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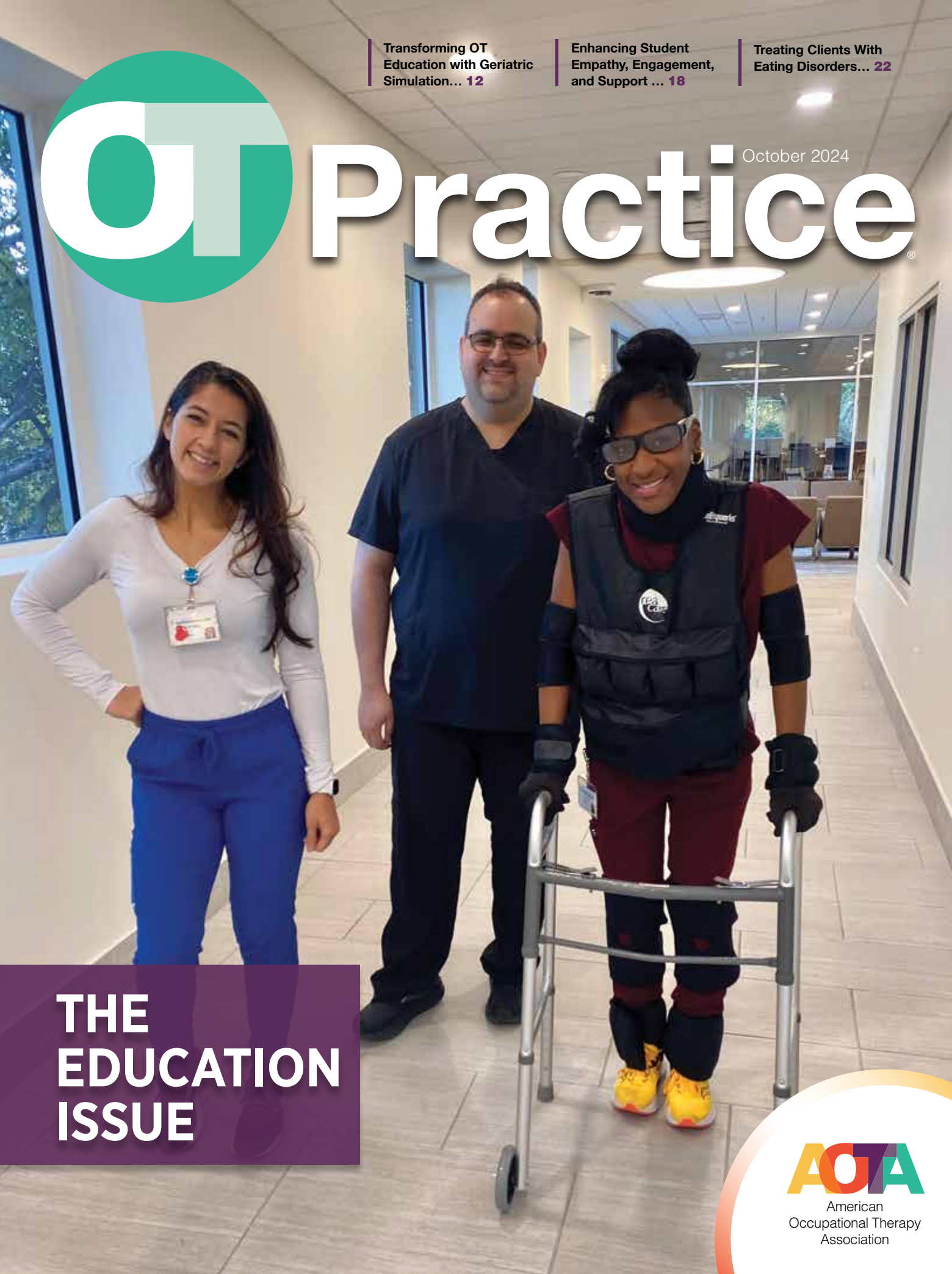
October 2024



# THE EDUCATION ISSUE

AOTA
American Occupational Therapy Association

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1 Dawson J, et al. Vagus nerve stimulation paired with rehabilitation for upper limb motor function after ischaemic stroke (VNS-REHAB): a randomised, blinded, pivotal, device trial. Lancet, 2021:397(10284), 1545.

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# Advancing Occupational Therapy Through Academics

Welcome to the education issue of *OT Practice*, where we delve into teaching and learning within the field of occupational therapy. Academics is not just about imparting and gaining knowledge, but also about pushing the boundaries of what is known through research, fostering innovation, and shaping the future of the profession.

This issue of *OT Practice* highlights the contributions of occupational therapy practitioners who are dedicated to advancing the field through academic pursuits. The articles explore the challenges the authors face, the impact of their work on clinical practices, and how academic excellence is, in part, driving the evolution of occupational therapy.

We hope these insights inspire you to appreciate the vital role of academics in strengthening the foundations of occupational therapy and in ensuring that the profession continues to meet the complex needs of clients.

Amy E. Ethridge and Daniel R. George discuss how their nature-centered educational program has a positive impact on participants with eating disorders regarding their physical, mental, social, and spiritual health (p. 22).

Sabina Khan and Jacqueline Achon explore an immersive educational experience that extends beyond the confines of a geriatric simulation lab, preparing students for the realities of professional practice and ensuring they are ready to meet the challenges of an aging population with empathy, competence, and innovation (p. 12).

Tara Mansour highlights the critical role of community and support systems in clinical education using Balint Groups, which provide a structured yet flexible platform for building community among students (p. 18).

If you're looking for educational opportunities to advance your career, AOTA resources can help you increase your knowledge and further your professional journey. Visit the AOTA website for more details about the educational opportunities (https://www.aota.org/membership).

All the best,

Lisa Gwaltney
Editor, *OT Practice*
lgwaltney@aota.org

**Discuss the topics in this issue on CommunOT!**

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OT inside

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# Features



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# Departments

# OT Updates

## AOTA Member Spotlight—Mary Walsh-Sterup

**Mary Walsh-Sterup, OTR/L, CHT**, is an Occupational Therapist and Partner at Central Nebraska Rehab Services. She spoke to **Jamar Haggans, MS, OTR/L**, Director of Quality at AOTA about her current position and how she became interested in quality.

### What is your current position?

I'm a partner at Grand Island Physical Therapy, where I oversee quality and compliance. We have 15 outpatient clinics. contract hospitals, school districts, and skilled nursing facilities. Our general philosophy is that if somebody needs services in Nebraska, we aim to make sure they can get those services in their own community.

I'm an occupational therapist (OT) and certified hand therapist by trade but my day-to-day role involves more of the oversight, contracting, quality assurance, billing, and negotiations with insurance companies.

### How did you become interested in quality?

I became interested in quality around the time occupational therapy practitioners were allowed to participate in the Physician Quality Reporting System (PQRS) (The Medicare Access and CHIP Reauthorization Act of 2015 replaced PQRS with the Quality Payment Program). Part of PQRS was having an outcome measure, so when that was implemented we really started really paying close attention to our outcomes and what measures we were using. That is how I became involved in it from an OT standpoint, and for our whole company.

### How has your interest in quality influenced what you do now?

Learning more about quality helped me guide our teams to really take a deep dive into outcomes, which drive our patients' success. In small communities, our outcomes are our best marketing tool. When our patients are successful, they tell their physician. Physicians want patients to have great outcomes and love their therapy; that makes the physicians happy, which leads to more referrals. That's truly what drives our business. We're very interested in overall quality because it's in the best interest of the patient.

I've also used my knowledge in quality to work with my state's Medicaid program, looking at outcomes and how we can best serve our Medicaid population.

### What advice would you give anyone else interested in quality?

If possible, opt into Medicare's quality reporting program. There aren't many OTs who are mandated to report MIPS, but there is an option to opt in and voluntarily report. I encourage practitioners to do this because it can change how you look at things and show you how you compare nationally. It helps with documentation, and communicating the results can further help patients to understand that they're truly making progress toward their goals.

### What can occupational therapy practitioners do to prepare for a future where quality is at the forefront of payment?

Get involved in the quality reporting program in your setting. Another thing I would add is working to create additional quality and outcome measures that adequately describe what we do and show our outcomes.

Think about things that you can work on now to create outcome measures, to make it easier for reimbursement and documentation, because in the long run as we move toward a quality payment system, they're going to be needed.

### Is there anything else that that you would like to add?

Quality is going to be what drives payment and payment is what drives our future as therapists. To continue being a viable profession, financially, you need to start looking downstream at the quality of services you provide, which is going to lead to your reimbursement. It's in the best interest of all our clients that we can continue to provide services to help them improve their engagement in meaningful occupations.

## Momentum Moments

### AOTA DEIJAB Committee Retreat

Building on momentum efforts to encourage belonging within the profession, the AOTA Diversity, Equity, Inclusion, Justice, Access, and Belonging (DEIJAB) Committee held its third annual retreat to review its strategic plan, highlight accomplishments and progress, and identify ways to integrate DEIJAB across the Association. Facilitated by member volunteer Lisa Jaegers, the 2-day virtual retreat brought together the Committee, members of the Board, and representatives from the MDI Network for a robust discussion on making advancements in the areas of governance, conference accessibility, and ethics through a DEIJAB lens. The retreat culminated with a working action plan for increased collaboration with volunteer groups and short- and long-term plans for the four pillars of the strategic plan—Governance and Accountability, Education and Awareness, Diversifying the Profession, and Language and Communication. For more information on the retreat outcomes, please visit the Dear DEIJA section of CommunOT.

# Spotlight on OT

**Shivanti Kariyawasam, OTD, OTR/L**, and **Melissa Stutzbach, MS, OTR, FNAP**, were featured on Rebuilding Together's podcast series highlighting the benefit and value of partnerships with occupational therapists in delivering home repairs, and its occupational therapy student fellowship program with Howard University (https://bit.ly/3XjFBKa).

**Stacey Mlodzianowski**, an occupational therapist with University of Pittsburgh Medical Center Mercy Hospital, is the reason local stroke survivors stare down rock walls and find community. Find out how an occupational therapy practitioner incorporates an empowering camping experience for stroke survivors and their caregivers as part of the recovery process (https://bit.ly/4dEdUBp).

## AOTA news & events

The **Fall Call for Papers and Reviewers** opens for AOTA INSPIRE Annual Conference 2025 on October 15. Submit a proposal or sign up to review colleagues' proposals by the November 11 deadline (https://bit.ly/3X4jndI).

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The **Fall 2024 Virtual Career Fair** will be held October 23. Attend from the comfort of the location of your choice, and take advantage of the opportunity to connect directly with recruiters who understand the various practice areas and are ready to hire (https://bit.ly/3APF4Xt).

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The **AOTA Specialty Conference: Mental Health** will be held in Oak Brook, IL, October 25 to 26. Sharpen your skills and champion mental health alongside your colleagues. This immersive event is designed for mid- to senior-level occupational therapy practitioners seeking to elevate their practice and make a lasting impact on their clients and their community (https://bit.ly/3UEIaFM).

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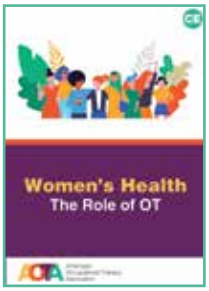
**The Education Summit** will be held in Charlotte, NC, November 8 to 9. Preconference sessions will be held November 7. Elevate your teaching and enhance student success. Discover innovative teaching strategies, network with colleagues, and gain valuable insights to transform your students' educational experience (https://bit.ly/3SkXAxm).

## Featured Continuing Education for October

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## Featured Book for October

**Parent/Caregiver Support of Children's Playfulness (PC-SCP)**
***A. Levi & A. Bundy***
This text is designed to assess parents' or other caregivers' support of children's playfulness and can guide clinicians in developing family-centered interventions that promote parent-child or caregiver-child relationships as well as skill development. **$112.95 for members**; $161.95 for nonmembers. Order #900635. Ebook, **$90.95 for members;** $129.95 for nonmembers. Order #900636.

**To Order: http://store.aota.org**
or call 800-729-2682
**Questions?** 800-SAY-AOTA (members); 301-652-AOTA (nonmembers and local callers)

## AOTA Podcast: Sexuality and Intimacy

On this recent podcast episode, certified sexuality counselor **Kathryn Ellis, OTD, OTR/L, AASECT-SC, CSOT**, discusses the book ***Sexuality and Intimacy*** (https://bit.ly/4dTfa3i). She provides expert opinions and recommendations to help students, clinicians, and researchers improve how they address sexuality and intimacy in practice. This podcast contains explicit sexual information and is not suitable for all audiences. Listener discretion is advised. Listen to the episode here (https://bit.ly/3XmYufu).

The 2024 AOTA Podcast episodes are sponsored by NYU Steinhardt's top-ranked Department of Occupational Therapy.

# Home Health Opportunities Improve Patient Access to OT Services

**Jennifer Bogenrief and Andy Bopp**

If you have worked in home health (HH) in the last 40-plus years, you are aware of policy barriers that can make it challenging for occupational therapy practitioners to deliver medically necessary skilled occupational therapy services to Medicare Part A beneficiaries. Combine that with current health care workforce shortages and an HH payment model with different incentives for HH agencies, and patient access to care can be even more difficult. Decades of AOTA advocacy have pushed Congress and the Centers for Medicare & Medicaid Services (CMS) to recognize the role of HH occupational therapy in achieving positive patient outcomes and avoiding negative events, such as rehospitalizations and falls, and helping to ensure timely access to care. CMS is now considering policy changes that would ease delays and obstacles for beneficiaries seeking Medicare Part A HH services.


SHUTTERSTOCK /

## A Little History

Occupational therapy was briefly a qualifying HH service under Medicare Part A in 1980 but lost this status in 1981 as part of a large package of general budget cuts. To avoid being cut from the benefit altogether, a compromise was made so that a Medicare Part A beneficiary can only receive occupational therapy as a part of an HH episode of care if they are also receiving nursing, physical therapy (PT), or speech-language pathology (SLP) services. In 2000, Medicare policy changed to require initial and comprehensive assessments to be completed by members of skilled disciplines that established eligibility for a patient's Medicare Part A HH benefit, and to require that the Outcome Assessment and Information Set (OASIS) be integrated into the comprehensive assessment. CMS determined that occupational therapists were not allowed to open Medicare Part A HH cases, meaning they could not complete the initial and comprehensive assessments. This led HH agencies to use fewer resources to educate OTs on OASIS data collection, even though occupational therapy is one of several skilled disciplines responsible for performing the OASIS. Historically, PTs and SLPs could only open an HH case if the beneficiary was not receiving nursing services. Then came the COVID-19 public health emergency (PHE).

## Recent Victories for OT

CMS issued numerous temporary PHE flexibilities to streamline delivery and allow patient access to care during a time when patients, families, caregivers, and providers were all trying to find the safest way to receive services and ease the burden on hospitals. The PHE triggered a key temporary waiver to allow OTs to perform the initial and comprehensive assessments for all HH patients receiving therapy as part of the plan

of care. The waiver to allow OTs to open Medicare HH cases was important because it meant CMS acknowledged that they are qualified to do so, and that occupational therapy has a role at the start of care.

In December 2020, AOTA advocacy led to the passage of the Medicare Home Health Flexibility Act, which allowed OTs to open Medicare HH therapy cases. On November 9, 2021, CMS published the CY 2022 final HH prospective payment system (PPS) rule and finalized provisions allowing OTs to perform the initial and comprehensive assessments required to open Medicare HH therapy cases, beginning on January 1, 2022. However, the rule did not alter Medicare's criteria for establishing eligibility for the HH benefit.

In September 2023, AOTA member Tracy Mroz, PhD, OTR/L, FAOTA, of the University of Washington, was invited to testify about home health access issues at a Congressional hearing, because of her ongoing research on rural health care. She reported, "In rural areas, less than 60 percent of Medicare beneficiaries who have a planned discharge from hospital to home health ultimately receive that care." She also noted that, "Even when rural residents are admitted to home health, many face disparities in access to rehabilitation services compared to beneficiaries in urban areas." AOTA anticipates a continuing Congressional focus on rural health issues and believes that occupational therapy can play a critical role in enhancing patient access in such areas if unnecessary statutory and regulatory barriers are eliminated.

