance in occupational therapy practice. Six distinct modes of interacting based on the author’s conceptual practice model teach how to best manage these emotions and behaviors so that treatment goals can be accomplished. The model is particularly useful when therapists are having difficulty engaging clients or sustaining active participation in therapy. Earn 2 AOTA CEU (2 NBCOT PDUs/2 contact hours). Order #4836, AOTA Members: $68, Nonmembers: $97. http://store.aota.org/view/?SKU=4836

AOTA CEonCD™ Ongoing Staying Updated in School-Based Practice. Yvonne Swinth, PhD, OTR/L, FAOTA, and Mary Muhlenhaupt, OTR/L, FAOTA. Provides information and practical strategies on issues, trends and knowledge related to providing services for children and youth in public schools. Topics include IDEA 2004, NCLB, and Section 504 of the Rehabilitation Act. Ideas and approaches presented can be implemented individually or in collaboration with colleagues or members of a school district team. Earn .15 AOTA CEU (1.5 NBCOT PDUs/1.5 contact hours). Order #4835, AOTA Members: $51. Nonmembers: $73. http://store.aota.org/view/?SKU=4835

AOTA CEonCD™ Ongoing Hand Rehabilitation: A Client-Centered and Occupation-Based Approach. Presented by Debbie Amini, MEd, OTR/L, CHT. Describes how to use the occupation-based intervention to enhance hand rehabilitation protocols without sacrificing productivity or detracting from the concurrent client factor focus. CD-ROM provides an interactive platform for the entire course. Earn .2 AOTA CEU (2 NBCOT PDUs/2 contact hours). Order #4832, AOTA Members: $68, Nonmembers: $97. http://store.aota.org/view/?SKU=4832

Available From AOTA Ongoing ASHT Test Preparation. This intermediate-level course provides a comprehensive overview of all topics related to upper extremity rehabilitation. There are twenty-five PowerPoint™ chapters with over 2,000 slides and sample multiple-choice test questions accompany each chapter. Earn 30 AOTA approved contact hours (3 AOTA CEUs/30 NBCOT PDUs). Order #4850, AOTA Members: $300, Nonmembers: $450. http://store.aota.org/view/?SKU=4850

AOTA/Genesis CEonCD™ Ongoing Seating and Positioning for Productive Aging: An Occupation-Based Approach. Presented by Felicia Chew, MS, OTR, and Vickie Rierman, MSHA, OTR/L. Reviews seating and positioning from evaluation to outcome, with a concentration on interventions. Information reviewed will be applicable to a variety of settings, including skilled nursing facilities, home health, rehab centers, assisted living communities, and others. Primarily addresses manual wheelchair mobility. Earn .4 AOTA CEU (4 NBCOT PDUs/4 contact hours). Order #4831, AOTA Members: $97, Nonmembers: $138. http://store.aota.org/view/?SKU=4831

AOTA CEonCD™ Ongoing The New IDEA Regulations: What Do They Mean to Your School-Based and EI Practice? Presented by Leslie L. Jackson, MEd, OT, and Tim Nanof, MSW. Understand what the 2004 reauthorization of IDEA and the new Part B regulations, released in August 2006, mean and what impact they have on your work as a school-based and early intervention practitioner. This CE course is an excellent opportunity to update your knowledge on IDEA. Earn .2 AOTA CEU (2 NBCOT PDUs/2 contact hours). Order #4825, AOTA Members: $68, Nonmembers: $97. http://store.aota.org/view/?SKU=4825

AOTA CEonCD™ Ongoing Occupational Therapy and Transition Services. Presented by Kristin S. Conaboy, OTR/L; Susan M. Nochajski, PhD, OTR/L; Sandra Schelkind, MS, OTR/L; and Judith Schoonover, MEd, OTR/L, ATP. Individualize your educational and research experiences. Choose between the Science of Human Occupation and Practice in Occupation tracks. Apply knowledge gained through the advanced study of occupational science and social justice to promote the health and participation of society. Courses available through a combination of online and directly supervised learning experiences. Select between part-time and full-time enrollment options. Located near Baltimore, MD, a great place to learn and live! http://grad.towson.edu/program/doctoral/osc-scd/
This course will present an overview of the importance of addressing transition needs as part of a student’s IEP and the key role of the occupational therapy practitioner as a potential collaborative member of the transition team. It is an excellent opportunity to update your knowledge about Transition Services and practice opportunities related to this area of school-based practice. Earn 1 AOTA CEU (1 NBCOT/PDU/1 contact hour). Order #4282, AOTA Members: $44.85, Nonmembers: $66.80. http://store.aota.org/view/?SKU=4282

AOTA Online Course Ongoing New! Falls Module I—Falls Among Community-Dwelling Older Adults: Overview, Evaluation, and Assessments. Presented by Elizabeth W. Peterson, PhD, OTR/L, FAOTA, and Roberta Newton, PhD, PT, FGSA. First module in a three-part series of online continuing education courses on fall prevention. This course will support occupational therapists in their efforts to provide evidence-based fall prevention services to older adults who are at risk for falling or who seek preventive services. This course is divided into two sections: Prevalence, Consequences, and Risk Factors and Approaches to the Evaluation of Fall Risk. Earn 6 AOTA CEU (6 NBCOT PDUs/6 contact hours). Order #OL34, AOTA Members: $210, Nonmembers: $299. http://store.aota.org/view/?SKU=OL34

AOTA Online Course Ongoing New! Falls Module II—Falls Among Older Adults in the Hospital Setting: Overview, Assessment, and Strategies to Reduce Fall Risk. Presented by Roberta Newton, PhD, PT, FGSA and Elizabeth W. Peterson, PhD, OTR/L FAOTA. The second module in a 3-part series on fall prevention, this online course provides an overview of the problem of falls that occur in the hospital setting and focuses further on the identification of older adults at risk for falls, the factors that contribute to fall risks, and the assessment strategies that involve occupational therapy expertise. Earn 2 AOTA CEU (2 NBCOT PDUs/3 contact hours). Order #OL35, AOTA Members: $68, Nonmembers: $97. http://store.aota.org/view/?SKU=OL35

AOTA Online Course Ongoing New! Driving and Community Mobility for Older Adults: Occupational Therapy Roles, Revised. Presented by Susan L. Pierce, OTR/L, SCDCM, CDRS, and Elin Schold Davis, OTR/L, CDRS. Targeted to occupational therapy professionals in all settings who work with older adults. Revised with expanded content and updated links on research, tools, and resources to help advance knowledge about instrumental activity of daily living (IADL) of driving and community mobility. Earn 6 AOTA CEU (6 NBCOT PDUs/6 contact hours). Order #OL33, AOTA Members: $180, Nonmembers: $255. http://store.aota.org/view/?SKU=OL33

AOTA Online Course Ongoing Elective Session 2 (2009): Occupational Therapy for Infants and Toddlers With Disabilities Under IDEA 2004, Part C. Presented by Mary Muhlenhaupt, OTR/L, FAOTA. An elective session in the Occupational Therapy for Infants and Toddlers With Disabilities Under IDEA 2004 series, this ES2 replaces the previous “Early Intervention: Service Delivery Under the IDEA.” The core course is not required as a prerequisite for this new elective. Earn 1 AOTA CEU (1 NBCOT/PDU/1 contact hour). Order #OLS82A, AOTA Members: $29.95, Nonmembers: $41. http://store.aota.org/view/?SKU=OLS82A


AOTA Autism Conference Session Webcast Ongoing Evidence-based Review of Interventions for Children with Autism Spectrum Disorders. Presented by Jane Case-Smith, EdD, OTR/L, FAOTA. Summarizes the up-to-date research evidence for occupational therapy practitioners with children with ASD. Addresses current research evidence for sensory integrative, sensory-based, social skills, behavioral, relationship-based, and physical therapy interventions. Earn 1 Contact Hour. Order #WA1004, AOTA Members: $45, Nonmembers: $64.

