SPEAKER:
You are listening to everyday evidence presented by the American Occupational Therapy Association helping the occupational therapy practitioner apply evidence to practice. Here's your host, Matt Brandenburg.

MATT BRANDENBURG:
Alright. Today, we are joined by Dr. Gordon Giles, an occupational therapist and professor at Samuel Merritt University in California. For those of you who do not know Gordon, his research focus is on the rehabilitation of individuals with neurobehavioral disability and the assessment of functional cognition. Thank you so much for being on the show today, Gordon.

DR. GORDON GILES:
Oh, it's great to be here. Thank you so much.

MATT BRANDENBURG:
It's our pleasure. Gordon, you work with AOTA as a quality advisor. Can you tell us about that role?

DR. GORDON GILES:
Yeah, sure. I think I got onto the quality advisor panel because of work that we were doing on functional cognition, which we're going to talk about quite a bit today. AOTA in responding to CMS, which was itself responding to the impact Act and trying to put the role of occupational therapy forward in terms of the impact Act. Now, the impact Act's goal was to regularize and bring some uniformity to data collection across post-acute care settings. So, that's skilled nursing facilities, home health rehabilitation and LTAC long term acute care. So, we've been talking about cognition and what was the role of occupational therapists in assessing cognition. So, AOTA called a number of people to the offices when we were still in Bethesda. We had some discussions about what was being proposed. Our thought was what was being proposed was not all that it could be. And so my invitation to join the quality advisor panel came out of that in a push to try and get CMS to include measures on functional cognition.

No, this is happening at more or less the same time that we're moving from value to value. Right. And the recognition that health care in the future is really going to be driven by outcomes. And so what occupational therapists need to be able to do is to demonstrate that client outcomes are significantly improved by receipt of occupational therapy services. Part of that, or at least the beginning of that, is to make sure that we are assessing the right things so that we can intervene in order to improve those outcomes. What we started was looking at what are the things that occupational therapists need to assess in order for us to say that there's some uniformity in what occupational therapists do because at least some uniformity in what we do is about quality. Right. So, when you go to a restaurant, well, if you're like me and you're a creature of habit, you go to a restaurant and you like a meal and you want to go back and you want that meal to be the same. You want to have the same experience when you go back the second time and at that same meal as occupational therapist, we've kind of not had any uniformity in what we do necessarily with clients.

So, the idea of quality includes the idea that occupational therapists are going to address certain key functions in individuals. In my little corner of that is social cognition and that's how I wheedle my way onto the quality advisors panel.

MATT BRANDENBURG:
Absolutely. Thank you for sharing that kind of career path or opportunity that you had. It sounds like it's been a wonderful chance to advocate for our profession and really help set up our profession for success in assessing cognition and that's wonderful. So, thank you so much for that. And you've touched on it already. Functional cognition that's our topic for today. What is really meant by functional cognition and how would you say a functional cognition perspective differentiates OT from other professions?

DR. GORDON GILES:
No, I actually I think that that differentiation is one of the things that's most useful about it. So, I think that most occupational therapists would agree that cognitive functioning contributes to an individual's ability to manage in their world. But in a lot of ways, many of us have ceded cognition to other healthcare disciplines. So, the construct of function cognition is a little bit different from what other professions are interested in. Would say functional cognition is on the borderline between cognition and AOTAs. So, it involves executive function, it involves other aspects of cognitive function. It involves performance patterns, habits and routines and it also involves self-awareness. So, metacognition in terms of strategy, use and application. Social cognition is where cognition gets real life, it's where the rubber meets the road. So, we are less interested in some of the more abstract cognitive processes that are of interest to other disciplines, right? We're not slicing and dicing cognition in the way that certain other disciplines do.

We're looking at cognition at the performance level. We're trying to see does the individual have the resources available to meet the needs of their daily life? Usually, in terms of AOTAs, you can meet these needs in various ways. We know that people, for example, can use various strategies in the face of what might be considered underlying cognitive deficits in order to continue to perform AOTAs, even though they have even sometimes quite severe cognitive deficits. So, that's what we're looking at and we know, because the research is pretty clear that there is no one to one correspondence between demonstrating cognitive impairrment and demonstrating impairment in performance, even quite complex AOTAs. One of the things that's really useful about this is that it gives occupational therapists a place to stand when it comes to talking about cognition. That is quite different from the types of assessments and the way we think about intervention that is different from that of other disciplines.

MATT BRANDENBURG:
I love that. I love that. It's a very eloquent way to put OT's role in perspective on functional cognition. I love that phrase of helping people to learn how to manage in their world. And you have a very rich history in functional cognition. I want to ask, how did your early experience as a student and a practitioner lead you to really pursue research and everything you've done related to functional cognition?