## Why OTs Should Open HH Cases

When OTs are not able to open HH cases, there is an even greater risk than before that occupational therapy may not be used for patients who need it. In the previous HH PPS model, because therapy visits helped increase reimbursement for the agency, there was less risk of occupational therapy being left out. Now that therapy is a cost for HH agencies, they are more careful about the amount of therapy they provide. AOTA has heard many reports of decreased utilization of occupational therapy under Medicare Part A HH, and we have told CMS our concerns that patient access to occupational therapy services should be based on individual need, determined by the therapist's clinical judgment. Occupational therapy is an excellent discipline to start an HH case because of the way OTs assess and evaluate a patient's home environment, how they function, possible safety issues, and other needs and strategies (e.g., medication management and daily management of conditions). OTs opening HH cases can reduce delays in patient access to care and help ensure patient access to skilled occupational therapy services.

## Medicare Home Health Accessibility Act

The Medicare Home Health Accessibility Act (HR7148) would establish occupational therapy as a qualifying Medicare home health benefit. Rep. Lloyd Smucker (R-PA), lead sponsor of the Act along with Rep. Lloyd Doggett (D-TX), has been actively working to promote the bill, which was first introduced in January 2024. He specifically addressed the importance of OT and HR7148 during a House Ways and Means Committee hearing on health care at home, and he authored an Op-ed on the bill that appeared in *McKnights Home Care*. In both the hearing and Op-ed, Rep. Smucker emphasized the benefits of occupational therapy in the home for Medicare beneficiaries as well as savings to Medicare that can be generated when occupational therapy services are provided to prevent falls and other accidents that can result in ER visits, hospitalizations, and even institutionalizations. HR7148 now has 11 House co-sponsors.

## Opportunities to Improve Patient Care Access

In its CY 2025 HH PPS proposed rule, CMS included a Request for Information (RFI) seeking input on whether CMS should shift its longstanding policy and permit all classes of rehabilitative therapists (PTs, SLPs, and OTs) to conduct the initial and comprehensive assessment for cases that have both therapy and nursing services ordered as part of the plan of care. CMS also included another RFI to better understand the HH agency referral process, the plan of care development process, and the scope of HH services patients receive. AOTA submitted comments to support a policy change to permit rehabilitation therapists to open cases when both therapy and nursing services are ordered as part of the plan of care. Such a policy change would help improve timely access to care and patient access to necessary therapy services. The OASIS is a multi-disciplinary assessment instrument, and agencies should properly train all clinicians administering it—including both nurses and therapists.

In addition, CMS proposed a new HH CoP standard to require agencies to establish an acceptance to service policy that would include the following criteria related to the agency's capacity to provide services: the anticipated needs of the referred prospective patient, the agency's case load and case mix, the agency's staffing levels, and the skills and competencies of the agency's staff. Agencies would be required to develop, implement, and maintain an acceptance to service policy and consistently apply it to each prospective patient referred to the agency for HH services, as well as make public accurate information regarding the services offered by the agency and any limitations related to the types of specialty services, service duration, or service frequency.

CMS will publish its CY 2025 HH PPS final rule by early November 2024. AOTA will monitor CMS' actions and share updates.

## Promoting the Role of OT in Your Home Health Agency

If it doesn't already do so, encourage your HH agency to allow OTs to open cases and support them through proper agency training. Look to AOTA's Micro Credential on Performing a Home Health Start of Care or CMS' free training to increase your skill and comfort with performing the OASIS.

Support the Medicare Home Health Accessibility Act. If CMS proposes changes to the CoP to allow OTs, PTs, and SLPs to conduct the initial and comprehensive assessment for cases that have both therapy and nursing services ordered as part of the plan of care, then support that as well. Watch for updates from AOTA on federal legislation and regulations and opportunities to advocate for occupational therapy in home health.

In the meantime, use AOTA's Quality Toolkit—including the quality checklists—to help demonstrate the objective value of occupational therapy and how it can help both the agency and patients to meet their goals. Tell your colleagues about how you engage patients in the plan of care to help them achieve their goals. Be a proactive member of the HH team to help your agency achieve quality outcomes.

### Resources


42 CFR 484.55 Condition of participation: Comprehensive assessment of patients: https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-G/part-484/subpart-B/section-484.55

AOTA Member testifies in Congress: https://www.aota.org/advocacy/advocacy-news/2023/aota-member-testifies-congress-home-health-rural-access

AOTA Professional Certificates and Micro Credentials: https://www.aota.org/career/continuing-education/micro-credentials-and-professional-certificates/certificates-and-credentials

AOTA Quality Toolkit: https://www.aota.org/practice/practice-essentials/quality/quality-toolkit

CMS HH PPS Proposed Rule: https://www.govinfo.gov/content/pkg/FR-2024-07-03/pdf/2024-14254.pdf

CMS HH PPS Proposed Rule Fact Sheet: https://www.cms.gov/newsroom/fact-sheets/calendar-year-cy-2025-home-health-prospective-payment-system-proposed-rule-fact-sheet-cms-1803-p

Medicare Home Health Accessibility Act Fact Sheet: https://www.aota.org/advocacy/advocacy-news/2023/ot-as-a-qualifying-service-in-medicare-home-health-fact-sheet

Medicare Home Health Accessibility Act Introduced: https://www.aota.org/advocacy/advocacy-news/2024/medicare-home-health-accessibility-act-introduced-118-congress

Rep. Smucker's testimony in House Ways and Means Committee hearing on health at home: https://www.youtube.com/watch?v=eI996VvhbyU&t=7742s

Rep. Smucker's Op-ed: https://www.mcknightshomecare.com/enhancing-access-to-ot-for-medicare-beneficiaries-improves-outcomes-lowers-costs/



**Jennifer Bogenrief, JD**, is AOTA's Director of Regulatory Affairs.

**Andy Bopp** is AOTA's Senior Legislative Representative.

# OT Technology Today: Running—and Tracking—Your Practice

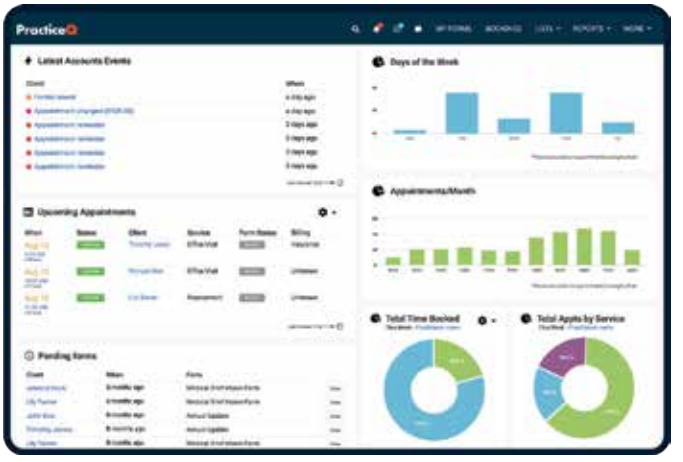
The 2014 start of **IntakeQ**—a web-based platform for managing your entire practice—was the result of marital collaboration. Melissa Mosqueira was running a nutrition practice but was frustrated by having to use a cumbersome and time-consuming onboarding process. Clients had to print forms, fill them out by hand, and return them by email. Melissa's husband, Cassio, figured there had to be a better way and set out to find a more efficient product for his wife. He couldn't find one.

So Cassio decided to create one. And IntakeQ was born.

Their original goal was simply to allow practitioners to easily access forms. But Melissa and Cassio began to add other practice management features and then made their platform available to other nutritionists, occupational therapists, and a full array of other practitioners.

"Cassio discovered that people were using it to run their entire clinic," says Jessica Heck, IntakeQ's head of marketing.

Today, thousands of small to mid-sized practices depend on IntakeQ for the platform's efficiency, effectiveness, and affordability. Dozens of specialties use IntakeQ, which is easily customizable for a given practice. "Our clients love having the ability to use IntakeQ to create what you want your practice to be, rather than someone prescribing how you must do things," Heck says. "Everything can be adjusted super quickly to exactly what a client prefers."




The range of what IntakeQ offers clients runs the gamut for a full practice: scheduling, appointment reminders, a booking widget, automated intake forms, consent forms, charts to show patients' needs and progress, data exports, team messaging, a secure patient portal, invoicing and payments, task management, and more, plus a customizable dashboard and telehealth.

And it can be operated from a smart phone.

Clients, says Heck, love that IntakeQ does not require a contract. Payments are made monthly and can be canceled at any time.

There is also a forms-only service that offers unlimited form templates plus branded custom forms at a cost of $49.90 a month for two assistant accounts. Adding an additional practitioner is $20 a month.

IntakeQ's full practice-management platform, known as "PracticeQ," costs $79.90 a month, plus $25 for each additional practitioner.

"In OT, when people start practices, they often have to use so many tools," Heck says. "The reality is that everyone wants to be self-employed, but then you wind up working more hours than you did before. To pay $79.90 a month to use one piece of software that you can run almost your entire practice from really allows you to enjoy your practice and focus on your patients.

"Our clients say that using our software allows them to enjoy their evenings."

> **"Everyone wants to be self-employed, but then you wind up working more hours … [With] one piece of software [to] run almost your entire practice … [you can] enjoy your practice and focus on your patients."**
> ***—Jessica Heck***

Dana Solomon, an occupational therapist and IntakeQ customer, recently wrote a blog post on the IntakeQ website offering business tips to help an OT practice thrive. One tip was to harness the power of metrics: "While numbers may not seem glamorous, they serve as invaluable tools for informed decision-making," Dana wrote, stressing "the significance of tracking key metrics such as referral sources, conversion rates, and session averages. With platforms like IntakeQ," she said, "you can gain insights into your business operations and tailor your strategies accordingly." ■

# Filipino-American Migration Stories

**Cecille Corsilles-Sy**

I was born in Manila but have now lived in the United States longer than I did in the Philippines. My family came to the U.S. under the family unification policy of the U.S. immigration system, but many Filipinos come as skilled labor migrants (American Immigration Council, 2024). As a Filipino-American occupational therapist, a trip home after 20 years gave me a new lens of discovery and deep reflection on the many Filipino migration stories I have come to know. I hope these reflections add to your strategies for working with Filipino Americans and with labor migrants in general.

Filipino identity can bring a sense of belonging that offers community support as we navigate unfamiliar and often unyielding environments here in the U.S. The strength of this identity can depend on the person's level of acculturation. First- and second-generation immigrants (Filipino-Americans born in the Philippines and their children born in the U.S.) may hold strongly to traditional values and practices compared with later generations. Teens and young adults may struggle with their identity when they experience a culture clash at home and in the broader community.

The Philippines is a traditionally matriarchal society which is often reflected in Filipino-American families. Women are often the final decision makers in money matters, including housing, education, and health care decisions for the family. Elders are revered members of the family, and caregiving for older parents is often shared among siblings. Sending our parents to long-term-care facilities is typically a decision of last resort. Most Filipino-American families will respond well to careful and respectful conversations as we navigate the contrasting demands of Filipino traditional values and the demands of the American health care system.

***The history of migration to the U.S. has created a highly diverse Filipino-American population. We are skilled clinicians, engineers, and business owners.***

Due to continuing economic instability, the Philippines has a culture of labor migration which can take parents and older siblings away from their large and extended family structures. The oldest child holds an honored position as they take on the responsibility of caring for the family in the absence of parents. Family separations and later reunification create significant challenges to the traditional family unit. To meet the financial demands of families here and abroad, a labor migrant often foregoes a healthy work-life balance that most Americans strive to achieve.

The history of migration to the U.S. has created a highly diverse Filipino-American population. We are skilled clinicians, engineers, and business owners. We are also dancers, couture designers, and filmmakers. We are essential workers as bus drivers, senior and childcare providers, postal employees, and food preparation workers. No matter the vocation, there is dignity and pride in our labor. Many Filipino Americans send remittances to ensure the health of families, build homes, pay for college education, and even build small businesses back home. However, there is violence in many Filipino migration stories including human trafficking (labor and sex trafficking) and anti-Asian hate crimes. In 2022, it was estimated that 784,000 Filipinos are living as modern-day slaves all over the world (McGeough, 2022) In the U.S., the National Human Trafficking Hotline received more than 51,000 reports of human trafficking (of all nationalities) in 2021 (National Human Trafficking Hotline, 2021). During the COVID-19 pandemic there was an increase in hate crimes targeting elderly Asians. This was a painful betrayal, and it left an indelible mark on our collective trust and sense of belonging.

Not all stories of migration are the same. Although there are common threads to migration experiences, each story is unique. The ideas and reflections shared here are one immigrant's perspective and are not true for all Filipino Americans. The richness of the Filipino-American experience lies in the many stories yet to be told and celebrated.

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National Human Trafficking Hotline. (2021). National human trafficking hotline data report for 2021. https://humantraffickinghotline.org/sites/default/files/2023-01/National%20Report%20For%202021.docx%20%283%29.pdf



**Cecille Corsilles-Sy, PhD, OTR/L**, is an Assistant Professor at the University of Puget Sound in Tacoma, WA.

# A LEAP Toward

# Empathy

## *Transforming OT Education with Geriatric Simulation*

**Sabina Khan and Jacqueline Achon**

In the dynamic and ever-evolving landscape of health care education, the limitations of traditional classroom learning in fully preparing students for the nuanced and complex realities of patient care have become increasingly apparent (Lewis et al., 2024). In response, simulation-based learning has emerged as a vital, innovative approach, merging theoretical knowledge with practical experience. This method not only offers students a safe environment to engage with a variety of professional scenarios, but also bridges the gap between academic learning and real-world application. Among the various simulation methods available, geriatric simulation is notably distinct for its ability to immerse students in the physical and sensory challenges often faced by older adults. This shift from passive to active learning deeply engages students in empathetic exploration of geriatric care (Giner Perot et al., 2020).

At The University of St. Augustine Miami campus, geriatric simulation has become a fundamental element of our occupational therapy education program, profoundly altering our students' perspectives on aging and patient care. As part of a research study conducted in January 2024, this lab activity exemplifies the transformative power of simulation-based learning in occupational therapy, providing students with a direct experience of the challenges associated with aging. More than a classroom activity, this lab encourages deep engagement with the conditions older adults face, fostering an immediate and profound empathy that traditional learning methods cannot achieve. Through this innovative educational strategy, students gain invaluable insights into the everyday realities of older adults, enhancing their preparation for professional practice in geriatric care.

SABINA KHAN AND JACQUELINE ACHON

**(Top) OT students donning the simulation equipment. (Bottom) An OT student bending to place a tray in the oven, using geriatric simulation equipment to understand the physical limitations and challenges faced by elderly individuals during meal preparation tasks**

**TABLE 1.** Geriatric Simulation Equipment and Associated Aging Impairments

| Equipment | Simulated Aging Impairment |
|---|---|
| **Weight vest (20 lbs.)** | Represents the general decrease in muscular strength and increased effort required for daily tasks. |
| **Ankle weights (5 lbs. each)** | Simulates reduced lower limb strength and mobility challenges. |
| **Wrist weights (2.5 lbs. each)** | Mimics diminished upper limb strength, affecting tasks requiring fine motor skills. |
| **Knee and elbow restraints** | Limits range of motion, representing joint stiffness and movement restrictions. |
| **Gloves** | Simulates decreased tactile sensation and fine motor difficulties. |
| **Cervical collar** | Limits neck mobility, reflecting common cervical spine issues in older adults. |
| **Cataract vision impairment glasses** | Replicates visual impairments such as reduced clarity and sensitivity to glare. |
| **Ear plugs** | Simulates the experience of age-related hearing loss, highlighting the communication barriers and increased effort in auditory processing common in older adults. |
| **Walker** | Provides experience with mobility aids, reflecting dependence on assistive devices for walking or standing (Zhai et al., 2023). |

**An OT student assisting a peer in donning gloves and wrist weights as part of geriatric simulation training to experience age-related physical limitations**

SABINA KHAN AND JACQUELINE ACHON

In our geriatric simulation lab, we use specialized equipment designed to authentically simulate the experience of aging, helping students understand the daily challenges encountered by older adults. For instance, weighted vests are utilized to demonstrate the effort required for simple movements when muscle strength is diminished—a common aspect of aging. This simulation brings to light why tasks that seem easy to many practitioners can be strenuous for some older individuals. Gloves are another key tool, designed to mimic the loss of tactile sensitivity and dexterity often experienced in older adulthood. Wearing these gloves, students experience firsthand the difficulty of performing daily tasks, such as manipulating household items or securing buttons on clothing—offering insight into the everyday frustrations encountered by older adults.

Vision impairment glasses play a crucial role as well, simulating common visual conditions like cataracts. Through these glasses, students experience the challenges of navigating their environment and performing tasks with blurred vision, increasing their understanding of and empathy for visual impairments common in older age. See Table 1 for equipment used and specific aging-related impairments each item simulates.