AOTA Autism Conference Session Webcast Ongoing A Family Affair: The Voices of Parents and Individuals With Autism. Presented by Janet V. DeLaury, EdD, OTR/L, FAOTA; Barbara B. Demchick, MS, OTR/L. Discussion among parents of children with autism, and youth and adults with autism on life realities and necessary services for full community involvement. Topics also include service delivery, connecting services to family goals and cultural expectations, and legislative and fiscal constraints, and how AOTA resources can assist practitioners with individuals and families. Earn 1.5 Contact Hours. Order #WA1006, AOTA Members: $68, Nonmembers: $97.

AOTA Autism Conference Session Webcast Ongoing Professional Collaboration to Maximize Successful Participation Across the Lifespan. Presented by Lisa Crabtree, PhD, OTR/L, OTR/L. The needs of individuals on the autism spectrum change from childhood through young adulthood. This session addresses strategies and environmental modifications to accommodate common themes across interventions yielding favorable outcomes. This webcast will present these evidence-based strategies and apply them to occupational therapy practice in early childhood through adulthood. Earn 1.5 Contact Hours. Order #WA1008, AOTA Members: $68, Nonmembers: $97.

AOTA Autism Conference Session Webcast Ongoing AOTAs in the Public Schools. Presented by Kristy Patten Koeng, PhD, OTR/L, FAOTA, Adolescent and Young Adults with ASD generate personal narratives and self-advocacy work that highlight life challenges and opportunities, perspectives that...
can significantly inform occupational therapy prac-
tice. This webinar provides a conceptual model of
intervention that offers an “inside out” perspective
of the individual with ASD and highlights strategies
and interventions that improve sex, motor, and
behaviors. Earn up to 1.5 PDUs. Order #3030
AOTA Members: $45, Nonmembers: $64.

AOTA Conference Session Webcast (available until June 30, 2011)
Hemianopsia: Strategies Based on Research and
Clinical Experience That Support Performance
and Movement Outcomes. Presented by Jennifer
Richman, OTR/L; and Sandra Schefkind, PhD, OTR/L.
AOTA members: $45, Nonmembers: $64.

AOTA Conference Session Webcast (available until June 30, 2011)
Raising the Bar: Elevating Knowledge in School Mental Health.
Presented by Susan Bazyk, PhD, OTR/L, FAOTA; and
Sandra Schefkind, PhD. This Webcast provides an overview
of school mental health (SMH) movement and how
occupational therapy helps address mental health
and psychosocial needs of children in schools,
including service in the 3-tiered model of school-wide
SMH using occupation-based practice, positive
behavioral supports (PBS), and social-emotional
learning (SEL). Earn 1.5 AOTA CEUs (1.5 NBCOT PDUs/1.5 contact hours).

AOTA CEUs (1.5 NBCOT PDUs/1.5 contact hours).
Order #CSC223, AOTA Members: $45.
Nonmembers: $64. http://store.aota.org/view/?SKU=CSC223

AOTA Conference Session Webcast (available until June 30, 2011)
Senior Mobility Choices: National Speakers Identify
Opportunities for Funding, Program Development,
and Education (featuring a tool for identifying
dementia-friendly transportation options).
Presented by Beth Shold, OTR/L, CDRS, EDS,
Wagner, MA; Lisa Tucker, MA; Nina M. Silverstein,
PhD, and Helen K. Krachner, PhD. Occupational
therapy programs have an opportunity to play a pro-
active role in developing services that meet commu-
nity mobility needs for clients. This session enables
learners to identify accessible options in their com-
munities including those for seniors with dementia,
and explores opportunities for advocacy, funding,
and enhanced mobility service networks. Earn .3
AOTA CEU (3 NBCOT PDUs/3 contact hours). Or-
der #CW5201, AOTA Members: $79, Nonmembers: $112.
http://store.aota.org/view/?SKU=CW5201

AOTA Conference Session Webcast (available until June 30, 2011)
Paradigm Shift and Innovations in Stroke Rehabilitation.
Presented by Leah S. Dunn, MS, OTR/L; Valerie Hill Hermann, MS, OTR/L; and
Lisa Finnen, MS, OTR/L. A growing body of evidence indicates that intense,
task-oriented therapy programs incorporating various technologies are ef-
ficacious in promoting upper-extremity function post-stroke. This workshop presents an overview
of the technologies for clients with stroke. Re-
search evidence and pragmatic considerations will also be discussed. Earn .3
AOTA CEU (3 NBCOT PDUs/3 contact hours). Order #CW5402, AOTA Members: $79, Nonmembers: $112.
http://store.aota.org/view/?SKU=CW5402

AOTA Conference Session Webcast (available until June 30, 2011)
Acute Stroke Rehabilitation: The Science and Practice
Innovations. Presented by Genevieve Braqua,
FAOTA; and Jennifer Bogner, PhD.
AOTA members: $45, Nonmembers: $64.

AOTA Conference Session Webcast (available until June 30, 2011)
Hemianopsia: Strategies Based on Research and
Clinical Experience That Support Performance
and Movement Outcomes. Earn 1.5 AOTA CEUs
(available until June 30, 2011)

Available From AOTA
Hemianopsia: Strategies Based on Research and
Clinical Experience That Support Performance
in Daily Occupations. Presented by Timothy Hol-
mes, OTR/L, COMS. Hemianopsia is the most common visual impairment resulting
from stroke or TBI. This short course will provide an up-
date on what appear to be the most effective inter-
ventions for occupational performance for people
from visual field loss, including research and clinical
experience with scanning techniques, vision res-
oration therapy, and optokinetic therapy. Earn 1.5
AOTA CEUs (1.5 NBCOT PDUs/1.5 contact hours).
Order #CSC223, AOTA Members: $45.
Nonmembers: $64. http://store.aota.org/view/?SKU=CSC223

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Paradigm Shift and Innovations in Stroke Rehabilitation.
Presented by Leah S. Dunn, MS, OTR/L; Valerie Hill Hermann, MS, OTR/L; and
Lisa Finnen, MS, OTR/L. A growing body of evidence indicates that intense,
task-oriented therapy programs incorporating various technologies are ef-
ficacious in promoting upper-extremity function post-stroke. This workshop presents an overview
of the technologies for clients with stroke. Re-
search evidence and pragmatic considerations will also be discussed. Earn .3
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Clinical Experience That Support Performance
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### NEBRASKA