DR. GORDON GILES:
Matt, I am very old and so I started. When did I start as a student of OT eighty three I think. Well, so I went to school at an occupational therapy school, called St. Andrews School of Occupational Therapy, which was the largest private psychiatric hospital in the United Kingdom. And it so happens that at that time, a group of physicians and neuropsychologists who would later become very famous were opening the first behavior disorder program for brain injured people in the world. Now, this is less impressive than it actually sounds, because at that time in the United States, there were seven programs devoted to working with people with traumatic brain injury. So, we have come a long way in terms of thinking about how to work with people with functional deficits based on brain damage. I kind of went around the houses there to get back to your question. We were developing ways to try and help people with very severe brain damage relearn basic self-care skills. So, we didn't call it this at the time, but we were essentially developing a perilous learning approach based out of behavior theory.

Now, a lot of people have kind of negative connotations around behaviorism and behavioral interventions. For us, what we were really taking from it was a set of mechanisms that would allow us through repetition and incentivization, ways to teach people self-care skills. So, that's what we were doing and that evolved with my colleague Joe Wilson in England into the neuro functional approach. Again, to get back to your question on functional cognition, an enduring question for me was how do you decide whether or not an individual is going to be able to make use of strategies, whether they're going to be able to help normative life, learn to adapt their behavior when given, you know, kind of put in the right circumstances or when encouraged to do so through experience or whether you're going to need to teach skills because the individual is not able to make the conscious adaptations that are necessary to improve their performance. And so really, for the last 40 years, this has been a preoccupation of mine.

How do we decide what intervention is going to be the most useful for an individual who has some level of cognitive impairments? And what are the kinds of assessments that we can use in order to direct our interventions? And really, the progress that has been made in functional cognition is really helping answer that question. Another bizarre aside from this is that a lot of the performance based testing of functional cognition was really stimulated by some papers that were written by Paul Burgess out of the UK. He, along with Tim Shallice, published a paper which really introduced the multiple Aarons test, which is quite a complex and interesting class. And a lot of the principles in that tests have been adapted into occupational therapy, performance based measures of functional cognition. Paul Burgess was a psych tech at the same time that I was an occupational therapist at this program in the UK. So, we've known one another for a long time. So, it's interesting that some of my interests have once again come back to the same area that Dr.

Burgess is working in.

MATT BRANDENBURG:
Absolutely. That is extremely interesting and I'm really happy that you brought up that question of how to determine what intervention or what approach is appropriate. I know for me as a student and a newer practitioner, that's a question that I'm constantly asking myself. And I'm so excited to have you on the show today to give us some guidance and then outline some of those approaches for our listeners and give some guidance on how someone can really determine what is appropriate. It really highlights the importance of this topic and what motivates you personally to generate and disseminate all this research and best practices? So, I'd love to just just go ahead and dive into functional cognition. What practice settings and client populations would you say are appropriate for applying principles of functional cognition.

DR. GORDON GILES:
Matt, it's an evolving area, right? And so this meeting that I told you about AOTA happened in 2015 and we have been working a group of which I am a junior member with both the Edwards (UNKNOWN) and others. We have been working on developing a screening tool called the Menu Task. And then the other great researchers John (UNKNOWN) for example. So, we can tell on the planning activity, the performance assessment of self care skills. And so now lots of performance based measures of functional cognition that can be implemented. So, let me talk a little bit about what they are, right? So, a performance based test rather than, again, slicing and dicing cognition into episodic memory, through the various types of attention and so forth. We really looking at cognition of the performance level and so we're giving individuals a relatively complex chance to perform in which we're setting the parameters of the performance, but then allowing the person to do it any way that they can. While the administration is standardized the way that the individual test taker is going to solve, the problem is really left up to them.

We're often looking at things like initiation inhibition, self regulation, safety awareness, or I should have mentioned also the executive function performance test would be another performance based measure of functional cognition. So, you're giving people a relatively complex task and say no have at it and see what you can do. And then we'll also frequently in these tests asking people to predict how they're going to do, to tell us how they did and to tell us about any errors that they made during the performance. You know, as I mentioned before, one of the principal components that we talk about and function cognition is self-awareness or metacognition. If an individual can't recognize that mistake. It's really tough to get them to use strategies. So, one of the things we're looking at is how does the person perform the task? And then another thing we're looking at is what is their awareness of the way that they perform that task? So, I and Dorothy Edwards from the University of Wisconsin and Tim Wolfe from University of Missouri and also a graduate student Tim Marks at the University of Wisconsin have been working on a menu task where we have people who sign a piece of paper.