Students then proceed to a series of activities that bring these simulations to life. Table 2 outlines these activities, ranging from bed mobility and transfers to meal preparation—each intentionally developed to cast light on changes in function during the typical aging experience.

Through engaging in these scenarios, students confront firsthand the combined effects of physical and sensory challenges, providing them with crucial insights into the necessity of patience, creativity, and personalized care in occupational therapy. The activities detailed in Table 2 offer students a hands-on chance to traverse the complexities associated with aging. These practical exercises serve as a bridge, translating the simulated impairments into real-world challenges that older adults face daily. It is a journey that not only educates but also transforms, fostering a deepened

**OT students participating in a wheelchair mobility exercise, navigating through a hallway to better understand accessibility challenges and improve their skills in assisting wheelchair users**

**An OT student practicing household management tasks using geriatric simulation equipment**

**TABLE 2.** Simulation Activities and Simulated Impairments

| Activity | Task Description | Simulated Impairment |
|---|---|---|
| **Bed mobility and transfer to commode** | Tasks such as getting in and out of bed and transferring to a commode, focusing on the complexities older adults encounter daily. | Functional mobility challenges highlight the effort required in basic movements. The use of knee and elbow restraints, along with the weight vest, simulates joint stiffness and reduced muscle strength, affecting the ease of moving and transferring. |
| **Lower body dressing** | The act of dressing oneself with added physical limitations. | Beyond coordination and strength difficulties, sensory impairments from gloves make it hard to manipulate fastenings like buttons or zippers and to pull the waistband on pants down or up. |
| **Meal preparation** | Preparing a meal under sensory and physical limitations. | The impact of tactile, visual, and fine motor impairments is compounded by difficulty in grasping utensils tightly or feeling textures of food. Vision impairment glasses add a layer of challenge in measuring ingredients correctly and reading recipes. |
| **Functional mobility** | Moving around with added weight and mobility restrictions. | Challenges extend beyond decreased strength and balance to include the difficulty of navigating spaces without the full range of motion, made harder by knee restraints and wrist weights, simulating the energy and effort many older adults expend in mobility. |
| **Laundry** | Completing laundry tasks, highlighting the effort and adaptation needed. | The combination of physical exertion and sensory limitations impact routine chores. Gloves and vision impairment glasses make sorting colors, reading care labels, and manipulating small detergent bottles or fabric softener sheets especially challenging. |

**TABLE 3.** Sample Geriatric Simulation Reflection Worksheet

| Task | Rating of Difficulty (0 to 4) | Observation (Student's Reflection) |
|---|---|---|
| **Functional Transfers and Mobility** | | |
| Stand up and sit down on a chair | 0 1 2 3 4 | |
| Transfer from bed to bedside commode | 0 1 2 3 4 | |
| Navigate up and down a flight of stairs | 0 1 2 3 4 | |
| **Meal Prep & Kitchen Tasks** | | |
| Pour a glass of water from a pitcher | 0 1 2 3 4 | |
| Retrieve an item from a refrigerator | 0 1 2 3 4 | |
| Heat food in a microwave | 0 1 2 3 4 | |
| Complete a simple meal prep task (e.g., make a sandwich) | 0 1 2 3 4 | |
| **Dressing & Personal Care** | | |
| Button a shirt | 0 1 2 3 4 | |
| Tie your shoes | 0 1 2 3 4 | |
| Put on a jacket | 0 1 2 3 4 | |
| **Medication Management & Finances** | | |
| Open a pill bottle | 0 1 2 3 4 | |
| Read a medication label and its directions | 0 1 2 3 4 | |
| Pick up and count five coins | 0 1 2 3 4 | |
| **Mobility & Accessibility** | | |
| Walk up and down stairs | 0 1 2 3 4 | |
| Open a door | 0 1 2 3 4 | |
| **Communication & Leisure** | | |
| Sign your name with a pen | 0 1 2 3 4 | |
| Use a cell phone | 0 1 2 3 4 | |
| Read a newspaper | 0 1 2 3 4 | |
| **Instructions for students:** Complete each task while wearing the Geriatric Simulator. For each task, circle the number that best describes the level of difficulty you experienced (0 being no difficulty, 4 being very difficult). After completing the tasks, reflect on your experience and jot down any observations about how your body felt or responded during the activity. These observations can include any challenges you faced, how the task might feel for an older adult, or how the experience has impacted your understanding of geriatric care. | | |

empathy and a nuanced understanding of the integral role occupational therapy practitioners (OTPs) play in enhancing the quality of life for older adults.

Integrating geriatric simulation into the occupational therapy curriculum enriches students' educational experiences by blending experiential learning with their academic studies. After participating in the simulation, students are encouraged to complete a worksheet rating the difficulty of various tasks, noting their observations. This reflective exercise is crucial for bridging theoretical knowledge with real-world application, facilitating discussions about age-related impairments and the importance of empathy in clinical practice. Table 3 outlines a sample geriatric simulation reflection worksheet.

Instructions for students: Complete each task while wearing the Geriatric Simulator. For each task, circle the number that best describes the level of difficulty you experienced (0 being no difficulty, 4 being very difficult). After completing the tasks, reflect on your experience and jot down any observations about how your body felt or responded during the activity.

**OT students engaging in bed mobility and functional transfers using geriatric simulation equipment to practice patient handling techniques**

These observations can include any challenges you faced, how the task might feel for an older adult, or how the experience has impacted your understanding of geriatric care.

This worksheet example serves as a foundation for subsequent classroom discussions, where students share their experiences and reflections. Facilitated by faculty, these discussions aim to deepen students' insights into the physiological and psychological aspects of aging, fostering a comprehensive understanding that will inform their approach to care in their future occupational therapy practice.

Undergoing the geriatric simulation marks a significant turning point for students. The reflective feedback collected post-simulation, as discussed in focus groups, highlights this transformative experience. Students share profound revelations about the physical and emotional challenges of aging, indicating a marked shift towards a more empathetic and comprehensive approach to care.

SABINA KHAN AND JACQUELINE ACHON

## Conclusion

The impact of this immersive educational experience extends beyond the simulation lab, fostering critical skills in interactive clinical reasoning that are essential for person-centered and strengths-based geriatric care. By emphasizing the resilience and capabilities of older adults, the geriatric simulation encourages students to engage in thoughtful problem-solving and empathetic, individualized care. This approach not only bridges academic learning with practical, hands-on experience but also prepares future OTPs to address the diverse needs of an aging population with respect, competence, and a commitment to enhancing quality of life through personalized, innovative care.

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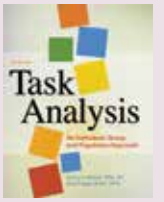
**Sabina Khan, PhD, OTD, MS, OTR/L**, is an Assistant Professor at the University of St. Augustine for Health Sciences in Miami, FL. With more than a decade of clinical experience, she specializes as a certified women's health and pelvic floor specialist, and holds certifications in trauma-informed approaches. Her research in academia encompasses women's health conditions, trauma-informed care, and innovative health care education methodologies.

**Jacqueline Achon, OTD, MS, OTR/L**, is a Clinical Instructor at the University of St. Augustine for Health Sciences in Miami, FL. She has been an occupational therapist for 10 years, specializing in adult and geriatric care and focusing on neuro rehabilitation, fall prevention, and aging in place. Certified in stroke rehabilitation and fall prevention, she works closely with clients with conditions such as brain injury, stroke, and spinal cord injuries.


## For More Information

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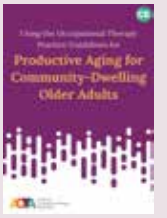
K. Matuska & C. Christiansen, 2014. AOTA Press. **$62.95 for members**, $89.95 for nonmembers. Order #900354. Ebook: $56.95 for members, $80.95 for nonmembers. Order #900430.




Online Course
**Using the Occupational Therapy Practice Guidelines for Productive Aging for Community-Dwelling Older Adults**
W. Molitor, 2019. American Occupational Therapy Association. Earn .15 AOTA CEU (1.88 NBCOT PDUs, 1.5 contact hours). **$24.95 for members**, $34.95 for nonmembers. Order #OL5175.

# Enhancing Student Empathy, Engagement, and Support

## *Balint and Level II Fieldwork*

**Tara Mansour**

**LEVEL II FIELDWORK IS CRUCIAL IN OCCUPATIONAL THERAPY EDUCATION,** allowing students to apply theoretical knowledge practically and develop key competencies in client care, assessment, and intervention with supervision (American Occupational Therapy Association, 2018). Although pivotal for professional growth, the demands of Level II fieldwork can also present significant challenges, including high levels of stress and anxiety among students, which may impede their learning and development (Brown et al., 2018).

As an Academic Fieldwork Coordinator (AFWC), I have observed these challenges firsthand and recognize the need for a structured yet flexible support system that resonates effectively with the needs of our students. Motivated by this need, we initiated a project to implement the use of Balint Groups within our program, aiming to enhance student engagement and provide more meaningful support during this critical stage of their professional development.

Balint Groups, initially developed for physicians by Michael Balint in the late 1950s, are designed to enhance therapeutic relationships through facilitated discussions of clinical cases. This approach helps health care professionals reflect on the emotional and psychological aspects of client care, fostering greater empathy and understanding (Lemogne et al, 2020). Although traditionally utilized in medical education, the application of Balint Groups in other health care disciplines has shown promise in supporting practitioners to deal with the complexities of clinical care (Kjeldmand & Holmström, 2008).

This article delves into the potential of Balint Groups as a supportive framework for occupational therapy students, addressing the dual challenges of maintaining community and managing the anxiety associated with Level II fieldwork. By integrating Balint Group principles into OT education, my department colleagues and I propose a model that not only supports the professional development of students but also nurtures their well-being and sense of connection with their peers. Through this approach, Balint Groups can serve as a powerful tool in preparing OT and OTA students to become empathetic, reflective, and effective practitioners.

### Traditional Support Mechanisms and Limitations

Traditional support during Level II fieldwork at the MGH Institute of Health Professions (IHP) included mentoring by fieldwork educators, periodic check-ins by the AFWC, and drop-in group sessions hosted by the university-based fieldwork team, though these were often poorly attended.

### Rationale for Choosing Balint Groups

The increased anxiety reported among students during fieldwork can be attributed to several factors. The geographic dispersal of students across various placement sites limits their ability to maintain regular contact with their peers and academic mentors, leading to a sense of isolation (Naylor, 2022). This disconnection from their established support networks at their educational insti-

**The adaptation of Balint Groups for OT students can potentially mitigate feelings of isolation by providing a consistent, supportive community irrespective of students' geographical locations.**

tutions may exacerbate feelings of stress and anxiety, particularly when faced with the intensive demands of fieldwork. Additionally, the transition from a structured academic environment to diverse fieldwork settings can be disorienting, heightening students' apprehensions about their performance and professional growth (Brown et al., 2018).

Given these challenges, there is a clear need for a more effective support mechanism that addresses both the emotional and professional needs of OT students during fieldwork. Balint Groups, with their emphasis on reflective practice and emotional processing, present a promising alternative. The core objective of Balint Groups is to facilitate discussions that explore interpersonal dynamics, thereby enhancing practitioners' empathy and self-awareness (Lemogne et al., 2020). In the context of occupational therapy, such discussions are vital as they enable students to process their experiences and feelings in a structured yet empathetic environment, promoting a deeper understanding of interactions and personal reactions with clients, fieldwork educators, or other members of the interprofessional team (Kjeldmand & Holmström, 2008).

The adaptation of Balint Groups for OT students can potentially mitigate feelings of isolation by providing a consistent, supportive community irrespective of students' geographical locations. This structured yet flexible approach can significantly enhance student engagement, reduce anxiety, and improve the overall fieldwork experience—making it a strategic choice for supporting students during this critical phase of their professional education.

## Balint Groups Initial Implementation

In the summer of 2023, the initial implementation of Balint Groups for OT students during their Level II fieldwork was structured to accommodate the geographic and temporal diversity of student placements. The student cohort was divided into four groups, each with no more than 11 members, organized primarily by their geographic location (East Coast versus West Coast) and corresponding fieldwork dates. To facilitate these groups, sessions were conducted via Zoom, which allowed for flexible interaction regardless of the physical location of the participants. Attendance was mandatory and students were required to attend a total of

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four group sessions, two sessions during each of their two Level II placements.

Each session commenced with two of the four groups together for an introductory review of the Balint process and group expectations. This introductory segment was crucial in setting the tone and ensuring all participants were clear on the goals and methods for the session. Following this, the groups split into two concurrent sessions in different breakout rooms in Zoom. These sessions were co-led by members of the IHP fieldwork team, who were most familiar to the students, with other IHP faculty outside of the OT department who had completed Balint intensive training serving as guest facilitators.

## Challenges Encountered

Despite careful planning, several challenges emerged with the initial group dynamics and facilitation styles. One of the primary issues was engaging students effectively; sessions often experienced long periods of silence as students hesitated to present a case. Some facilitators were more comfortable than others with sitting in this silence. This reluctance to speak up might have stemmed from uncertainty about the process, discomfort with exposing personal reflections, or a lack of exposure to experiences that could leave students feeling unsettled. Additionally, when cases were presented, there was a noticeable difficulty among students in taking the perspective of anyone other than the OT student presenting the case. This tunnel vision frequently sidetracked the group's focus toward problem-solving instead of exploring the emotional and relational aspects of the cases presented—which are central to the Balint method. In addition to these challenges, using Zoom as a platform allowed students across the country to gather, but brought its own set of difficulties. There are various reasons why students might be less likely to contribute to a conversation via Zoom than in an in-person classroom environment. These include reduced non-verbal cues, such as eye contact, body language, and facial expressions—which facilitate communication and engagement. It can also be difficult to gauge when it is an appropriate time to speak, especially if multiple people talk simultaneously. The perceived lower level of accountability in a virtual setting might lead students to feel less pressure to participate actively. Lastly, the home environment or other remote settings often come with more distractions than a controlled in-person setting, and students may be tempted to multitask, reducing their focus and willingness to engage in discussions.

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**The initial implementation phase, despite its challenges, provided valuable insights into how Balint Groups could be tailored to better support OT students during their fieldwork.**

## Observational Insights

It became clear that further training or preparatory sessions might be necessary to help students become more comfortable with the format and objectives of the Balint process. Additionally, the facilitation style needed to be more proactive in encouraging participation and guiding the discussions to ensure they remained focused on personal and emotional reflections rather than clinical problem-solving.

The initial implementation phase, despite its challenges, provided valuable insights into how Balint Groups could be tailored to better support OT students during their fieldwork. The lessons learned, including the need for additional training and preparatory sessions for students, adjustments to facilitation styles and facilitators, addressing challenges with student engagement, overcoming difficulties in perspective-taking, and tackling challenges associated with the Zoom platform were crucial for refining the approach and enhancing the effectiveness of support sessions in subsequent meetings.

## Restructuring Balint Groups to Increase Engagement

Restructuring Balint Groups for OT students involved several key changes aimed at better aligning the sessions with the needs of the students. Introducing new facilitation techniques was pivotal for reshaping the dynamics of the Balint Groups. The previous format, which involved multiple guest facilitators who were not familiar to the students, was revised. Instead, we consolidated the number of groups from four to two, increasing the size of each group but ensuring that the facilitators were familiar members of the fieldwork team. This change appeared to foster a more trusting and open environment, as students felt more comfortable sharing their experiences with familiar faces.

Additionally, we implemented a structured approach to discussions, scaffolding the therapeutic conversation. This technique involved identifying the stakeholders in the case discussions and structuring the feedback around these stakeholders, one at a time. This methodical approach helped focus the discussion and prevented the conversation from becoming disjointed or overly broad, which had previously led to significant periods of silence and disengagement.

## Impact of Changes on Group Dynamics and Student Participation

The impact of these changes on group dynamics and student participation was profound. By providing familiar facilitators and more structured discussion frameworks, students demonstrated increased willingness to engage in the sessions. The focused discussions on specific stakeholders allowed each student to contribute more meaningfully, reducing anxiety around speaking up and enhancing the overall quality of the reflective process.

These adaptations underscored the importance of flexibility and responsiveness in the design and implementation of support structures like Balint Groups in educational settings. Our experience provides valuable insights into how such groups can be effectively used to support students in high-pressure, professional training environments.