**Regional Employment Outlook**

#### What Every Practitioner Needs To Know About Nebraska

- **Mean Annual Salary**
  - OT: $62,650¹
  - OTA: $42,140¹
- **Licensure Status**: Required for OTs and OTAs²
- **Nebraska Board of Occupational Therapy Practice**
  - P.O. Box 94986
  - Lincoln, NE 68509-4986
  - Phone: 402-471-2299
  - Fax: 402-471-3577
diane.hansmeyer@nebraska.gov
  - www.hhs.state.ne.us/crl/rcs/ot/ot.htm

#### Highlights

- Nebraska has the lowest concentration of OTAs in the Midwest.¹*
- Creighton University in Omaha and College of St. Mary in Omaha are listed among U.S. News & World Report’s “Best Graduate Schools” for occupational therapy.³

#### Big Picture

- Living, working, and doing business in Nebraska are made easy with a wide variety of employment opportunities, minimal commute times, safe communities, and exceptional environmental air and water quality. The cost of living in Nebraska is well below the national average, and the state’s education is ranked among the best in the nation based on its high school graduation rates and low student-to-teacher ratio.⁴

#### Want More?

Visit the Employment Opportunities pages starting on page 29 and www.OTJobLink.org to view job openings from the following employers in NE:

- Banner Health, p. 33
- College of St. Mary, p. 29
- Peoplefirst Rehabilitation, p. 35

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### NORTH DAKOTA

#### What Every Practitioner Needs To Know About North Dakota

- **Mean Annual Salary**
  - OT: $55,330¹
  - OTA: $40,420¹
- **Licensure Status**: Required for OTs and OTAs²
- **North Dakota State Board of OT Practice**
  - 2900 E. Broadway, Suite 1
  - Bismarck, ND 58501
  - Phone: 701-250-0847
  - Fax: 701-224-9824
  - ndotboard@aptnd.com
  - www.ndotboard.com

#### Highlights

- University of North Dakota in Grand Forks and University of Mary in Bismarck are listed among U.S. News & World Report’s “Best Graduate Schools” for occupational therapy.³

#### Big Picture

- North Dakota’s home prices are well below the U.S. median and the state has the lowest number of foreclosures in the nation. It is one of only a few states with a budget surplus, and the readily available high quality health care makes it one of the healthiest states in the United States. Clean air, a good education system, and safe and family-friendly communities make it a great place to live.⁵

#### Want More?

Visit the Employment Opportunities pages starting on page 29 and www.OTJobLink.org to view job openings from the following employers in ND:

- RehabCare, OTJK

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### SOUTH DAKOTA

#### What Every Practitioner Needs To Know About South Dakota

- **Mean Annual Salary**
  - OT: $59,480¹
  - OTA: $34,160¹
- **Licensure Status**: Required for OTs and OTAs²
- **South Dakota Occupational Therapy Committee**
  - 101 N. Main Ave. Suite 301
  - Sioux Falls, SD 57104
  - Phone: 605-367-7781
  - Fax: 605-367-7786
  - SDBMOE@state.sd.us
  - www.sdbmoe.gov/occupational_therapists.aspx

#### Highlights

- South Dakota has the second-lowest concentration of OTs and OTAs in the Midwest.¹*
- University of South Dakota in Vermilion is listed among U.S. News & World Report’s “Best Graduate Schools” for occupational therapy.³

#### Big Picture

- South Dakota ranks high on lists such as trustworthy neighbors, low commute times, happiest state, best state for retirement, and best place to build a nest egg. Four full seasons of outdoor recreational opportunities, Mount Rushmore, and the Badlands National Park make it a tourist destination. Residents enjoy a low cost of living, high quality medical and health care, low violent crime rates, and the best business tax climate in the country.⁶

#### Want More?

Visit the Employment Opportunities pages starting on page 29 and www.OTJobLink.org to view job openings from the following employers in SD:

- Amedisys, OTJK

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¹Source: www.bls.gov
²www.aota.org
³www.grad-schools.usnews.rankingsandreviews.com
⁴www.neded.org
⁵www.business.nd.gov
⁶www.sdreadytowork.com

*Regional data uses the U.S. Census Bureau designations of regions and division in the United States.

For a directory of state regulatory contacts, visit www1.aota.org/state_law/reglist.asp.
Faculty Position Recruitment

Touro University Nevada, College of Health and Human Services, School of Occupational Therapy is seeking a full-time faculty member in the Master of Science in Occupational Therapy degree program.

The ideal candidates will join a dedicated faculty in this 24-month program. Touro University Nevada utilizes classroom, experiential lab, community-based practice settings, and technology-based teaching resources to foster student learning. Faculty members participate in university, professional and community service activities.

Minimum Requirements:
A doctoral degree (or significant progression toward completion) is required along with experience in classroom instruction and practice in the identified content areas. Faculty members must be eligible and obtain a Nevada Occupational Therapy License.

Preference will be given to individuals with expertise and teaching experience in the following areas: psychosocial/mental health aspects of practice, adult and older adult conditions, and research. Individuals with expertise in other areas of occupational therapy foundation are also encouraged to apply.

Additional Information:
Touro University Nevada offers generous benefits to eligible employees including: health and optional dental/vision coverage; life insurance, long-term disability, a tax-deferred retirement plan, tuition benefits, three weeks of paid vacation the first year; numerous paid holidays, and more. TUN is an Equal Opportunity Employer.

To Apply:
Qualified applicants should forward a letter of interest and current vitae to:

William Wrightsman, MS, OTR/L, Search Committee Chairperson
Touro University Nevada
School of Occupational Therapy
874 American Pacific Drive
Henderson, NV 89014
william.wrightsman@tun.touro.edu

Applicants should fully describe qualifications and experience, since the initial review will serve to evaluate applicants based on documented, relevant qualifications and professional work experience.

Position is available in April 2011. However, position will be opened until filled.
**Faculty**

**Brown Mackie College–Tucson**

is recruiting for full-time COTA instructors. Associate's degree required and previous teaching experience is strongly preferred.

**Join our team!** Brown Mackie College offers a competitive salary and an excellent working environment, along with a generous benefit package that includes health, dental, and vision insurance; vacation and holidays; 401(k) plan with company match; and tuition support for you and your dependents.

Interested candidates should submit resumes to www.edmc.edu/careers/jobpostings.aspx.

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**Faculty**

**Brown Mackie College–Greenville**

is recruiting for an OTA fieldwork coordinator. Associate's degree is required and a bachelor's degree is required by July 2012.

- 2–5 years of experience as an occupational therapist or an occupational therapy assistant is required.
- 0–2 years experience in instruction or formalized education process, preferably in a postsecondary or college institution, is also required.

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Interested candidates should submit resumes to www.edmc.edu/careers/jobpostings.aspx.

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**West**

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Contact Kate Konopasek at 907-742-6121 (Konopasek_Kate@asd12.org) or apply online at www.asdk12.org.
Postdoctoral Training Opportunity

The University of Southern California, seeks trainees for two-year NICHD-NCMRR-funded postdoctoral fellowships. This Ruth L. Kirschstein NRSA Institutional Research Training Program in Rehabilitation Efficacy and Effectiveness Trials (TREET) proposes a multidisciplinary training program which will enable doctoral level scholars from rehabilitation-related fields to gain the expertise necessary to perform sophisticated clinical trials, including comparative effectiveness studies. Ph.D. level researchers will undergo an intensive two-year training sequence which involves exposure to all phases of clinical trials research. Research among fellows and training faculty is diverse and spans multiple areas. Potential candidates are encouraged visit http://www.usc.edu/research/centers/schools for more details about research opportunities at USC.

Candidates should have demonstrated research interests relevant to rehabilitation science. Mentors are working in the following areas: (1) pediatric rehabilitation; (2) protective and risk factors in adults with disabilities; (3) acute and community-based rehabilitation; (4) applications of innovative technology, and (5) neurorehabilitation.

Qualified individuals must have completed a PhD, or equivalent (within the last five years) in occupational therapy, physical therapy, neuroscience, bioengineering and design, medicine or other disciplines relevant to rehabilitation science and must be a US citizen or have permanent resident status. Candidates with clinical doctoral degrees (e.g., MD, DPT, OTD) will be considered only in exceptional cases in which the clinical degree is supplemented by significant research experience and other supporting evidence of strong scholarship. Health insurance, tuition, and conference travel provided.

The training program will be jointly administered by the Division of Occupational Science and Therapy and the Division of Biokinesiology and Physical Therapy at the Herman Ostrow School of Dentistry.

Interested candidates should submit the following documents by June 15th:
1. Curriculum Vitae
2. Description of past research experience and accomplishments
3. Personal Statement describing career goals and research interests
4. Letter of recommendation from dissertation chair and at least two other faculty

Submit materials to:
Patricia Gutierrez
USC Division of Occupational Science and Occupational Therapy
1540 Alcazar Street, CHP 133 MC 9003
Los Angeles, CA 90033

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**Faculty**

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- Conducting scholarship in occupation-based practice through a research line consistent with the mission of the Department, College, and University
- Developing and obtaining external grant funding to support research line and contributing to service mission of the Department, College, and University

For optimal consideration, applications should be postmarked by April 30, 2011.

Sonia Lawson, PhD, OTR/L, Acting Chair

Department of Occupational Therapy & Occupational Science
Towson University
8000 York Road
Towson, MD 21252-0001
410-704-2762
slawson@towson.edu

**Qualifications:** Applicant must be licensed or eligible for licensure as an occupational therapist in the State of Maryland and have a minimum of three years of occupational therapy practice experience with expertise in children and youth or adult physical rehabilitation or both. CHP-N-2438

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Foreword by Gary Kielhofner, DrPH, OTR/L, FAOTA

People experience and value their health in terms of its impact on their lives or their ability to participate in life. Occupational therapy strives for meaningful occupational performance as an outcome with clients, recognizing that physical, mental, and emotional health can enable that outcome.

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Faculty

CHICAGO STATE UNIVERSITY
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Chairperson—
Department of Occupational Therapy

The Department of Occupational Therapy at Chicago State University invites applications for the position of chairperson. This is a 12-month full-time appointment. Academic rank and compensation are commensurate with qualifications and experience.

QUALIFICATIONS: Qualifications include a degree in occupational therapy and an earned doctorate in occupational therapy or a relevant field. The ideal candidate will have a minimum of 10 years of experience in the field of occupational therapy, including practice as an occupational therapist and administrative experience as well as at least 5 years experience in a full-time academic appointment with teaching responsibilities. Candidates must hold current certification by NBCOT and a current Illinois occupational therapy license or eligibility, with a good track record of scholarship and grantmanship.

The chairperson provides leadership for a combined Bachelor of Health Sciences and Master of Occupational Therapy program. Additionally, the chairperson participates in research, service, and some teaching within the professional program.

APPLICATIONS: Review of applications will begin on March 1, 2011, and applications will be reviewed until position is filled. The position will begin July 1, 2011. Applications for the position should be submitted through the university portal at https://chicago.state.peopleadmin.com.

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South

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National

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OT PRACTICE • APRIL 25, 2011
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Northeast

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Faculty

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Developing occupational therapy assistant program in south-central Pennsylvania is seeking a COTA or OTR for the position of fieldwork coordinator. This full-time individual will work with the program director to coordinate all aspects of Level I and Level II fieldwork education for students enrolled in the OTA program and will have some direct teaching responsibilities. Some travel to fieldwork sites will be required. Minimum requirements are a bachelor’s degree in OT or a related field, teaching experience in an academic setting, professional experience working with COTAs, and at least 3 years of clinical experience. Must hold a Commonwealth of Pennsylvania occupational therapy assistant or occupational therapist license or be eligible for licensure. Must have a valid driver’s license. Currently accepting applications. Expect to hire in summer 2011. Please submit resume and cover letter with salary requirements to carriewiddowson@centralpenn.edu. EOE

NEW SELF-PACED CLINICAL COURSE

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Edited by Susan Bazyk, PhD, OTR/L, FAOTA

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Occupational Therapy’s Role in Mental Health Promotion, Prevention, and Intervention With Children and Youth is a critically important professional development tool for occupational therapy practitioners who work with children and youth. It provides a necessary framework on mental health that can be applied in all pediatric practice settings and lays a foundation for conceptualizing the role of occupational therapy in promoting, preventing, and providing mental health intervention for children that may or may not have disabilities, mental illness, or both, in school and community settings. Chapters take a public health approach to occupational therapy services at all levels—universal, targeted, and intensive—with a clear emphasis on helping children develop and maintain positive mental health psychologically, socially, functionally, and in the face of adversity.

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**West**

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For more information regarding this opportunity, please call Lesley Vaughan at 253-966-5058 or e-mail resume to lesley.vaughan@us.army.mil. References required.

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**National**

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Peoplefirst Rehabilitation EOE

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**Northeast**

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[Image of a sign for Ivymount School]

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**West**

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Peoplefirst Rehabilitation EOE
The Continuing Need for Effectiveness Studies in Occupational Therapy

Susan H. Lin

Occupational Therapy’s Effectiveness in Depression

Recognizing that depression can negatively affect work outcomes, Hees and colleagues designed a two-arm randomized ongoing controlled trial to evaluate the effectiveness of adjuvant occupational therapy in employees diagnosed with depression. The participants (N=117) are randomized to either “care as usual” or “care as usual with occupational therapy” groups. The occupational therapy intervention strives to enhance the employees’ self-efficacy and acquiring adaptive coping skills via six individual sessions, eight group sessions, and a workplace visit over a 16-week period. Work participation (primary outcome measure), work functioning symptomatology, health-related quality of life, and neurocognitive functioning will be assessed at baseline, 6, 12, and 18-month follow-up assessments. To inform policy decisions, cost effectiveness will also be evaluated. Mechanisms of change will be examined as well. This study is based on early intervention, which was found to be effective in improving work outcomes in employees with depression.