## Unexpected Results

The Balint group sessions introduced unexpected benefits, one of which was the valuable opportunity for students and fieldwork team members to see each other face to face. This visual connection appeared to enhance students' comfort and willingness to seek additional support. Recognizing this, we deliberately allocated fifteen minutes at the end of each session to touch base with students in individual breakout rooms as needed. This practice not only facilitated immediate personal interactions but also led to follow-up meetings where students received further support and a compassionate listening ear. These interactions underscored the importance of visibility and personal attention in educational settings, contributing to a more supportive and responsive learning environment.

## Next Steps

The next steps for our program involve formally gathering data from students about their experiences in Balint groups after they complete their two Level II fieldwork placements. Initially, we planned to collect this feedback following the summer and fall 2023 sessions. However, due to significant changes and refinements in the structure of the groups, we felt that the approach had not been perfected until the end of the cycle. After modifying the sessions, along with implementing additional training and practice opportunities within students' final semester of didactic coursework, we are now better prepared. Consequently, we aim to begin collecting student data at the end of the 2024 fieldwork placements. This systematic feedback will help us evaluate the efficacy of the Balint Groups and further tailor our approach to meet the evolving needs of our students.

## For More Information


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G. Graebe & A. Cronin, 2018. AOTA Press. **$78.95 for members**, $112.95 for nonmembers. Order #900388. Ebook: **$56.95 for members**, $80.95 for nonmembers. Order #900480.

## Discussion

Implementing Balint Groups highlighted the critical role of community and support systems in clinical education. The sense of isolation commonly experienced by students in dispersed clinical placements can significantly impact their learning and emotional well-being. Balint Groups provide a structured yet flexible platform for building community among students by fostering a shared space for emotional and professional support. It reaffirms the notion that the foundation of effective clinical education lies not only in the acquisition of technical skills but also in the cultivation of a supportive educational community that encourages reflective practice and emotional growth (Geller, 2013).

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**Tara Mansour, OTD, MS, OTR**, serves as an Assistant Professor and Academic Fieldwork Coordinator at the MGH Institute of Health Professions, where she champions progressive educational methodologies and interdisciplinary collaboration in occupational therapy and clinical education. With more than two decades of diverse clinical experience, Dr. Mansour has transitioned into academia, bringing a wealth of practical knowledge to her teaching and administrative roles. She is currently a PhD candidate in Health Professions Education, underscoring her dedication to elevating OT education through innovative curricular design and advanced pedagogical strategies. Her scholarly work spans a variety of innovative approaches to optimize fieldwork education and enhance learning efficiency, as showcased in her national presentations, including those at AOTA INSPIRE and the Association of Schools Advancing Health Professions (ASAHP).

# Forest Bathing in

## Treating Clients With Eating Disorders

**Amy E. Ethridge and Daniel R. George**

THE RECENT USE OF NON-CLINICAL, OUTDOOR GREEN SPACES as an effective therapeutic modality to promote biopsychosocial health and quality of life—a practice sometimes referred to as *forest bathing* (Li, 2018)—has created new opportunities for occupational therapy practitioners (OTPs). Particularly in an era shaped by the Patient Protection and Affordable Care Act (ACA, Pub. L. 111-148), institutions have found it useful to invest in creating outdoor community spaces such as farmers' markets, community gardens, and farms that promote preventive health. We (the authors) have used three such outdoor green spaces on our Penn State Hershey hospital campus to facilitate occupational practice at an eating disorders clinic, including forest bathing in the woods, shopping at an outdoor hospital farmers' market, and harvesting produce from the hospital community garden as therapeutic programming for clients living with eating disorders.

Forest bathing - view from behind the hospital

# Outdoor Green Spaces

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**TABLE 1.** Eating Disorders (American Psychiatric Association, 2013)

| Anorexia Nervosa | Bulimia Nervosa | Binge-Eating Disorder | Avoidant/ Restrictive Food Intake Disorder (ARFID) |
|---|---|---|---|
| • Restriction of energy intake<br>• Fear of weight gain<br>• Disturbance in body image | • Episodes of binge eating and lack of control<br>• Compensatory behaviors to prevent weight gain (self-induced vomiting, laxatives, diuretics, or other medications, fasting, or excessive exercise)<br>• Self-evaluation influenced by body shape and weight | • Episodes of binge eating and lack of control<br>• Three or more of the following: eating rapidly, eating until uncomfortably full, eating when not hungry, eating alone due to embarrassment, feelings of guilt afterward<br>• Compensatory behaviors not present | • Restrictive dietary variety and/or food intake due to low appetite<br>• Selective eating: aversion to the sensory characteristics of food<br>• Fear-based: aversive consequences from eating (choking or contamination)<br>• No body image issues |

Forest bathing or forest therapy was derived from the Japanese *Shinrin yoku* in the early 1980s by Japanese physicians who noticed their urban clients had increasing rates of physical and mental health issues that might be ameliorated by time in nature (Li, 2018). Although the name evokes the wilderness, forest bathing has more recently come to encompass bringing clients into any natural environment or green space and encouraging them to simply be conscious of their surroundings rather than fixated on their illness. Indeed, research has consistently shown that taking in nature through the five senses can have a beneficial impact on heart rate, blood pressure, pulse, blood sugar, stress, mood, sleep, and the immune system (Li, 2018). It allows humans to experience a liminal state and shed the stressors of the day, thereby promoting flow and other positive mental health states, such as relaxation and mindfulness. At a deeper existential level, "being in nature can contribute to one's sense of connection beyond themselves to a common good" (Delbert et al., 2023, p. 1). This emerging research, as well as recent changes in the U.S. health care system, have created an impetus for OTPs to think more strategically about how green spaces might be used in client care.

Wide lens view of garden

Clients holding produce from the garden used for recipes

## Background

Since the 2010 passage of the ACA, hospitals have been incentivized to conduct community health needs assessments and implement programs to address chronic disease and mental health issues (George & Ethridge, 2023). At Penn State Milton S. Hershey Medical Center, we established a market (2010) and garden (2014) and are located next to a wooded hillside with 10 miles of hiking trails. Given the benefits of nature exposure, we have sought to explore ways to use these green spaces with Partial Hospital Program (PHP) clients in an eating disorders clinic (EDC). See Table 1 for types of eating disorders.

## Implementation

### *Community Garden*

In 2023, a dietitian and an OT from the EDC took four clients to the Hershey Community Garden (HCG) and used horticulture therapy as well as integration of garden produce into the clinic kitchen (e.g., to prepare homemade salsa). Client A is an 18-year-old male presenting with avoidant/restrictive food intake disorder (ARFID). He has a longstanding history of only eating approximately 10 different

AMY E. ETHRIDGE

**The activities also rely on people in public places being sensitive to client needs, such as avoiding potentially triggering comments and respecting activity restrictions. Activities are weather dependent and seasonal.**

food items and hopes to expand his food choices (especially vegetables) prior to starting college. Client A harvested vegetables from the HCG and worked with an OT on introducing a harvested tomato as a novel food. He progressively increased from bite-sized pieces of tomato to eating an entire serving in occupational therapy treatment, following the EDC ARFID protocol (Lane-Loney et al., 2022).

### *Farmers' Market*

We took five clients to the hospital market where they listened to live music, shopped at stands, and purchased peppers for later use in food preparation. Client B is a 23-year-old female presenting with ARFID. She developed selective eating as a child, and it became more restrictive 2 years previously in the context of severe anxiety resulting in nausea and vomiting. At the market, she purchased tomatoes with a plan to prepare cowboy caviar (a bean salad dip) to return to eating a vegetable she used to enjoy. Research shows that food preferences are developed through tasting (even if the amount is only a crumb) and that learning to like a food requires repeated tastes (Williams & Seiverling, 2018). The occupational therapist encouraged her with a short-term goal of gradual and increased bite sizes and a long-term goal of eating a full serving. By discharge from the program, she was able to tolerate eating small portions of her recipe.

### *Hiking Trails*

A group of four clients, one medical student, and the authors of this article took a field trip to the woods behind the hospital. We used a combination of story-sharing, sensory activities, and information about the medicinal value of plants. We recommended that clients use deep breathing and sensory awareness for stress management, and we encouraged the group to pause and take in the Blue Ridge Mountains on the horizon and the surrounding beauty. Participants descriptively used terms such as calm, happy, and peaceful after the intervention, using an important recovery skill of tuning in to their bodies and how they feel, versus the eating disorder tendency to tune out cues. Client C is a 17-year-old female presenting with anorexia nervosa, binge-purge type. She initially refused to eat lunch prior to the field trip; however, she compromised by drinking a supplement which enabled her to participate in the fieldtrip as well as the remainder of the program day.

**Forest bathing provides heightened awareness of sensory experiences. Nature therapy could be applied to any setting as wide ranging as occupational therapy settings themselves, spanning the lifespan from young children to older adults, and including both physical and mental health.**

## What we Learned

Forest bathing field trips provided opportunities for clients to leave the clinical setting and be outside, allowing a reprieve from their Cognitive Behavior Therapy (CBT) eating challenges at structured mealtime and in snack groups. We asked patients about their anxiety level—both at the beginning and end of the group sessions—using 10-point modified SUDs rating scale (Cuncic, 2023, November 9), with 10 being unbearably upset and 0 being peaceful and calm. We observed that scores changed from 8 to 10 out of 10 at the start, to 4 to 6 out of 10 at the conclusion. Providing client education about interoceptive awareness is especially important. Based on informal observations during 15 years of experience, Amy (first author), has noticed that this patient population tends to have differences in perceptions of body cues. An ARFID patient may be hyperfocused on food texture or the fear that a particular food will make them vomit, and an anorexic or bulimic patient is prone to tuning out body cues and emotions).

Since one of the main lessons of eating disorder (ED) recovery involves healthy stress management, patients are asked about their best coping activities (both at admission and discharge), and it is beneficial when patients add new activities to include any of the outdoor activities presented to them in during the program (i.e., forest bathing, attending farmers markets, gardening, stepping outside for a breath of fresh air). A foundational component of ED treatment is to work on food variety, which we were able to do via expanding client palates after field trips. For example, client A was exposed to a brand new food and client B independently selected a food to incorporate in a recipe. Clients had increased motivation to participate in clinical treatment in order to return to previously desired outdoor activities. Patients who were underweight and/or had critical signs of malnutrition in their lab work became motivated to gain weight to return to hiking or biking. Instead of just discussing nature therapy as a healthy coping skill, we were able to actually experience it in-vivo.

In terms of limitations, some clients were not able to participate due to program schedules. We were fortunate to have access to a tour guide, community garden, farmers' market, and hospital shuttle without cost to our clinic. The activities also rely on people in public places being sensitive to client needs, such as avoiding potentially triggering comments and respecting activity restrictions. Activities are weather dependent and seasonal.

## Implications for Practice

The beauty of forest bathing is its simplicity. Simply seeking green space can be incorporated as a therapeutic intervention for inpatient and outpatient treatment, as well as group or individual sessions. To implement therapeutic field trips, staff need to identify participants who may benefit—anyone who is open to outdoor exposure and physically capable of movement, interaction, and appropriate conduct in such spaces—obtain field trip destinations, secure funding for any costs, and coordinate client schedules and transportation. As outlined in the fourth edition of the *Occupational Therapy Practice Framework: Domain and Process* (*OTPF-4*; American Occupational Therapy Association [AOTA], 2020), all performance components of the tasks, consisting of the required motor, sensory, and social skills, could be adapted to the client and their diagnosis. Forest bathing provides heightened awareness of sensory experiences. Nature therapy could be applied to any setting as wide ranging as occupational therapy settings themselves, spanning the lifespan from young children to older adults, and including both physical and mental health.

Documentation and reimbursement are site specific. For example, our ED field trips were documented in the clients' daily group notes and incorporated in daily PHP bundle code. Some ED treatment centers offer nature walks and beach outings, but few appear to make time in nature a central aspect of their programs. Precautions include potential allergies, flight risk, and identifying clients who are unsafe—those severely underweight and/or with critical signs of malnourishment in bloodwork, or clients with active self-harm or suicidal thoughts. Our population required adaptations to limiting the forest presentation to the trail head (versus hiking trails) due to the clients' activity limitations. These activities could be adapted to other physical rehabilitation issues by considering things like wheelchair accessibility.

If unable to incorporate field trips with clients, *park prescriptions*, similar to a prescription for medication, can be used to recommend time spent in nature (Golden Gate National Parks Conservancy, 2023). A formal prescription is unnecessary; one can simply recommend clients step outside in their backyards or go to a local park. If the client is on bedrest, nature can be brought inside by placing a table near a window containing plants, rocks, and nature photos, to create a naturescape.

## Conclusion

Consistent with prior studies on the effects of outdoor activities on well-being, our preliminary programs had a positive impact on the physical, mental, social, and spiritual health of participants, for example, by increasing food exposure and variety, introducing patients to new ideas for stress management, providing opportunities for socialization within the field trip setting, and increasing motivation to recover in order to return to previously enjoyed activities. Nature-centered activities that guide people out of clinics and into green spaces can be incorporated into occupational


**Eating Disorder Clinic - garden plot**

therapy interventions to demedicalize the health care experience and positively impact patient health. There may be particular benefits in intergenerational activities that partner younger populations with assisted living residents or master gardeners.

Although a significant amount of research has demonstrated the health benefits of nature, there are a lack of studies examining the role nature plays in eating disorder recovery (Siber, 2022). Future research might focus on the benefit of simply stepping outside the clinic by collecting longitudinal data such as blood pressure, cortisol levels, weight scores, and mood scores to explore the effects of outdoor opportunities on treatment.

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**Amy E. Ethridge, MS, OTR/L**, is an Occupational Therapist and Clinical Psychiatric Specialist who is passionate about bringing creative programming to the Penn State Hershey Medical Center Eating Disorders Clinic.

**Daniel R. George, PhD, MSc**, is a Professor of Humanities and Public Health Sciences at Penn State College of Medicine, and has been involved in the leadership of the Farmers' Market in Hershey and the Hershey Community Garden.


## For More Information

**Practice Guidelines for Adults Living With Serious Mental Illness**
S. Noyes & E. Lannigan, 2019. AOTA Press. Ebook: **$39.95 for members**, $57.95 for nonmembers. Order #900594.


Online Course
**Mindfulness for You and Your Clients**
D. Costa, 2021. American Occupational Therapy Association. Earn .15 AOTA CEU (1.88 NBCOT PDUs, 1.5 contact hours). **$29.95 for members**, $39.95 for nonmembers. Order #OL8311.

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# Mental Health: A Key OT Practice Area for the 21st Century

**Following AOTA's lead, colleges and universities are more focused than ever on the best ways to treat people with a wide range of mental health conditions.**

(LEFT) SACRED HEART FACULTY DEMONSTRATE HOW GROUP SENSORY ACTIVITIES CAN BE FACILITATED WITH CHILDREN TO PROMOTE "JUST RIGHT" LEVELS OF AROUSAL. (RIGHT) PROFESSOR SYLVIA SOBOCINSKI WITH STUDENTS IN ONE OF HER MENTAL HEALTH PBL GROUPS.

While general awareness of mental health issues has increased greatly only in the past decade or two, the profession of occupational therapy has deep roots in the treatment of mental health. It was during World War I that early OT practitioners provided therapies to soldiers suffering from both physical and mental health impairments, with a goal of helping them return to work and daily life.

It's no wonder that AOTA has promoted a return to a comprehensive awareness of mental health issues, not only for OTs who practice in mental health settings but for all OTs whose patients' needs and goals may be affected by their mental health. AOTA has identified mental health as a key practice area for the 21st century.

"The roots of occupational therapy are grounded in psychiatry," AOTA states. "The moral treatment movement, from which the profession evolved, sought to replace the brutality and idleness of earlier treatment of disorders of the mind with attention to establishment of health routines and participating in meaningful occupation."

Following AOTA's lead, colleges and universities are more focused than ever on teaching students and practicing professionals about the latest research on mental health conditions and how best to treat those with a wide range of impairments and challenges.

## LOOKING AT THE *WHOLE* PERSON

**Sacred Heart University**, in Fairfield, Connecticut, has embedded mental health education into its Master's Degree in Occupational Therapy program for a decade. Lola Halperin, Ed.D., OTR/L, an assistant professor, developed a course covering mental health conditions as well as additional courses that cover OT assessments and interventions for people with mental health diagnoses delivered through problem-based learning (PBL), labs, and a seminar. "It was really because of AOTA's emphasis on going back to our roots that we developed the curriculum," Halperin says.

The OT curriculum's goal is to educate practitioners who are effective at dealing with people's overall well-being, which must include mental health, says Sharon M. McCloskey, Ed.D., MBA, OT/L, CTP, chair of occupational therapy at Sacred Heart. "Our team of fulltime and adjunct faculty is not looking at the mental health condition separately, but at the whole person who may have mental health issues," she says. "We take the mind and body into account."