Comparing Two Interventions for Hemiplegic Cerebral Palsy

High-level evidence indicates that upper limb botulinum toxin-A (BTX) combined with occupational therapy effectively improves outcomes in children with cerebral palsy at both the body function/structure and activity levels. But what amount and type of occupational therapy will maximize functional outcomes and prolong the beneficial effects of BTX? Hoare and colleagues described the methodology of a randomized controlled trial to compare the effects of modified constraint-induced movement therapy to bimanual occupational therapy (bimanual therapy) in children with hemiplegic cerebral palsy following BTX injection. The primary outcome measure was the Assisting Hand Assessment, and secondary outcome measures included the Pediatric Evaluation of Disability Inventory, the Canadian Occupational Performance Measure, and the Quality of Upper Extremity Skills Test. Described in this paper are the rationale, hypotheses, outcomes measures, and interventions of this evaluator-blinded, prospective parallel–group trial. Results will be disseminated through peer-reviewed journals.

Occupational Therapy for Cognitive Impairment Poststroke

Individuals who have had a stroke may demonstrate cognitive impairment that can negatively affect their occupational performance. To determine whether occupational therapy results in improved functional performance of activities of daily living (ADLs) and cognitive abilities, Hoffman and colleagues searched for published, unpublished, and ongoing trials. Based on the search, they included one trial with 33 participants. No difference was found between the groups on two outcome measures (improvement in judgment skills and improvement in basic ADLs on the Barthel Index). The researchers concluded that the effectiveness of occupational therapy for cognitive impairment poststroke cannot be supported or refuted based on the evidence in this review.

References

NOTE: To view the abstracts and full-text options of these articles, visit Google Scholar at http://scholar.google.com/schhp?hl=en&tab=ws or PubMed at http://www.ncbi.nlm.nih.gov/sites/entrez and type the article title into the search box, then click on Search. If you would like your in-press or recently published research featured in this column, please contact Susan Lin at slin@aota.org or 301-652-6611, ext. 2091.
As an AOTA member, you are a powerful advocate for occupational therapy and you have a lot to celebrate. You are part of a body of professionals that help children with disabilities participate in school, individuals recovering from injuries regain their skills, older adults stay as independent as possible, and people of all ages and in all circumstances benefit from specialized support and services that only occupational therapy can provide.

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How would your family continue the life they’ve built without your paycheck to help make ends meet?

What about your family’s dreams of the future? College for your children? Who would help out your parents as they got older or take care of other family members who already rely on you?

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Secondary Prevention Related to Work
The Role of Occupational Therapy

CARRIE SCHEEL, EDD, OTR
Associate Professor, Occupational Therapy
Concordia University Wisconsin
President, Synergistic Solutions

CHRISTINE HERZGER, MBA, PT
Adjunct Professor, Physical Therapy
Concordia University Wisconsin
CEO, Synergistic Solutions

This CE Article was developed in collaboration with
AOTA’s Work & Industry Special Interest Section.

ABSTRACT
Occupational therapy plays a key role in workplace injury prevention programs. This article discusses three types of work injury prevention—primary, secondary, and tertiary—with a focus on occupational therapy’s role in secondary prevention. Research supports a biopsychosocial model for injury prevention that uses a client-centered, occupation-based approach to screening and interventions for the injured worker (Noonan & Wagner, 2010). The secondary prevention process includes a nonmedical referral, screening, frame-of-reference identification, and intervention. Since the Occupational Safety and Health Administration (OSHA) defined categories of secondary prevention in 2001, our experience with numerous companies shows that the intervention employers prefer is first aid (OSHA, 2001). Many benefits may be found in implementing a preventative program for both injured workers and their employers (Ramos, 2006; Sullivan et al., 2005). These benefits can be financial, social, and psychological, and can apply to all involved parties. This article, which includes a case example, discusses the importance of occupational therapy in the emerging market of secondary prevention for work-related injuries.

LEARNING OBJECTIVES
After reading this article, you should be able to:
1. Define and differentiate between primary, secondary, and tertiary care in the field of work practice.
2. Identify the theoretical background of secondary prevention.
3. Describe and apply components of secondary prevention.
4. Identify the benefits of secondary prevention.

INTRODUCTION
The practice area of work appears to be growing for occupational therapy, as evidenced by anecdotal reports of increased requests for work injury prevention services in Wisconsin. In AOTA’s Centennial Vision, several areas of emerging practice in work and industry are identified: disability prevention, ergonomic consulting, and health and wellness consulting (Baum, 2006). The U.S. Bureau of Labor Statistics (BLS) reported that there were 3.3 million nonfatal occupational injuries or illnesses in 2009, down from 3.7 million in 2008 (BLS, 2010). Anecdotal evidence shared by members of the Wisconsin Occupational Therapy Association suggests that one of the reasons for this decrease may be the increase within workplaces of onsite work injury prevention programs provided by physicians, nurses, athletic trainers, physical therapists, and occupational therapy practitioners. The American College of Occupational and Environmental Medicine and the 60 Summits Project, a national program that brings stakeholders together to minimize the effects of work-related illness or injuries, recommend a disability prevention model that prevents work injury by screening and intervening with symptomatic workers early (Christian, 2009). Secondary prevention is one approach to early intervention. Recent studies demonstrated the positive effect of secondary prevention on work-related injuries, workers’ compensation costs, and psychosocial factors (Krause, Dasinger, & Neuhauser, 1998; Loisel et al., 2005; van Duijn, 2004; van Duijn, Lotters, & Burdorf, 2005). Many of the studies emphasized the need to intervene from the first day of reported symptoms (Noonan & Wagner, 2010). This article will focus on the role of occupational therapy in secondary prevention.

TYPES OF PREVENTION
There are three forms of work injury prevention services occupational therapists provide: primary prevention, secondary prevention, and tertiary prevention (Thompson, 2006).

Primary prevention is implemented before an injury or illness occurs in the workplace, with interventions either identifying and reducing risk factors prior to injuries occurring or promoting good health in general. Secondary prevention focuses on identifying symptoms and risk factors early to minimize or reduce the duration, severity, and costs of work-related injuries. The goal is to keep the symptomatic worker on the job safely and effectively while simultaneously resolving the worker’s symptoms. Tertiary prevention occurs after an injury or illness is diagnosed, with interventions focused on medically treating the work-related injury to limit the disability and restore function (Thompson, 2006).

From an occupational therapy perspective, the differences between primary, secondary, and tertiary prevention can be seen in Table 1 on p. CE-2. Primary prevention looks at a
population of workers with no injuries through use of a needs-based analysis in order to prevent injuries from occurring and to create or promote wellness through ergonomic interventions. The focus of secondary prevention is on an individual worker who is reporting symptoms. The occupational therapist screens and selects an intervention for the employee to facilitate his or her ability to stay at work through modification, compensation, or adaptation. First aid, as defined by the Occupational Safety and Health Administration (OSHA), may be used for intervention (OSHA, 2001). In addition to first aid, individual task-specific interventions may be used. Tertiary prevention occurs when a worker is diagnosed by a physician and is referred to an occupational therapist. A comprehensive evaluation with the intent to identify strengths and weaknesses is performed in order to restore or remediate occupational performance. Rehabilitation treatment such as exercise and modalities (e.g., ultrasound, iontophoresis, splinting with metal stays), along with client-centered treatments like work conditioning or work hardening, are implemented.

Once a worker begins to report symptoms, an intervention is urgently required to keep the worker on the job. This can best be done using secondary prevention strategies.

### THEORETICAL APPROACH

Many rehabilitation disciplines use the medical model of evaluation, treatment, and intervention, but the field of occupational therapy tends to focus on a more holistic approach that includes occupation throughout this process (Kaskutas & Snodgrass, 2009). This is reflected in the application of the biopsychosocial model of medicine to managing work-related injuries. This comprehensive model addresses biological, psychological, and sociocultural issues related to the employee’s injury or illness (Drench, Noonan, Sharby, & Ventura, in press; Meyers, 2009; see Figure 1 on p. CE-3).

When working with the injured worker, the occupational therapist must consider biological, psychological, and sociocultural influences. Biological considerations include obesity, gender, age, medical history, family history of work-related injuries, anthropometrics, previous work-related injuries, and the body’s response to the physical requirements of the job. The occupational therapist needs to perform a thorough interview and physical screening related to the biological components.

Therapists must also consider psychological factors that influence the worker’s response to his or her symptoms. There are negative learned expectations and consequences for reporting injuries in the workplace, including pressure from peers to not lose safety incentives, lack of supervisor response, and lost time from work. Fear of those consequences as well as the inability to continue performing the worker’s job may decrease early reporting and extend healing time. The occupational therapist’s role is first to educate the employer regarding the benefits of early intervention and the importance of supporting the worker in the return to work process. Second, the occupational therapist must educate the worker on emotional-regulation skills such as responding to coworker feelings of frustration or resentment, controlling anger about the current work situation, and using relaxation techniques to reduce stress related to the return to work process.

Many social and cultural factors affect the recovery process of the injured worker. Coworkers, supervisors, managers, and unions create the cultural environment for work injuries. A supportive employer who is willing to work with the worker and the occupational therapist provides a positive social environment for successful recovery. This can foster an environment that encourages early detection and reporting. Families may influence the worker’s attitude about his or her injury in either a positive or negative way. They can support the worker by encouraging follow through on work modifications and exercise programs. Cultural influences may include language barriers, health beliefs about healing, and religious beliefs. Health beliefs are based on expectations for healing within society—for example, how quickly people generally believe certain injuries heal, and to what extent healing requires help from others. Religious beliefs that encourage workers to, for example, pray as opposed to take medicine or follow the guidance of physicians will also impact workers’ recovery. Occupational therapy can provide workers with coping techniques when social issues such as low socioeconomic status or poor communication interferes with secondary

### Table 1. Three Types of Prevention

<table>
<thead>
<tr>
<th></th>
<th>Primary prevention</th>
<th>Secondary prevention</th>
<th>Tertiary prevention</th>
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</thead>
<tbody>
<tr>
<td>Injury type</td>
<td>No injury</td>
<td>Injury with symptoms</td>
<td>Injury with diagnosis</td>
</tr>
<tr>
<td>Type of client evaluation</td>
<td>Population needs-based analysis</td>
<td>Individual screening</td>
<td>Individual evaluation</td>
</tr>
<tr>
<td>OT approach</td>
<td>Prevent</td>
<td>Modify/compensate/adapt</td>
<td>Maintain remediation</td>
</tr>
<tr>
<td>Type of intervention</td>
<td>Ergonomic</td>
<td>First aid</td>
<td>Medical treatment</td>
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<tr>
<th></th>
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Figure 1. Biopsychosocial Approach to Secondary Intervention (Modified from Drench, Noonan, Sharby, & Ventura, in press)

**Biological Influences**
- Genetic predisposition to injury (family history)
- The body's ability to adapt to changing work demands
- The body's natural ability to identify and respond to pain

**Psychological Influences**
- Fear of inability to continue to perform job
- Fear of consequences of reporting
- Learned expectations
- Emotional-regulation

**Social Cultural Influences**
- Coworkers
- Supervisors/management
- Union
- Safety compliance/expectations
- Family
- Ethnic background

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prevention, and it can also facilitate positive communication and social interactions or act as a buffer between the worker, employer, and families when there are different viewpoints on the individual's injury and healing process. The occupational therapist helps identify and explain the impact of symptoms on work and home activities.

The biological and pathological processes of work injuries are often seen as separate from the employee's psychosocial perception of his or her injury, but both the pathology and the perception of illness are treated simultaneously when using the biopsychosocial model. More traditional rehabilitation models focus on the biomedical aspects of injury and may neglect cultural and social factors (Noonan & Wagner, 2010).

Although the biopsychosocial model identifies the factors that can influence the treatment of the injured worker, a theoretical approach based on client-centered, occupation-based factors can help guide the screening, evaluation, and intervention process. Occupation-based theories that are typically used by occupational therapists in work practice include, but are not limited to, Occupational Adaptation (Cole & Tufano, 2008), the Model of Human Occupation (Kielhofner, 2002), the Ecology of Human Performance (Dunn, Brown, & McGuigan, 1994), and the Person–Environment–Occupation–Performance Model (Baum & Christiansen, 2005). The Occupational Adaptation process looks at factors that occur when a person is faced with an occupational challenge, like a musculoskeletal injury in the workplace, reducing his or her ability to work. Treatment focuses on the occupational adaptation process. The Model of Human Occupation is a conceptual model for practice that focuses on the person and the effect of the environment on motivation, behavior, and performance. In a work environment, the worker's motivation, behavior, and job performance will be affected by the company culture related to work injury, the ability to adapt job tasks, and the worker's ability to effect changes to improve the work injury. The Ecology of Human Performance theory focuses on the person (worker), the task (work), the context (workplace) and the personal-context-task interaction. It emphasizes the context or environment the person is working in and how the interaction between the worker and context influences the performance of his or her job or role as worker. The Person–Environment–Occupation–Performance Model allows the therapist to consider a person's intrinsic factors (motivation), extrinsic factors (environment), and chosen activity (work tasks) that all contribute to occupational performance. It is through the interplay of these factors that the therapist and client can work toward successful occupational participation.

Many factors influence the occupational therapist's choice of which model, theory, or frame of reference to use. The end goal is to follow a client-centered, occupation-based approach that allows workers to heal on the job safely and effectively. This approach is the cornerstone to successful secondary prevention.

SECONDARY PREVENTION PROCESS

The secondary prevention process provided by an occupational therapist includes a nonmedical referral, screening, identification of a frame of reference, and intervention.

Referral

The referral for occupational therapy services originates at the place of employment for a symptomatic worker. Each employer has its own policies and procedures related to the secondary prevention process. Typically, workplace policies include a referral process that gets a symptomatic worker to a therapist as quickly as possible. For example, an employee might first report symptoms of back pain to his or her supervisor, with an occupational therapist then notified by a supervisor, human resources, or the safety department.

Screening

Screening is the “process of reviewing available data, observing a client, or administering screening instruments to identify an individual’s…strengths and limitations and the need for further assessment” (Hinojosa, Kramer, & Crist, 2010, p. 2). There is variation in what the occupational therapist is allowed to screen due to differing state practice...
acts, even though screening in general is supported by the American Occupational Therapy Association (AOTA, 2010). In the workplace, screening for secondary prevention issues includes an interview of the worker's history (e.g., medical, work, social, cultural), general demographics (e.g., age, race, gender), job requirements, and the worker's reported symptoms and/or injury. Also screened are the physical aspects of reported symptoms, with therapists performing range of motion, strength, provocative testing, and palpation; and observing the worker's functional status and work methods.