The semester focusing on mental health conditions revolves around 13 clinical cases involving people from diverse backgrounds who face trauma, psycho-social challenges, and more. Students engage in team-based and problem-based learning and have a weekly seminar to discuss solutions to a clinical situation.

For their field experiences while completing the mental health semester, Sacred Heart students visit a range of mental health

**"As OTs, you focus on daily life. So we want to give our students the knowledge and skills they need for a wide range of experiences."**
***—Lola Halperin***

facilities and interact with those affected by mental health issues. Facilities include programs in nearby Bridgeport that support people in need, people with persistent mental illness, those battling substance use disorders, and former inmates reentering society. In addition, a Monday Night Social clinic serves around 20 neurodivergent young adults, offering meaningful field experience for students as well as fitness, safe body mechanics, healthy nutrition, and wellness-related activities, with emphasis on leisure and social participation. Other clinics include a driving simulator and a Women's Health Center that incorporates elements of psychosocial OT.

In another notable project, students work with the American Veterans Archaeological Recovery, which helps veterans overcome feelings of isolation and a loss of purpose by involving them in archaeological fieldwork.

"We are very focused on service learning and community engagement across the curriculum, so that students hone their skills and competencies," McCloskey says.

Halperin notes that OTs are not psychologists or social workers but help people with mental health challenges succeed in meaningful occupations. "As OTs, you focus on daily life—study skills, looking for a job, cognitive-behavorial strategies to manage daily stress, building healthy relationships, and healthy leisure activities to keep your life balanced," she says. "So we want to give our students the knowledge and skills they need for a wide range of experiences."

## MEETING A GROWING DEMAND

When **Bay Path University** in Longmeadow, Massachusetts, launched a post-professional occupation therapy doctorate (OTD) program in 2017, it decided to offer five tracks, including one in mental health. The all-online, 36-credit doctorate program with a mental health track is designed to meet a wide range of practitioners' needs, including those who want to practice in a mental health setting.

"There is a growing demand for mental health services in OT," says Julie Watson, PhD, OTR/L, program director and fulltime faculty member. "OTs help people find purpose and promote participation in work and activities. It's a person-centered, holistic approach."

Bay Path's OTD program, which supplements Bay Path's on-campus and hybrid Master's degree programs in OT, has close to 100 students—working OTs with busy schedules. The mental health concentration attracts OTs who want to work in mental health or already do. But it also attracts other practitioners, Watson says, "because of what the program will add to their practice in pediatrics or older adults or something else. In any setting, you're dealing with mental health. The program broadens their skills and advances their clinical practice."

Doctoral students take psychology courses where they learn with mental health professionals, the goal being to offer an interdisciplinary perspective. "Our students really appreciate the collaboration and understanding from other professionals outside the OT profession," Watson says. "Those different perspectives can really help them be successful."

**"The stigma around mental health is steadily decreasing. We're seeing more people openly discussing their experiences." —*Julie Watson***

Bay Path's OTD program also offers tracks in administration, advanced general practice, autism spectrum disorders, and productive aging.

All doctoral students do a capstone research project designed to advance their practice and support the OT field. All mental health track students have been accepted for national level presentations, Watson says.

"The stigma around mental health is steadily decreasing," says Watson. "We're seeing more people openly discussing their experiences. When Simone Biles competed in the recent Olympics, she shed light on her own mental health struggles. We've made significant progress in recognizing that mental health impacts everyone." ■


RAE ANN SMITH, A FULLTIME BAY PATH FACULTY MEMBER, PRESENTS A POSTER FROM A STUDENT'S MENTAL HEALTH CAPSTONE PROJECT AT AOTA INSPIRE 2024, THIS PAST MARCH IN ORLANDO, FLORIDA.

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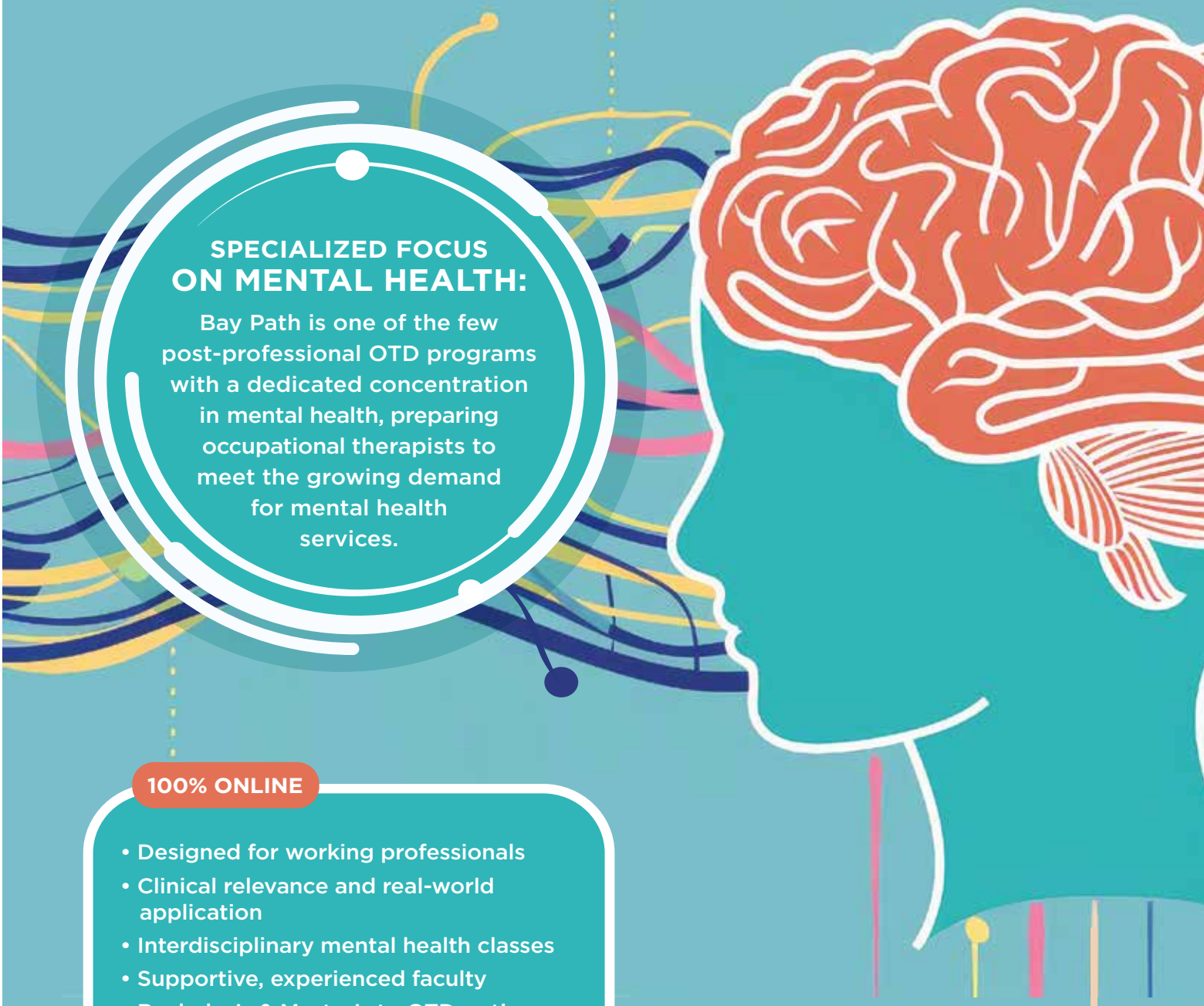

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# Cognitive Behavioral Therapy

## Treatment of Insomnia in an Outpatient OT Clinic

**Amy Harper and Sunny R. Winstead**

Two years ago, if you had asked me (Amy, first author) whether an occupational therapy practitioner (OTP) could provide cognitive behavioral therapy for insomnia (CBT-I), I would have said no. Traditionally, psychologists have been the primary providers of cognitive behavioral therapy. However, research shows that well-trained OTPs can effectively use CBT-I as part of an occupation-based sleep intervention (Eakman et al., 2022; Leland et al., 2014). My learning journey has led me to discover a new opportunity for the occupational therapy community.

I have been an occupational therapist for 20 years, and I currently work in a hospital-based outpatient clinic as a leader and clinical provider. My curiosity about sleep was sparked by complaints over the years about sleep disruption from my clients with orthopedic injuries. Through research and networking, I discovered that although many people experience sleep dysfunction, there are not enough providers addressing this issue. I am excited to share details about how I developed a specialty practice that integrates CBT-I into occupational therapy sleep intervention in an outpatient setting.

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### The Literature on Sleep and Sleep Dysfunction

Getting enough quality sleep is a concern in the U.S. and globally. Lack of sleep can impact clients' healing times, energy levels, and rehabilitative performance (Goorman et al., 2019; Gorski, 2019). One of the most common sleep conditions is insomnia, which affects 25% of people across the lifespan (Koffel et al., 2018), but particularly impacting older adults (Leland et al., 2014). Insomnia is a subjective sleep disorder that impacts the quality and quantity of sleep and creates daytime fatigue.

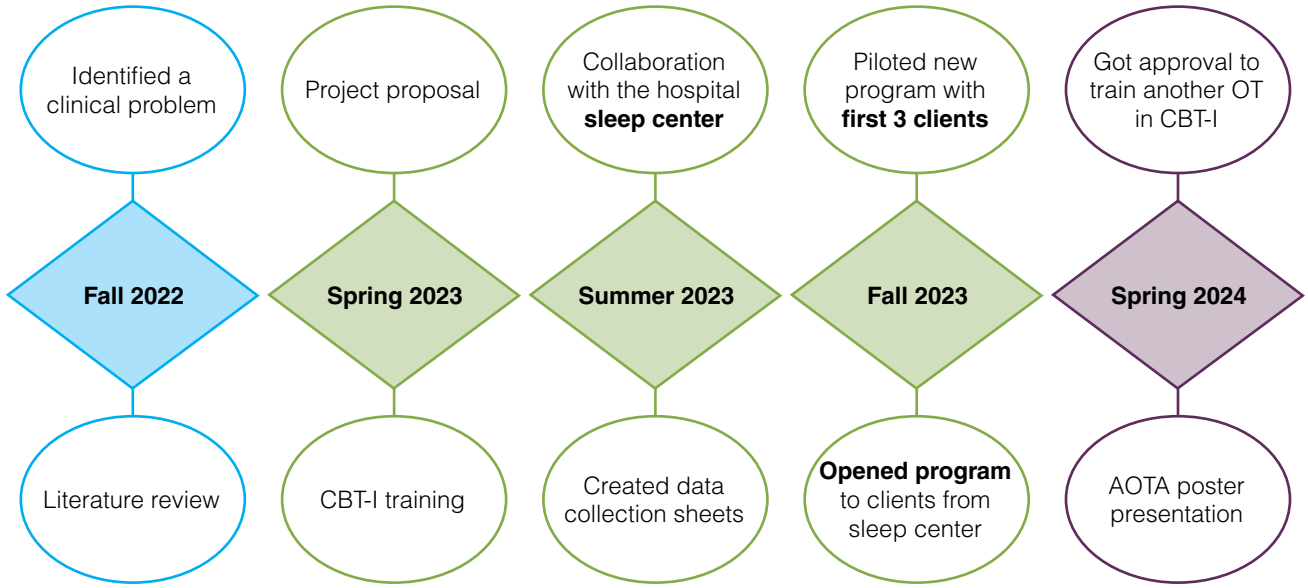
Getting diagnosed and finding effective treatment can be challenging for people with insomnia. According to Koffel and colleagues (2018), there are several barriers to timely, effective sleep intervention.

- Many primary care physicians lack training in sleep conditions or lack the time to assess sleep.
- Clients may not be aware of CBT-I or its effectiveness in treating insomnia.
- Finding a local CBT-I provider can be difficult due to a shortage of professionals.

According to the *Occupational Therapy Practice Framework: Domain and Process*, fourth edition (American Occupational Therapy Association, 2020), sleep and rest are under the self-care domain, and interventions include activities that prepare the individual and the environment for sleep. Common occupational therapy interventions to address sleep dysfunction include:

- providing sleep education,
- addressing sleep habits such as routines and sleep environments,
- teaching stress management and relaxation techniques, and
- promoting healthy daytime activities.

**FIGURE 1.** ProgramDevelopment Timeline for Adding a New Practice in an Outpatient Clinic




## Defining Sleep and Insomnia

A fundamental way to describe sleep is a state of rest or unconsciousness vital to living (Suni, 2021). Many sleep experts have recommended that adults receive 7 to 9 hours of uninterrupted sleep each day (Suni, 2021). Some functions of sleep include tissue growth and restoration, memory consolidation, immune system and central nervous system regulation, and removal of BETA-amyloid and other waste in the central nervous system (American Academy of Sleep Medicine, 2022; Suni, 2021).

Chronic insomnia is a disorder that is characterized by the inability to sleep properly (i.e., sleeping poorly, difficulty falling asleep, difficulty remaining asleep) and can impact daily activities. According to Perlis and colleagues (2008), there is often a triggering event that precipitates sleep loss. However, sleep challenges may linger beyond the initiating factor. People struggling with insomnia often experience difficulties falling asleep or remaining asleep, and daytime fatigue impacts daily performance. Most people experience acute insomnia at some point in their lives. When sleep challenges occur for 3 months, it is classified as chronic insomnia (Perlis et al., 2008).

## CBT-I and Training

There is strong evidence for the effectiveness of CBT, and CBT-I is considered a first-line treatment for people with insomnia (Tester & Foss, 2018). CBT-I is a multi-component treatment consisting of stimulus control, sleep restriction, sleep hygiene, cognitive therapy, and relaxation strategies (Climent-Sanz et al., 2022). OTPs interested in becoming a CBT-I provider need to pursue continuing education, including:

- taking a continuing education course in CBT-I to learn the treatment protocol (typically 8 to 16 hours of learning),
- observing sessions (1 to 3 cases), and
- receiving consultation and/or supervision from a qualified CBT-I provider (until competency is reached).

## Developing a New OT Program for People With Insomnia

As part of my Post-Professional OTD Innovation Project (capstone) at the MGH Institute of Health Professions, I developed an occupational therapy–led sleep program that integrates traditional occupational therapy strategies with CBT-I interventions. I started by completing a 16-hour CBT-I course taught by OTPs at Colorado State University (Eakman & Rolle, 2023). See Figure 1 for other steps I took to create this new outpatient service. This project was reviewed by the Mass General Brigham IRB and determined to be a quality improvement project consistent with non-human subject research (NHSR).

## Resources for OT's Role in Sleep

**www.aota.org/practice/clinical-topics/sleep**

**www.myotspot.com/occupational-therapys-role-in-sleep/**

**www.sleepfoundation.org/insomnia/treatment/cognitive-behavioral-therapy-insomnia**

**TABLE 1.** AF's Baseline Information From the Consensus Sleep Diary

| Assessment | Score | Clinical Significance |
|---|---|---|
| Consensus Sleep Diary (Baseline data averaged during a 2-week period) | 58% sleep efficiency | Normal sleep efficiency is 85% or higher. It is the percentage of actual sleep time compared to the time spent in bed awake |
| | Total time in bed: 9.5 hours | This is the time from when a person gets into bed at night, to the time they get out of bed for the day. |
| | Total sleep time: 5.5 hours | Eight hours is considered the average, or ideal number of hours. Fewer than 6 hours can be problematic |

## Evaluation Process

A comprehensive occupational therapy evaluation for clients with insomnia helps obtain a clear picture of how insomnia is impacting their lives, identify the contributing factors, and rule out contraindications. This evaluation involves an interview, client-rated outcome measures, a sleep diary, and a thorough sleep history. There are many available screening and assessment tools to help gather data, including the Consensus Sleep Diary (Carney et al., 2012), Epworth Sleepiness Scale (Johns, 1991), Insomnia Severity Index (Bastien et al., 2001), and Sleep Disorders Symptoms Checklist-25 (Klingman et al., 2017). Other assessments include screens for mental health, sleep environment, quality of life, daily activity performance, and tools to rule out other sleep disorders. The purpose of the interview is to identify:

- Precipitating events
- Duration of sleep loss
- Chronotype
- Contraindications
- Insomnia subtype(s)
- Medications impacting sleep
- Current sleep hygiene
- Impacts on activities/social participation

## Case Example

AF is a composite client based on real cases from my practice. AF is a 55-year-old female with a diagnosis of chronic insomnia. Initially, AF was screened to determine if she meet the criteria for the sleep program. This screening included a basic sleep history, ruling out contraindications such as a seizure disorder, and ensuring the ability to complete an 8-week program. Next, she was asked to complete a Consensus Sleep Diary (n.d.) for 2 weeks to obtain baseline sleep information. See Table 1 for details. AF's initial evaluation revealed that she had a 10-year history of poor sleep, possibly triggered by hormonal changes. She reported sleeping poorly 3 out of 7 days per week, including difficulty falling asleep and remaining asleep. AF stated that due to low energy and daytime fatigue, she was no longer taking walks, having dinner with friends, or painting. Table 1 highlights the baseline details from AF's consensus sleep diary.

## Interventions

The interventions provided are based on evaluation findings and are individualized for each client. I typically see clients for eight visits lasting 30 to 60 minutes each, following a 2-week baseline data collection. During these sessions, I provide education about the circadian system, homeostatic sleep driver system, arousal system, sleep hygiene, stress management, emotional regulation, and theories to demonstrate how insomnia occurs. In addition to CBT-I interventions, I provide tips and strategies for schedule management, balancing daily occupations, establishing a bedtime routine, engaging in meaningful tasks, exercising, and participating in social activities.

Interventions for AF included a structured sleep schedule; her sleep time was restricted to 5.5 hours (1:30 am to 7:00 am). She was also given stimulus control goals of getting out of bed after 20 minutes if she could not sleep and avoiding other activities in bed such as online shopping and watching television. As AF improved, she was given an earlier bedtime, which continued to increase throughout the program. Figure 2 demonstrates how AF improved her sleep efficiency by reducing the time awake in bed during 8 weeks of treatment.

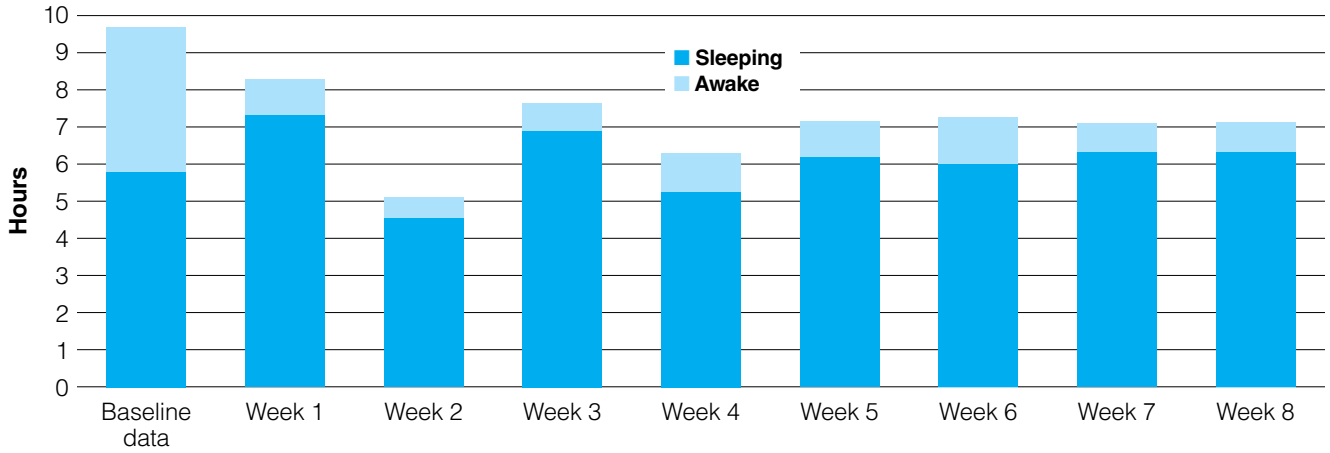
## Outcomes

Clients often demonstrate an improved quality of sleep after receiving CBT-I and other OT interventions for insomnia. Figure 2 demonstrates how AF improved her sleep efficiency by reducing the time she spent awake while in bed during 8 weeks of treatment. Other benefits reported by clients completing the sleep program include less daytime fatigue, increased social and physical activities, a reduction in client-rated anxiety scores, and an improvement in concentration. Many clients also express improved confidence in managing their sleep and the ability to handle other challenges in their lives. For AF, as her sleep quality improved, she had the energy to re-engage with valued occupations, including walking several times a week, painting, and socializing in the evenings.

## Conclusion

Sleep dysfunction is a growing problem in the U.S., and OTPs have an opportunity to add a new intervention to their practice. CBT-I is well-studied and has been proven effective in the treatment of insomnia. Additionally, research shows that well-trained OTPs can effectively use CBT-I as an intervention to help clients experiencing sleep dysfunction.

**FIGURE 2.** Outcome From a Sample Client With Insomnia—Time in Bed

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**Amy Harper, OTR/L, CHT**, is a Supervisor of Rehabilitation Services at Phelps Hospital Northwell Health in Westchester, NY. Amy recently completed her PP-OTD at MGH Institute for Health Professionals. Her experience includes working with clients who have orthopedic, developmental, musculoskeletal, neuromuscular, and neurological conditions. Recently, Amy has started a program to add sleep as an area of practice in the outpatient setting.

**Sunny R. Winstead, EdD, OTR/L**, is a faculty member in the Department of Occupational Therapy at the MGH Institute of Health Professions in Boston. Sunny holds a BA in English Literature and Rhetoric, an MS in Occupational Therapy, and an EdD in Educational Leadership. Her professional background includes adult inpatient, outpatient, and community-based practice, management and supervision, program development and consultation, private practice, and academia.

# Exploring Kawa

## A Collaborative Pilot Program

**Lisa Brewer**
**Andrea Ondish**
**Jill Brown**
**Jill Ewend**
**Kadie Schultz**

The Kawa Model is recognized in the field of occupational therapy as an approach that supports culturally responsive assessment and intervention through increased understanding of diverse populations. Dr. Michael Iwama developed the model with a team of occupational therapists in the 1990s, with an emphasis on harmony between person and environmental factors that influence health and well-being (Iwama, 2006). The term *Kawa* means river in Japanese and is a metaphor to symbolize the flow of life. Additional constructs of the Kawa Model include driftwood (individual assets and liabilities), rocks (personal challenges), and the riverbed (physical and social contexts). This metaphoric model can be especially useful in facilitating self-reflection with neutral terms that elicit more details than a typical interview (Newbury & Lape, 2021; Paxson et al., 2012). Ober and colleagues (2022) highlight use of the Kawa Model for a wide range of needs, including mental health, multiple sclerosis, post-traumatic stress disorder, aging in place, and even teambuilding among rehabilitative professionals.

Application of the Kawa Model in this collaborative pilot program includes individuals with developmental disabilities, the Marshall M Fredericks Sculpture Museum, and the Saginaw Valley State University (SVSU) MSOT department.

## Applying Kawa in Three Sequential Art Sessions

Initial discussions for collaboration began following an exhibit on the art of inclusion at the Marshall M Fredericks Sculpture Museum at SVSU. Feedback on the exhibit was overwhelmingly positive, and the SVSU MSOT department was invited to discuss potential programming ideas for community outreach. SVRC Industries offers programs for individuals with developmental disabilities including employment assistance and community-based activities in the Great Lakes Bay Region. Groups from SVRC frequently visit the museum and the MSOT department was asked to collaborate on programming ideas for participants.

The Kawa Model was mentioned early in the collaboration, and it became clear that facilitating activities based on this model could help build relationships and foster self-awareness among community participants and occupational therapy students. It was decided that more than one art session would be beneficial, and Kawa elements would be introduced using basic terms. For example, the meaning of driftwood was adapted to represent strengths (see Figure 1), as opposed to using the detailed description that includes assets, liabilities, beliefs, and values.

Some participants explored concepts in more depth, depending on individual levels of understanding, but simplified descriptions helped avoid confusion as concepts were introduced.

A plan emerged using three sequential art sessions over several weeks to build relationships and increase self-awareness (see Table 1).

All art activities were completed at the

**FIGURE 1.** A Simplified Description of Kawa Metaphors

| | |
|---|---|
| **Water** | The flow of life |
| **Rocks** | Problems and challenges |
| **Driftwood** | Strengths |
| **Riverbed** | People and things in the environment (may or may not be supportive) |

**TABLE 1.** Exploring Kawa Using Three Sequential Art Activities

| Art Lesson Plans | Questions and Statements to Facilitate Self-Reflection |
|---|---|
| **Activity 1**<br>• Discuss and make a list of individual assets and strengths.<br>• Some may be related to characteristics within yourself, but others can be things related to your environment.<br>• Trace outlines of hands. Words or images of strengths can then be drawn within—or around outlines of their own hands.<br>• (see Figures 4, 5, and 6) | • What do you like most about yourself?<br>• What are your strengths?<br>• How do your strengths help you?<br>• I am proud of myself because…<br>• What people help support you in your life?<br>• What things are you thankful for? Family? Friends? Places? Activities? |
| **Activity 2**<br>• Participants pick several sticks or driftwood and rocks from a bowl.<br>• Discuss sticks (strengths and assets) and rocks (challenges and barriers) to generate a list. Strengths from the previous activity can be reviewed.<br>• Participants trace the rocks and sticks and then label their drawing with the most meaningful challenges and strengths. They may also paint or label the actual rocks and sticks. Components can be saved for potential use in Activity 3.<br>• (see Figures 7, 8, and 9) | • What are your challenges?<br>• Name something you want to improve in your life.<br>• What are your goals?<br>• I want to learn how to….<br>• What things do you need to achieve your goals? Skills? Time? Support? Money? |
| **Activity 3**<br>• Participants start their Kawa composition by painting the river, then picking out sticks and rocks to be added. These can be objects or ideas from Activities 1 and 2<br>• Participants are encouraged to label strengths (wood), challenges (rocks), and contextual variables (riverbed). Rocks and sticks are added with hot glue guns and assistance as needed.<br>• (see Figures 10, 11, and 12) | • If life is like a river, what is your river like?<br>  • Is your river fast or slow?<br>  • Is it curvy or straight?<br>  • Is it wide or narrow?<br>• Who or what makes up your environment?<br>  • Who do you enjoy being with? Who provides support to you when needed?<br>  • What things in your life are you grateful for? Family? Friends? Things? Activities?<br>• What rocks or challenges are in your river?<br>  • What would you like to improve in your life?<br>  • What do you need to achieve your goals?<br>• What driftwood or traits do you have?<br>  • What do you like most about yourself?<br>  • What are your strengths? |

Marshall M Fredericks Sculpture Museum where occupational therapy students were paired with community participants. Two groups from SVRC participated in the KAWA pilot. These groups were chosen because their schedules aligned with the museum's availability, as well as MSOT student and faculty schedules to meet over the course of three Wednesdays during the semester. Each 90-minute session began with 10 minutes to explore the museum and talk with one another before starting the art activities. sessions ended with a snack, and participants were encouraged to share their artwork with others in the group.

## Grading Activities for Community Participants and Graduate Students

The graduate occupational therapy students taking part in this collaboration had completed a Kawa painting in a previous semester that depicted their perceived strengths, challenges, and contexts (see Figure 2). However, students had not previously taken part in a series of Kawa art projects, and had not applied the model to an actual person other than themselves. These activities provided an opportunity for students to act as facilitators engaging with community participants as they discussed strengths and challenges. Students provided guiding questions to facilitate self-awareness (see Table 1). Due to inclement weather and scheduling conflicts, the final Kawa paintings were completed separately (students and community participants participated in the third activity on different days). Despite this challenge, positive outcomes were noted for students and community participants. The graduate students were in their final semester of coursework prior to Level II fieldwork, and the Kawa activity provided opportunity for reflection as they prepared for the transition (see Figure 3).


**Figure 2.** This KAWA painting was completed by an MSOT student prior to this collaboration as they were first introduced to the model.

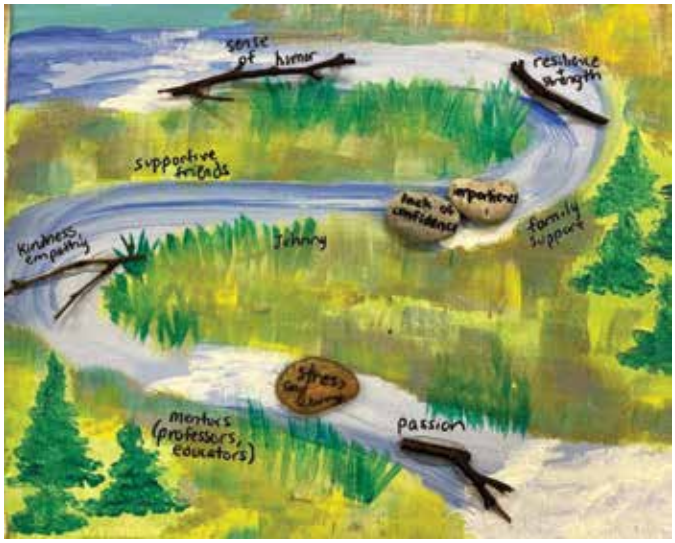


**Figure 3.** This KAWA project was completed by an MSOT student as part of this collaboration and provided an opportunity for self-reflection before starting Level II Fieldwork.

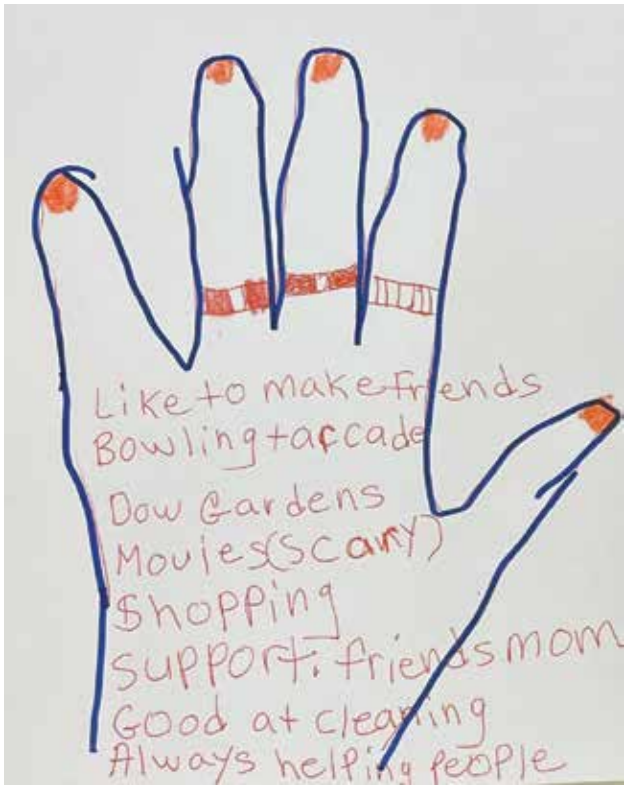


**Figure 4.** In activity 1 SVRC participants and MSOT students traced hands and listed personal strengths within the outlines such as bowling, cleaning, and helping people.

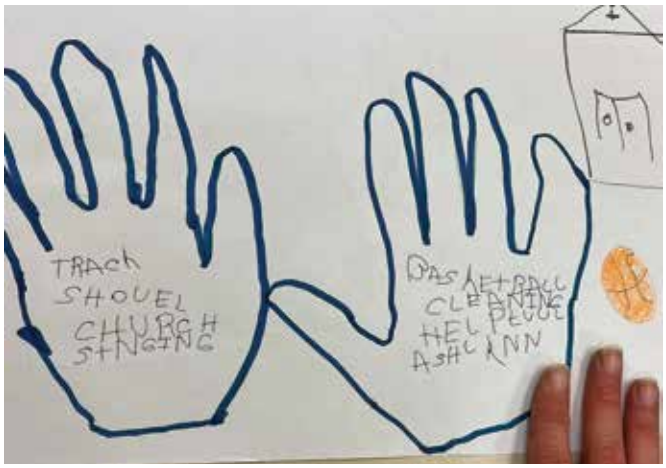


**Figure 5.** In this example from activity 1 the participant's perceived strengths included singing, cleaning, and being helpful.


**Figure 6.** In activity 1 some participants added drawings, in addition to words, to symbolize strengths as seen in this example with a depiction of a family.

LISA BREWER

**Figure 7.** In activity 2 sticks and rocks were traced. SVRC members and MSOT students were paired up and each completed their own project while talking with one another about their personal strengths and challenges.