**Frame of Reference**

After completing the screening process, if occupational therapy services are deemed appropriate, the occupational therapist may use the biopsychosocial model to determine the worker's greatest weaknesses and identify the most appropriate occupational therapy frame of reference or model for intervention. These frames of reference or models for intervention might include, but are not limited to, the biomechanical frame of reference, rehabilitative frame of reference, motor learning, motor control, neurological approach, and Ecology of Human Performance. The chosen frame of reference or model used for intervention depends on the clinician's educational background and work experience.

**Interventions**

After selecting a frame of reference, the therapist can choose from a variety of interventions to help workers stay on the job. These interventions may include recommending new work practices, including body mechanics training and modified or alternate work arrangements; providing ergonomic modifications; and recommending additional occupational therapy services for which a physician's referral is required. With case management, another type of intervention, the occupational therapist advocates for, coordinates, and communicates with employers about needed client services (Bergey & Flagg, 2010). Case management is required when the screening identifies biological, psychological, and/or sociocultural factors that significantly affect a worker's ability to remain at work. Case management may be done by occupational health nurses, occupational therapists, risk managers, or insurance carriers. When the screening process identifies the need for medical consultation or management, a referral is initiated by the primary care physician, occupational health physician, or other health care professionals as deemed appropriate by the workers' compensation system and state licensure laws. Based on our clinical experience, the client-centered nature of secondary prevention interventions increases the likelihood of the injured worker complying with recommendations and modifications.

The initial intervention used in secondary prevention is first aid as defined by OSHA. The use of first aid results in no recordable injuries, thereby eliminating workers' compensation costs. (OSHA, 2001; see Table 2 on p. CE-5 for clarification of OSHA's first aid criteria). The occupational therapist's chosen intervention will have an impact on "recordable injuries" for the employer. Whether an injury is considered recordable or not is determined by medical care provided that is beyond first aid, days away from work, restricted work or transfer to another job, loss of consciousness, or a significant injury diagnosed by a physician or other licensed health care professional (OSHA, 2001; see Table 2 on p. CE-5).

**Follow-Up**

Every 2 weeks, the occupational therapist should interview and rescreen the injured worker using the appropriate tests, including provocative tests, to ensure accurate intervention. If an injured worker does not show improvement in symptoms such as pain or functional limitations, alternate intervention is warranted. Lack of improvement can be the result of several different issues. A referral to a physician may be appropriate for accurate diagnosis or to a case manager to manage psychosocial concerns. A successful occupational therapy secondary prevention program requires well-developed assessment skills, because assessment is key to appropriate intervention. Screenings that result in inappropriate or inadequate interventions may delay the launch of appropriate interventions, delaying healing time and adding costs to the workers' compensation system as a result. Based on our experience and networking within work practice and ergonomic conferences, the average length of a secondary prevention program is 4 to 6 weeks. Symptoms that persist beyond 6 weeks require additional evaluation or alternate intervention.

**Documentation**

The documentation standard for secondary prevention includes an initial screening report, a SOAP note or other daily visit note format, and a discharge summary. Workers' compensation rules differ by state as to how long documentation for each worker must be maintained and what confidentiality standards exist (Healthcare Providers Service Organization, 2011). Effective, defensible documentation has the following characteristics (Healthcare Providers Service Organization, 2011).

- Records when and what care is provided.
- Avoids exaggeration and subjective descriptions (e.g., "unbearable pain" instead of actual pain levels, such as 5/10 on the Visual Analog Scale).
- Documents observable behavior (e.g., "Client lifted 50 pounds from floor to waist with no facial grimacing or postural guarding").
- Is legible and limits the use of abbreviations.
- Includes all related communications (e.g., to the safety department, supervisors, insurance carriers).
- Records missed or canceled visits.
- Documents a follow-up plan that will keep the worker on the job while safely and effectively addressing symptoms.
Billing

Typical secondary prevention services will be billed directly to the injured worker's employer. CPT codes and ICD-9 codes are not used. Secondary prevention services are billed on an hourly basis. If additional occupational therapy services are required beyond screening and first aid, a physician's referral is required and care becomes tertiary instead of secondary. The billing of tertiary care includes use of CPT and ICD-9 codes (Kaskutas & Snodgrass, 2009).

CASE EXAMPLE

Marco is a 43-year-old Hispanic male who works in a manufacturing company that specializes in making small engines. Marco speaks broken English but appears to have good comprehension skills. He reports symptoms to his supervisor that include pain in his right elbow and forearm for the past 10 days. Marco is referred by the human resources department to the secondary prevention program provided by an occupational therapist. The screening process begins with an interview. Marco reports that he has been an employee for 15 years and has worked as an assembler for the last 2 years. He has a family history of arthritis and is married with two young children. According to Marco, both he and his wife are concerned about his recovery and are afraid that he will not be able to work. Marco's coworkers have not been supportive and are angry that their workload has increased as a result of his injury, while Marco's supervisor is unsure if this injury is work related. Marco noticed some minor discomfort in his right elbow 10 days ago. Symptoms have slowly increased in severity over the past few days. Marco does not report a specific injury but rather a progression of symptoms. Pain ratings at rest are a 2/10 and during work activities are a 6/10. A verbal task analysis helps identify that two job tasks increase Marco's symptoms. Marco reports that although he is able to do his job tasks, he is concerned because he is getting slower and falls behind on the line when his pain increases. He also reports that he is having difficulty with chores at home like cutting the grass, washing his car, and taking out the garbage. Marco shares with the therapist that his goal is to be able to do his job pain free at the same pace he did it before.

The next step is the physical screening process. Range of motion is within functional limits but Marco experiences pain with wrist extension and end range elbow flexion. Grip strength is 45 pounds on the right and 90 pounds on the left.
Palpation of his right elbow and forearm reveals tenderness over the lateral epicondyle and the extensor muscle origin. Trigger points are present in the distal portion of the extensor muscle, with referred pain down the forearm and into the back of the hand and wrist. Marco reports no numbness or tingling in his right arm. Provocative testing is positive for the lateral epicondyle test and the grip test, but negative for the elbow flexion test. Marco is observed performing his work tasks, and two tasks that increase his symptoms are identified: reaching overhead to pull down the inline nut driver and flipping the engine over.

After completing the screening process, the therapist initiates an intervention plan based on the biopsychosocial model that was chosen to address the musculoskeletal issues related to his elbow pain, the psychological issues related to his fear of not being able to work and fear of reprisal from his supervisor and coworkers, and the social issues related to dealing with angry coworkers and a supervisor who is questioning the work-relatedness of his injury. Marco is educated in icing techniques to use during and after work and is issued a counter strain elastic brace with a pad to be worn during work and home activities. He is educated in the use of massage techniques to decrease forearm and elbow pain and provided with stretching exercises for the wrist extensors. Work modifications are implemented to move the inline driver closer to Marco and reduce the resistance required to pull the driver down. Alternate work methods are explored with Marco regarding the flipping of the engine. Marco has primarily using his right hand to flip the engine, so two-handed techniques are introduced.