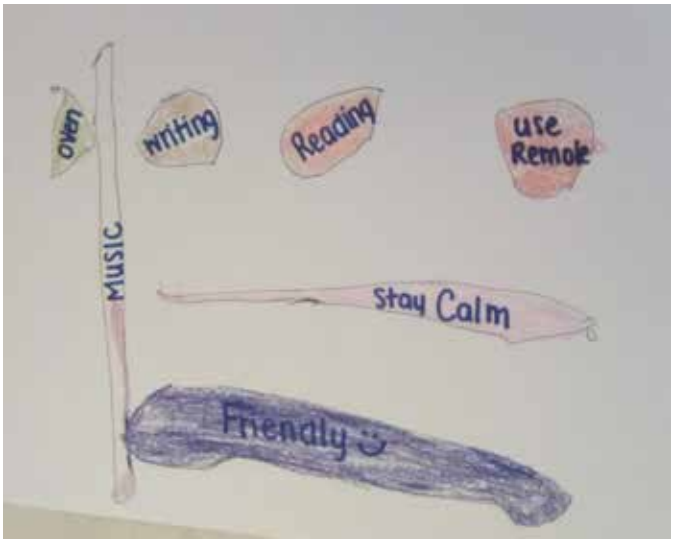


**Figure 9.** Another example of activity 2 shows reading, writing, using the remote and oven as challenges (rocks) and staying calm, being friendly and music as strengths (sticks)

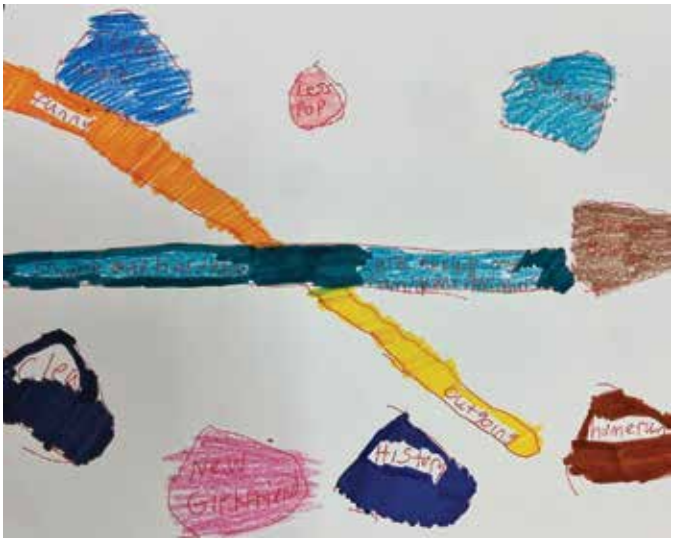

**Figure 8.** In this example of activity 2, the yellow stick represents being outgoing (perceived strength) and the small red rock is labeled "less pop" (perceived challenge).

**Figure 10.** This KAWA project from activity 3 shows a painted river, with sticks labeled with strengths (walks, library) and rocks with challenges (slow down, be patient, organize).


**Figure 11.** Cooking and golf are listed as challenges (rocks) in this creative example of activity 3, while showering and making the bed are perceived strengths (sticks).


**Figure 12.** In this creative example of activity 3 the river appears to take over the canvas and many sticks and rocks were added to represent perceived strengths (good friend, brother) and challenges (cooking and laundry).

## Outcomes for Community Participants

During the planning phase of the collaboration, potential outcome measures were discussed. In addition to using the Kawa Model to increase self-awareness (among both students and community participants), the team was also interested in other aspects of art engagement such as stress, social interaction, and well-being. The UCL Museum Wellbeing Toolkit provides scales to assess levels of well-being related to participation in art activities (Thompson & Chatterjee, 2013). One of the scales was adapted for the first two art activities (see Table 2) and relied on self-reported changes in mood and emotions—pre- and post-participation in the art activities.

Data reviewed after the first and second activity showed most participants checked yes for all questions for both pre- and post-activities. In order to obtain more specific information regarding individual outcomes, observations were noted. For example, two participants initially had difficulty with social engagement, demonstrating no eye contact and minimal verbal interaction. By the third session, both were able to answer some questions and demonstrated intermittent eye contact. Table 3 describes observations of community participants. In addition, application of the Kawa Model resulted in exploration of personal strengths and challenges. Some strengths shared by SVRC participants included knitting scarves, drawing action figures, winning medals at Special Olympics, bowling, cleaning, and being kind. Some challenges noted included cooking, doing laundry, technology, making friends, reading, writing, and transportation.

## Conclusion

This program provided a semi-structured format for improving self-awareness, as well as understanding among SVRC participants and MSOT students. The process of creating art has the potential to enhance self-awareness, increase understanding of individuals, and improve overall well-being.

Future endeavors with the KAWA model include expressive art and social

LISA BREWER

participation opportunities at the SVSU Marshall M Fredericks Sculpture Museum that will take place with SVRC participants and second year MSOT students. We look forward to the ongoing creative collaborations that use art as an occupation to increase self-awareness, increase understanding of individuals, and enhance overall well-being.

**TABLE 2.** Simplified Outcome Measure Adapted From UCL Museum Wellbeing Toolkit

| | Yes | Somewhat | No |
|---|---|---|---|
| Are you happy? | | | |
| Are you feeling safe? | | | |
| Are you enjoying the company of other people? | | | |

*Note. Provided before and after art activities.*


**Lisa Brewer, OTD, MOT, OTRL**, is an Associate Professor of Occupational Therapy at Saginaw Valley State University in Saginaw, MI. She obtained her MOT from Duquesne University and specializes in early intervention for children with autism. Lisa completed her OTD from the University of St. Augustine

**Jill Brown, PhD**, is an Associate Professor of Occupational Therapy, for the MSOT Program at Saginaw Valley State University. Jill has community-based and acute care clinical experience and has worked as a Grant-Funded Occupational Therapy consultant to advocate for trauma-informed school systems. She earned her MSOT degree from Saginaw Valley State University, and her PhD in Occupational Therapy from Nova Southeastern University.

**Jill Ewend, OTL**, is a Simulation Laboratory Associate at Saginaw Valley State University in Saginaw, MI. She completed her BS in Occupational Therapy from Western Michigan University. Jill has many years of experience providing occupational therapy services for individuals with mental health, orthopedic, and neurological conditions and she specializes in working with adults with traumatic brain injuries.

**Andrea Ondish** received her BFA from Marywood University in Painting, Drawing, Printmaking, and Illustration, and an MA from Eastern Illinois University in Painting and Printmaking. She completed her MFA at Indiana State University in Printmaking. She has been the Curator of Education at the Marshall M Fredericks Sculpture Museum since 2001 and is also Adjunct Faculty in the Art Department at Saginaw Valley State University.

**Kadie Schultz, MSOT, OTRL, CBIS, ITOT**, is a Simulation Lab Associate for the MSOT Program at Saginaw Valley State University. Kadie is a graduate of the MSOT Program at SVSU and has a background in inpatient rehabilitation with an emphasis on neuro rehabilitation. Kadie is a Certified Brain Injury Specialist and an ImPACT Trained Occupational Therapist, specializing in concussion rehabilitation and management of symptoms.


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**TABLE 3.** Observations During Art Activity Sessions

| | Observations: Activity One and Two | Observations: Activity Three |
|---|---|---|
| **Participant A** | When asked to list strengths, participant A listed things he liked (such as movies or food), but not necessarily things he considered strengths. When prompted, "What things are you good at?" or "What are you proud of?" He did not articulate specific strengths. Participant A demonstrated limited use of one upper extremity and often required cues to use the affected extremity as a stabilizer. | By the third art activity, participant A was able to identify specific strengths such as showering and dressing independently. He stated that he is not always great at drying himself off, which demonstrated self-awareness. When donning his jacket, he expressed that he was proud of his ability to zip his jacket with only one hand. |
| **Participant B** | Participant B got up frequently from the chair, walked out of the room several times, and did not remove coat or hat during activities. | Upon arriving for the third activity, participant B removed coat and hat and remained in the room for the 90-minute art session. |
| **Participant C** | Participant C frequently asked for assistance during activity 1 and demonstrated difficulty initiating and continuing the task, requiring frequent verbal cues and hand-over-hand assistance. | By the third art activity, participant C required just intermittent verbal cues and no physical assistance. |

# Impact of Vision Boards for Meaningful Occupations

**Jeffery Lucas**
**JaLonta Brogdon**
**Breanna Daley**
**Karon Jeter**
**Ashley Loyd**
**Andre Ross Jr.**

In 1967, members of the Winston-Salem community opened the Rescue Mission to relieve the burden of men who struggle with substance abuse, addiction, and homelessness. The Winston-Salem Rescue Mission (WSRM, 2020) carefully established a vision and mission considering the needs of those who felt hopelessness, and spiritually, emotionally, and mentally wounded. Offering support and a judgment-free space, the WSRM uses a client-centered and holistic approach to transform the lives of individuals of the community. Being a service to the community, WSRM stands firm in the belief that we are, "not to be served, but to serve." The philosophy, or model of care, is focused on meeting three basic levels: physical, emotional, and spiritual needs. Physical needs are met through short- and long-term interventions, which include providing clothing, housing, employment assistance, education opportunities, and medical assistance. Emotional needs are met through a high-quality substance abuse


Winston-Salem State University MSOT students pose with a Winston-Salem Rescue program graduate.

DUSTY WILSON

recovery program, life skills training, and anger management courses to focus on growth and development. Spiritual needs are met by encouraging individuals to connect with a higher power, providing meaning and significance to one's life as well as self-worth (Collins et al., 2002; Oakley et al., 2010).

Today, more than 55 years later, the WSRM continues to serve this population, as well as other individuals in the community who may have physical, emotional, and spiritual needs. The WSRM receives funding through donations and fundraising to maintain their programs and operations.

Although the mission serves the community, its focal point has maintained that of assisting men, as they are more likely to have substance abuse disorders (Winston-Salem/Forsyth County Community of Care, 2022), and make up the highest proportion of the homeless population (Winston-Salem, n.d.). Factors such as poverty, exposure to trauma, and social endorsements of substances, as well as dual diagnoses with mental illness contribute to homelessness (Moyer, 2019). The U.S. Census Bureau's data reveals that poverty may be a driving factor in the growing need for the WSRM's services, as Winston-Salem has a poverty rate of 19%, which is significantly higher than the state average of 13.4% (2023, July 1). Substance abuse, mental illness, and homelessness all disrupt one's ability to perform occupations that promote health and well-being, such as rest and sleep, work, education, leisure, and social participation. The most common disruptions occur within role fulfillment, personal and family routines, social relationships, coping skills, employment, home and self-care, and leisure engagement (Moyer, 2019).

One of the many programs at WSRM is the Life-Builders' Program, which is designed to help men overcome their addictions and gain tools required to become productive members of society. Through work therapy and courses in anger management, financial management, life skills, and more, residents are taught recovery principles as well as the skills needed to make positive changes in their lives.

Another important WSRM program is the Transformers Program, which is a 1-year recovery program where residents are guided through a process of total life transformation involving physical, social, cognitive, emotional, and spiritual growth. This program is designed to assist residents in changing their thought patterns, which in turn changes behaviors and overall approaches to life. This program includes courses such as computer skills, adult education, financial management, healthy living, leadership skills, and career development. Upon completing the Transformers Program, residents are assisted with gaining permanent employment and housing as they transition back into society.

During the fall and spring semester, Winston-Salem State University first year occupational therapy students complete an 8-week Level I fieldwork placement at WSRM under the supervision of a WSSU OT faculty member, providing group and individual interventions to a group of 8 to 10 men. Students are exposed to community mental health, while understanding the various mental health diagnoses, an individual's experience living with a mental health diagnosis, and additional community services and resources provided to support individuals in Winston-Salem. Students address issues such as healthy eating, medication management, writing a resume, using a computer, mock job interviewing, positive leisure pursuits, and more. Using a client-centered approach, students begin to partner with residents at WSRM to identify the primary issues and barriers that impede occupation. When the data is collected, the students design meaningful therapeutic interventions to maximize performance in occupations to return to society. Interventions are tailored to address ways to enhance health and wellness for clients through balancing areas of occupation related to ADLs and IADLs, such as education, work, rest, sleep, leisure, and social participation.

During the spring 2023 semester, five students were assigned to the Winston-Salem Rescue Mission. Each student partnered with one resident. Every week, students were responsible for designing and implementing a group and an individual intervention to assist the residents with achieving their goals. JaLonta Brogdon, a second year occupational therapy student was inspired to lead a group intervention involving a vision board. JaLonta gained inspiration when she conducted an individual intervention session. She stated that her client wanted to create something tangible to keep him motivated to achieve his goals. The following week, as a group activity, students brought magazines to cut out pictures and create a vision board. The purpose of the vision board was to identify and establish goals to create a path to ignite reintegration into the community. Occupational therapy interventions move "beyond the individual treatment of a client working with systems that affect the ability of an individual or group to achieve work, leisure, and social goals" (Brownson, 1998, p. 61). Each resident was receptive to the intervention. After completion of their vision board, each resident and student discussed the significance, meaning, and strategies on how they were going to achieve the items listed on the vison board.

The first year occupational therapy students returned to WSRM during the fall 2023 semester to partner with a new group of residents in the Transformers Program. On the first day of arrival, Richard Combs, former resident of WSRM Transformers Program informed the current students that the vison board that he had completed with the previous group was an integral part of his life. Richard stated that using the vision board taught him how to live from start to finish. In Richard's words, the vision board allowed him "to take an ugly mess and make a beautiful picture." As a

previous turner for a world championship drag racing team, Richard had earned all the money that he could ask for working behind the scenes in the entertainment industry. However, drugs and associating with the wrong crowd led to the loss of his family, and eventually, circumstances led him to homelessness. Through the programs at the Winston-Salem Rescue Mission and support from Winston-Salem State University occupational therapy students, he was able to seek new employment.

He shared, "I had all of the finer things, but eventually, no matter what I did, I was miserable." Recently, Richard graduated from the Transformers Program at WSRM. He will be attending Man Camp in Royston, GA, to strengthen his spirituality journey and continue to discover and follow through with his future endeavors. Man Camp is a 5-day catalyst experience to help men identify who they are and discover who they can become. The purpose of Man Camp is to develop a healthy man in body, soul, and spirit. Richard stated that prior to attending the Transformers Program, he "put money before his spirituality," but this time, he is "putting his spirituality before the money." Richard achieved all his goals on his vision board except finding a beautiful queen. He states that he is waiting and trusting in a higher power to make that happen.

## Conclusion

The WSRM and WSSU occupational therapy program has been a gratifying partnership that bridges the gap in the community.

The experience with the vision boards was so powerful, that the next semester when I saw a few of the men, including Richard, they shared how influential the vison boards were. They stated that the boards provide daily motivation to meet their goals. Several of the men stated that their vision board keeps them on track to prevent relapse.

In addition, residents often testify to the miraculous power of their belief and the significant change in their lives because of the Rescue Mission. By participating in daily devotions, spirituality services, and one-on-one and group counseling, residents are equipped with strategies on how to live a successful life and continue to be connected to their spirituality.

Communities provide a unique setting for occupational therapy practice (Fidler, 2001). Through this experience, students can identify and understand the needs of the residents in the community while facilitating skills and strategies to reintegrate residents back into the community. Through the partnership at WSRM, students are gaining insight on meaning and occupation in a community and non-traditional settings. According to Mattila (2019), students in community settings improve their clinical and communication adaptability and professional competence. The community connects students and residents through occupational engagement and a collaborative sense of meaning.

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**Jeffery Lucas, PhD, OTR/L, CDP, CKTP, CAPS**, is an Assistant Professor in the Department of Occupational Therapy at Winston-Salem State University in North Carolina.

**JaLonta Brogdon, OTS**, received a bachelor's degree in Kinesiology with a minor in Human Development and Family Studies from the University of North Carolina at Greensboro. JaLonta has a desire to work in the school system and acute care.

**Breanna Daley, OTS**, received a Bachelor of Science in Recreational Therapy at East Carolina University. She has a strong desire to work in inpatient rehabilitation setting with the brain injury population.

**Karon Jeter, OTS**, earned his Bachelor of Science degree in Exercise Science from Winston-Salem State University. He would like to do work in acute care and skilled nursing.

**Ashley Loyd, OTS**, is a graduate of Winston-Salem State University State University with a Bachelor of Science in Rehabilitation Studies. Her preferred practice setting is acute care or an outpatient adult clinic.

**Andre Ross Jr, OTS**, graduated from Winston-Salem State University State University with a Bachelor of Science in Exercise Physiology. He plans to practice in SNF/LTC or inpatient rehabilitation.

# National Representation in Quality and Value Initiatives

**Jamar Haggans**


Note. (AOTA, n.d.)