The occupational therapist meets individually with Marco, his supervisor, and the human resources director to implement the intervention plan. In the meetings, the occupational therapist educates the supervisor and human resource director about Marco’s symptoms, explaining that they are valid and consistent with the type of work he performs. The occupational therapist recommends that Marco’s productivity be temporarily reduced and the workload redistributed on the line to reduce the tensions between coworkers. One coping strategy that was implemented with Marco was to request help from his supervisor instead of his fellow employees if he feels he is unable to keep up with the work required due to increased symptoms.

Marco is re-evaluated on a weekly basis, with no referrals for additional medical care required. Marco’s symptoms disappear after 5 weeks and he is able to perform his job at his regular production rate.

**Benefits of Secondary Prevention**

Secondary prevention programs provide many financial, social, and psychological benefits to both injured workers and their employers. Secondary prevention also promotes the family stability of injured workers (Eliff, 1998), who by remaining on the job are better able to maintain self-esteem, income, job skills, and positive psychosocial relationships (Sullivan et al., 2005). Another benefit of secondary prevention includes access to immediate medical consultation through the occupational therapist, who can identify the most appropriate level of care needed to facilitate a quicker recovery (Chong & Cheng, 2010).

Employers benefit from secondary prevention in multiple ways. Identifying injuries early and taking a proactive approach to intervention reduces the ultimate financial impact of the injuries. By taking a first aid intervention approach, the resulting fewer restricted days and lost time on the job reduces the number of OSHA recordables. Additional financial benefits to employers include lower employee turnover, which helps in retaining experienced employees and reduces overall hiring and training costs (Marinescu, 2007; Massengarb, 1996). Travel expenses and time away from work are reduced through the onsite component of secondary prevention that allows the occupational therapy visit to occur while the injured worker is on the job. Several other benefits to the employer of secondary prevention are more difficult to quantify but are nevertheless significant. The first is improved communications (Ramos, 2006). With the therapist on site, information is shared about workplace injuries, and methods to reduce symptoms are implemented and upgraded as needed. Secondary prevention also promotes general problem solving of safety and ergonomic issues that may affect overall worker productivity (Burton, Kendall, Peach, Birrell, & Bainbridge, 2009).

Overall, secondary prevention interventions promote a climate of health and wellness and benefit both the injured worker and employer. Evidence is increasing that prevention programs are cost-effective and can lead to financial as well as physical and psychosocial gains; however, no research was located that specifically addressed secondary prevention from the perspective presented in this article (OSHA, 2001; Gerg & Smith, 2008).

**Conclusions**

Occupational therapy plays a key role in secondary prevention programs in the workplace. One model that can be used by occupational therapists to support their screening and intervention process is the biopsychosocial model. Therapists should consider the effect of the biological, psychological, and sociocultural factors on an employee’s ability to remain at work (Noonan & Wagner, 2010). Because occupational therapy is client centered and occupation based, our profession is well suited to address the wide variety of needs of the injured worker. This population challenges the occupational therapist to use knowledge and skills from not only a medical perspective but from a financial and business one as well.

**References**

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Final Exam

Secondary Prevention Related to Work: The Role of Occupational Therapy

April 25, 2011

Learning Level: Entry

Target Audience: Occupational therapists

Content Focus: Work Injury

1. The role of occupational therapy in secondary prevention is best summarized as:

A. Performing a comprehensive evaluation and developing an appropriate plan of care for an injured worker

B. Performing a job site analysis based on a need-based analysis

C. Working under a physician's order to provide occupational therapy services

D. Performing a screen of an injured worker's symptoms and developing an appropriate intervention

---


2. Using a biopsychosocial model to provide secondary prevention services, which of the following biological factors should you consider when screening your client?
   A. Family predisposition and obesity
   B. Fear and peer interaction
   C. Medications and use of modalities
   D. Job tasks and ergonomic recommendations

3. Which of the following statements is not true when comparing a screening to an evaluation?
   A. Both a screening and a comprehensive evaluation require an extensive interview and history of the injured worker.
   B. A screening requires identifying a frame of reference based on the injured worker's needs.
   C. A screening requires a plan of care.
   D. Both a screening and comprehensive evaluation use specialized or provocative testing.

4. Which of the following secondary prevention intervention is the most important when an injured worker demonstrates psychological and/or sociocultural influences that impede the return-to-work process?
   A. Case management
   B. Comprehensive evaluation by occupational therapist
   C. Physician referral
   D. First aid

5. Businesses prefer the intervention of first aid because:
   A. Adding more health care professionals to the care that is provided to the injured worker makes it more confusing.
   B. The injury may not become a recordable injury on the Occupational Safety and Health Administration (OSHA) 300 logs.
   C. It is the best approach for all injured workers.
   D. It is the least expensive approach.

6. Which of the following medical interventions would be considered medical treatment and therefore a recordable injury?
   A. X-rays and blood work ordered by a physician
   B. Job site analysis based on a worker population
   C. Referral to a physician for medical management of care
   D. OT screening

7. Based on the case study, which of the following statements suggests that Marco has developed a musculoskeletal disorder?
   A. Marco reports working for the company for 15 years.
   B. Marco reports pain ratings during work of 6/10.
   C. Marco reports that symptoms have persisted in his elbow for over 10 days.
   D. Marco reports no specific injury incident, but rather a progression of symptoms over time.

8. Based on the case study in the article, which of the following interventions are not considered first aid and, if implemented, would cause Marco's injury to become a recordable injury:
   A. Ice
   B. Stretching exercises to wrist extensors
   C. Education
   D. Massage

9. Which of the answers below is not an employer benefit of a secondary prevention program?
   A. Better workplace communication
   B. Creating a culture of wellness
   C. Financial savings from the early intervention
   D. Increased recordable injuries

10. Which of the following statements would be considered effective, defensible documentation?
    A. Injured worker tolerated icing techniques well.
    B. Injured worker appeared to be in severe pain when flipping the engine.
    C. Injured worker grimaced and rubbed right elbow when flipping the engine.
    D. Injured worker had difficulty with home exercise program of wrist extension stretch.

11. When billing for secondary prevention, the occupational therapist needs to:
    A. Submit an invoice with hourly billing directly to the company
    B. Determine and bill using ICD-9 codes and CPT codes
    C. Contact the workers' compensation company for approval
    D. Make a copy of the worker's insurance card

12. Using the biopsychosocial model and a client-centered approach, which of the following social-cultural interventions could be considered with Marco?
    A. Marco will demonstrate his different job tasks to the therapist so that they can decide how to improve his performance while maintaining symptom control.
    B. Marco and the therapist will work with the employer to identify a walking path throughout the building that Marco can use on his breaks to improve his aerobic level.
    C. Marco will wear an elbow splint and ice as needed to reduce his symptoms.
    D. Marco and the therapist will work with the supervisor to communicate and problem solve regarding Marco's fear of being yelled at by his peers for not being able to do his job fast enough due to increased symptoms.