The American Occupational Therapy Association (AOTA) represents the interests of more than 230,000 occupational therapists, occupational therapy assistants, and occupational therapy students. One way that AOTA represents the interests of occupational therapy practitioners (OTPs) and our clients is through involvement in national health care quality and value initiatives. Participation in national quality initiatives facilitates promoting the role of occupational therapy in client care with other health care providers on these committees, as well as ensuring practitioner input into the selection of quality measures that support the role and outcomes of occupational therapy.

National Healthcare Quality Week is celebrated each year in October. It dates back to 1985, when it was established by the National Association for Healthcare Quality (NAHQ) to celebrate the contributions of health care quality professionals (NAHQ, 2024). To celebrate National Healthcare Quality Week 2024 (October 20 to 26), AOTA will highlight OTPs involved in national quality initiatives and provide tips for practitioners to improve health care quality in occupational therapy.

Practitioners were recently involved in the following national quality and value initiatives:

- Centers for Medicare & Medicaid Services (CMS) Home Health Value-Based Purchasing Program Expansion Model Technical Expert Panel (TEP) (https://go.cms.gov/4cUMIy7)
  - *Tracy Mroz, PhD, OTR/L*
  - *Trudy Mallinson, PhD, OTR/L, FOTA*
- Battelle's Partnership for Quality Measurement (PQM) Committee Participation (https://p4qm.org/about). Battelle is a CMS-certified consensus-based entity that endorses quality measures (Partnership for Quality Measurement, n.d.).
  - Acute Events, Chronic Disease, Surgery, Behavioral Health Committee *Jamie Wilcox, MPH, OTD, OTR/L*
  - Cost and Efficiency Committee *Pamela Roberts, PhD, MSHA, OTR/L, SCFES, FAOTA, CPHQ, FNAP, FACRM*
  - Post-Acute Care/Long-Term Care Committee, *Pamela Roberts, PhD, MSHA, OTR/L, SCFES, FAOTA, CPHQ, FNAP, FACRM*
- National Quality Forum (https://bit.ly/46jBa4Z)
  - Social Drivers of Health Data Utilization: Integrating Healthcare and Community Services to Address Health-Related Social Needs (https://bit.ly/3LJjciV), *Julie Malloy, OTD, MOT, OTR/L, PMP, CPHQ, FNAP*
- Agency for Healthcare Research and Quality (AHRQ) (https://www.ahrq.gov/)
  - Measuring Documentation Burden in Healthcare (https://bit.ly/4bPqHPY), ulie Malloy, OTD, MOT, OTR/L, PMP, CPHQ, FNAP

AOTA will continue to highlight practitioners who are involved in national quality and value initiatives on our social media during Healthcare Quality Week and throughout the year.

If you are interested in being involved in national quality and value initiatives, please send your résumé or CV to quality@aota.org.

## References

American Occupational Therapy Association. (n.d.). *Volume to value*. https://www.aota.org/practice/practice-essentials/quality/volume-to-value

National Association for Healthcare Quality. (2024, April 17). *Healthcare quality week 2024*. https://nahq.org/event/healthcare-quality-week-2024/

Partnership for Quality Measurement. (n.d.). *About partnership for quality measurement (PQM)*. https://p4qm.org/about

**Jamar Haggans, MS, OTR/L, CPHQ**, is the Director of Quality at AOTA.

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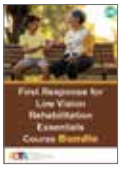
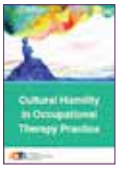


**First Response for Low Vision Rehabilitation Essential Courses.** These courses are a requirement for the First Response for Low Vision Rehabilitation micro credential. Order #OL8908


**Women's Health and the Role of OT** by Zesarae Bodie, OTD, MPH, OTR/L. Learn how to integrate holistic OT interventions into women's health, addressing life-altering concerns and fostering positive transitions throughout a woman's life. Earn .1 AOTA CEU (1.25 NBCOT PDUs/1 Contact Hour). Order #OL8963


**Occupational Therapy and LGBTQIA+ Health: Let's Start the Conversation** by Colton Sayers, OTR/L, CNS. This course will provide OT students, faculty, and practicing clinicians' greater knowledge and understanding of the unique characteristics of LGBTQIA+ individuals to enhance meaningful lives and participation in valued occupations. Earn .25 AOTA CEUs (3 NBCOT PDUs/2.5 Contact Hours). Order #OL8917


**Suicide Awareness** by Stephen Nawotniak, OTR/L, NYCPS. This basic course has been designed to assist occupational therapy practitioners in understanding more about the risks, warning signs of suicide, and how to respond and act in an appropriate manner. Earn .1 AOTA CEUs (1.25 NBCOT PDUs/1 Contact Hour). Order #OL8412




**Cultural Humility in Occupational Therapy Practice** by William Tarleton, DrOT and Sarah Corcoran, OTD, OTR/L. This course will educate participants on the principles of cultural humility and introduce them to strategies to implement those principles into practice. Earn .15 AOTA CEUs (1.88 NBCOT PDUs/1.5 Contact Hours). Order #OL8413

AOTA American Occupational Therapy Association

## Upcoming AOTA Events

Discover a variety of events and live webinars to earn contact hours.

**October 25–26, 2024**
AOTA Specialty Conference: **Mental Health**
Oak Brook, IL

**November 8–9, 2024**
**Education Summit**
Charlotte, NC

**December 13–14, 2024**
AOTA Specialty Conference: **Children & Youth**
Seattle, WA

**April 3–5, 2025**
**AOTA INSPIRE 2025**
Philadelphia, PA

Visit **aota.org/events/calendar** for an up-to-date list of professional growth opportunities.

# Continuing Education Opportunities

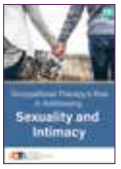
**Everyday Ethics: Core Knowledge for Occupational Therapy Practitioners and Educators, 4th Edition** by Deborah Yarett Slater, OT, MSOT, FAOTA. This important CE course provides an overview of key ethical theories, the Occupational Therapy Code of Ethics and Standards of Conduct, a Framework for Ethical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

**AJOT CE: Cognition Mediates Playfulness Development in Early Childhood: A Longitudinal Study of Typically Developing Children**. This article explores the development of playfulness and its relation to cognitive functioning from infancy to toddlerhood. Design: Longitudinal study with data collected at ages 6 mo, 18 mo, and 24 mo. Earn .1 AOTA CEUs (1.25 NBCOT PDUs/1 Contact Hour). Order #CEAJOT116

**AJOT CE: What If Deliberately Dying Is an Occupation?** This article aims to open a dialogue within the field of occupational science and occupational therapy about this sensitive and potentially controversial issue. Earn .1 AOTA CEUs (1.25 NBCOT PDUs/1 Contact Hour). Order #CEAJOT121

**Addressing Sexuality with Community Dwelling Older Adults** by Keeley Cowley, OTD/S. This course will serve as an introduction to understanding the importance of sexuality for older adults, the impact of the natural aging process, and how individual practitioners can address sexuality- related concerns within practice. Earn .1 AOTA CEUs (1.25 NBCOT PDUs/1 Contact Hour). Order #OL8372

**Addressing Social Determinants of Health in Occupational Therapy Service** by Sierra Clair, Dr.OT, OTR. In order to successfully address clients' social determinants of health, practitioners must first recognize their impacts on daily practice and determine which of the various levels within OT practice offers the best solution. This course will serve as an introduction to understanding social determinants of health, their impacts on clients, and how individual practitioners can address them on micro, meso, and macro levels. Earn .1 AOTA CEUs (1.25 NBCOT PDUs/1 Contact Hour). Order #OL8320



**Occupational Therapy's Role in Addressing Sexuality and Intimacy** by Tiffany Lee, OTD, and Jacqueline Marquez, OTD. The topic of sexuality and intimacy is often under-addressed by health care professionals, despite its importance to clients. According to the Occupational Therapy Practice Framework, engagement in sexual activity is not only an ADL, but can be a key aspect of social participation in the context of familial and peer/friend roles. The purpose of this course is to provide an opportunity for OT practitioners to increase their knowledge and confidence when advocating for an occupation that is often overlooked. Earn: .1 AOTA CEU (1.25 NBCOT PDU/ 1 Contact Hour). Order #OL5165.

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

**Occupational Therapy's Role in Trauma-Informed Schools** by Sharon M. McCloskey, EdD, MBA, OT/L, CTP; Meghan Suman, OTD, OTR/L, BCP, SCSS. The purpose of this course is to familiarize you with the typical response to trauma in the brain, and sequelae of experiences and behaviors that can occur when the thinking brain is deactivated, and the emotion brain takes the lead in response to future perceived threats. Also discussed is the need to address trauma through the inclusion of trauma-informed approaches within the school and school system. Earn .1 AOTA CEU (1 contact hour; 1.25 NBCOT PDU) Order #OL8376.

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

**3D Printing Adaptive Equipment for Individuals with Arthritis or Rheumatic Conditions** by Elizabeth Fain, EdD OTR/L and Jeff Powell, MS. This course offers an overview of arthritis and the impacts it has on occupations as well an overview of 3-D printing process from beginning to end. Earn .1 AOTA CEU (1.25 NBCOT PDU/1 contact hour). Order #OL8306.

**AOTA Fieldwork Ethics, Second Edition** by Deborah Yarett Slater, MS, OT/L, FAOTA. For most of us, there will come a time in our professional career when we will either work alongside or supervise fieldwork students. Awareness of ethical issues that may arise in these situations and thoughtful ways to analyze and resolve them is an important skill. This online course provides helpful information on fieldwork ethics to the student, fieldwork educator, and academic fieldwork coordinator. This course is appropriate for clinical fieldwork educators, academic fieldwork coordinators and occupational therapy and occupational therapy assistant students. Earn .15 AOTA CEU (NBCOT 1.88 PDUs/1.5 Contact) Order #OL8400

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

# Continuing Education Opportunities

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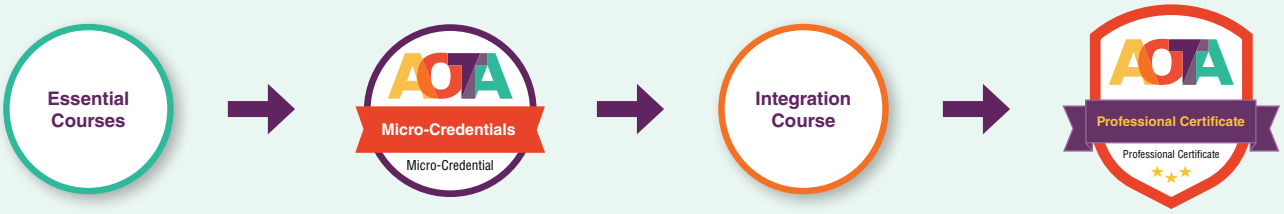
**Professional Certificates:** Completion of three related micro credentials, the associated Essential courses, and a final integration course.




## School-Based Practice Micro Credentials and Professional Certificate

### Essential Courses

These courses are a requirement for all School-Based Practice micro credentials and professional certificate.

**School-Based Practice Essential Courses**
AOTA Members: $89.85, Nonmembers: $114.25. Order #OL8375

### Micro Credentials

Complete these three micro credentials to earn a professional certificate in School-Based Practice or complete individually as a stand-alone micro credential.

**Supporting Social and Emotional Wellbeing in K-12 Micro Credential**
Total credit: .7 AOTA CEUs, 7 Contact Hours, 8.75 NBCOT PDUs. AOTA Members: $174.65, Nonmembers: $244.65. Order #OL8426

**Supporting Academic Achievement in School-Based Practice Micro Credential**
Total credit: .8 AOTA CEUs, 8 Contact Hours, 10 NBCOT PDUs. AOTA Members: $164.70, Nonmembers: $224.70. Order #OL8425

**Supporting Educational Transitions from K-12 to Adulthood Micro Credential**
Total credit: .7 AOTA CEUs, 7 Contact Hours, 8.75 NBCOT PDUs. AOTA Members: $149.70, Nonmembers: $214.70. Order #OL8450

### Integration Course

This course is the last step in completing your professional certificate in School-Based Practice, You must have already completed all required Essential courses, and the required micro credentials to take this integration course.

**School-Based Practice Professional Certificate Integration Course**
Earn .1 AOTA CEU, 1 Contact Hour, 1.25 NBCOT PDUs. AOTA Members: $19.95,Nonmembers: $29.95. Order #OL8434

## Home & Community Safety and Driving Micro Credentials and Professional Certificate

### Essential Courses

These courses are a requirement for all Home & Community Safety and Driving micro credentials and the professional certificate.

**Home & Community Safety and Driving Essentials Courses**
AOTA Members: $84.85, Nonmembers: $114.25. Order #OL8338

### Micro Credentials

Complete these three micro credentials to earn a professional certificate in Home & Community Safety and Driving or complete individually as a stand-alone micro credential.

**Participation, Resilience, and Wellness Micro Credential**
Total credit: .9 AOTA CEUs, 9 Contact Hours,11 NBCOT PDUs. AOTA Members: $154.70, Nonmembers: $214.70. Order #OL8337

**Home Modifications and Falls Prevention Micro Credential**
Total credit: .95 AOTA CEUs, 9.5 Contact Hours,11 NBCOT PDUs. AOTA Members: $198.75, Nonmembers: $279.75. Order #OL8335

**Driving and Community Mobility Micro Credential**
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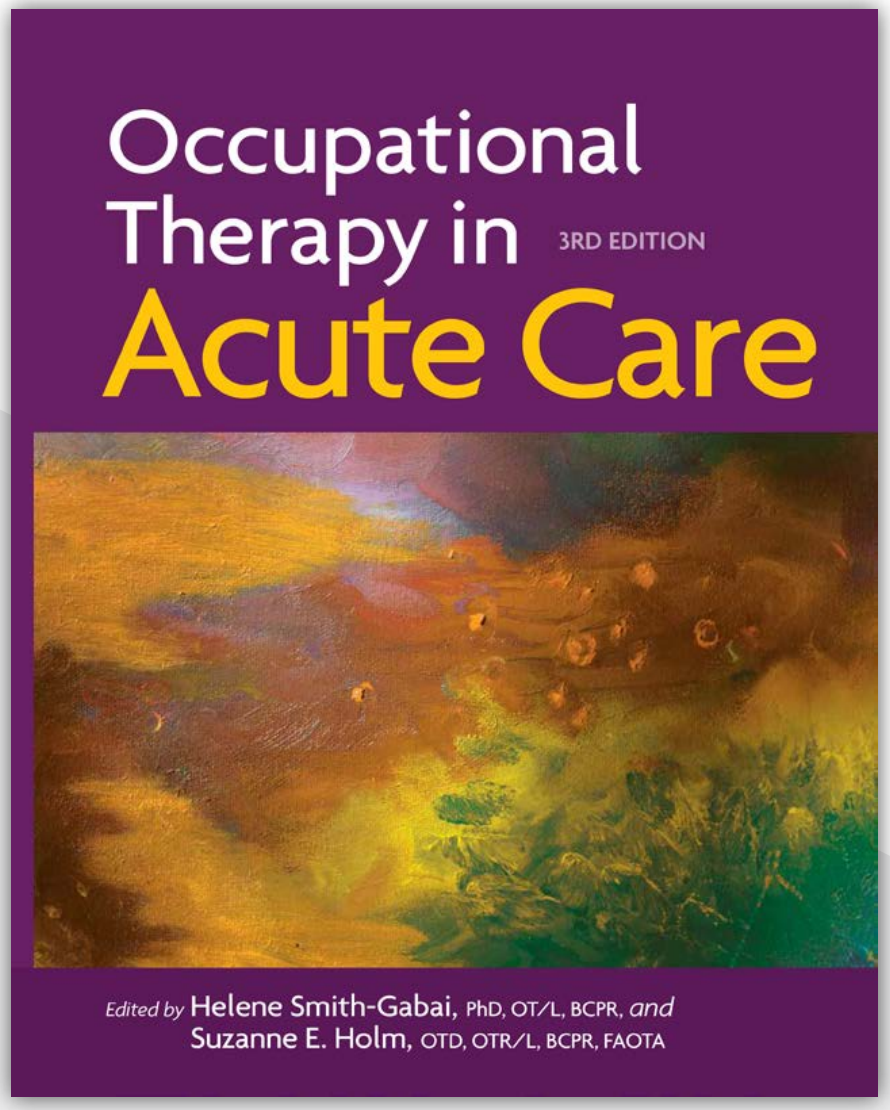


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