We tell them certain rules that follow and we ask them to pick out menu items for breakfast, lunch, dinner and snacks while, as I said, following certain rules. That's a screening task that we have been using with people in the community. We've probably administered that to six or 700 people at this point and have been looking at its ability to predict the performance of more complex performance based assessments. So, when I go back to talk about quality, one of the things that certain classes of individuals that we see or with certain diagnoses that we really I think should be assessing is functional cognition. I think it will really help us in selecting treatment outcomes. So, one of the objections to performance based tests is that they take too long. So, we have been focused on trying to develop a particular test, the menu test that takes three or 4 minutes. So, at the moment we administer this in community settings. It has also been administered in acute care settings. We were with Tim Marks, the Ph.D.

student at the University of Wisconsin. We were right on the cusp of doing acute hospital of large acute hospital study, and then COVID hit and everything stopped. So, I think we're just about to begin that again, other people have been using it. It's being translated into about seven different languages at the moment. But there are also things like the weekly calendar planning activity that have shortened versions where people are beginning to report using these in acute and post-acute care settings. So, typically when you do a screening test or you screen somebody in some way, you do that when you don't know if the individual has a problem. So, you screen if the evidence suggests that there is a problem, then you move forward to more of a diagnostic assessment. So, as you know, occupational therapists often have to move very, very quickly. There are lots of benchmarks that we need to hit. So, you can't spend 20 minutes assessing whether or not somebody has a cognitive problem. In many, many settings.

So, testing screening tools can be really helpful. Right now we are thinking community post-acute and acute care settings. But then the issue becomes actually getting the word out and talking with people about actually doing this.

MATT BRANDENBURG:
We'll get back to our interview right after this quick message. You all know we really try to make research more consumable and applicable on everyday evidence. But did you know that just one minute of your time could help us to improve the show, improve the resources? The American Occupational Therapy Association provides for practitioners and improve the application of evidence to practice within our whole field. Please take our one minute survey. It's only three questions and you can find the link in this and every episode's description and support the AOTA in continued efforts to improve our podcasts and to improve the translation of research to practice. Now, back to the interview. Absolutely. That's always a challenge that that dissemination piece. I think this information is painting a really wonderful picture of how functional cognition is used to address performance skills and patterns, really across a variety of settings within OT. Those are some great tips and recommendations for being effective in screening and assessment as well.

And I want to follow that up by asking you what are some effective occupational therapy interventions that you would encourage practitioners to implement after completing an assessment that includes an occupational profile?

DR. GORDON GILES:
So, Matt this is one of the major advantages, I think, of performance based testing of functional cognition, right? Because it's at the performance level. So, it really helps guide therapists into what to do with clients. And as the instructors, I have capstone students. And I've been teaching a course on functional cognition. And the only thing about capstone students is that, or at least prior to COVID, they were off doing their level tw iInternships. And then they came back and they would take my application course. And what they were saying was that it was really difficult because many practitioners, they will find they really did not know at what level to intervene with individuals who had cognitive impairments. And so the nice thing about function cognitive assessments is that it really helps in that decision making process. As I said before if you really have no insight into the errors that you're making, you can't really use strategies. Now, they could be attempts to help people develop that insight but depending on how profound the lack of insight is, that can be an uphill struggle.

So, I think the basic rule would be is the person able to adapt their behavior based on feedback? If the person is able to adapt to the behavior based on seeing their own performance or being guided to see their own performance deficits, then I think there is the opportunity to strategy based interventions. So, things like don't Toby is multi context approach or Helen Paula touch close up intervention in a processes of guided discovery where the individual is adapting their performance on the fly to try and improve their performance. If an individual is really not able to make use of those kinds of interventions, then I think we should be thinking about skills training. What are the specific things that an individual needs to be able to do in order to function in their environment? And you would also so you you'd think that and then you would also think about environmental modification, environmental support. So, if the client can kind of learn about their deficits and adapts, even if that's quite structured by the therapist, then a strategy training approach is going to be useful.

If they're not, then still have it training or environmental modification. It's going to be more useful for them. Now, that, of course, is at the very basic level in terms of the decision tree. I mean, you're basically developing two or three parts. Many of the performance based tests of functional cognition, such as the weekly calendar, the planning activity, gives you a ton more information about how the individual learns and how they're going to be able to adapt their performance that you can build into your intervention plan.

MATT BRANDENBURG:
I love that. Thank you for emphasizing that, that keyword insight and the ability to adapt behavior. It sounds like such a key performance factor or pattern for practitioners to look for when they're conducting these assessments. And you mentioned the difference between kind of more skill training or strategy based. I want to focus now on the neuro functional approach which you helped to develop, and it has been demonstrated to be the only training approach to accelerate recovery in the early period following traumatic brain injury. What is the neuro functional approach and when is this form of skill or habit training appropriate to be used in practice?

DR. GORDON GILES:
Yeah, no. I mentioned this a little bit earlier when we were at the behavior disorder program for people with brain injury. We were really interested in the mechanism of practice. How does practice facilitate performance? And so one of my colleagues has said that you want people to initially to practice till they can get it right, and then you want them to continue to practice until they can't get it wrong, which was episode five, but not mine. Initially, we started with a very straightforward behavioral approach, in which we were attempting to reward people in some way for engaging in our program. So, that's because we were working a behavior disorder unit and people were quite irritable a lot of the time. When I started working with people who were less behavioral disregulated. I realized that most people want to learn, and particularly they want to learn skills. If you're not confronting them about the fact that they have a head injury and they have deficits. So, we don't talk about that at all, we develop relationships and we engage people positively on their own goals.

Now, this is sometimes problematic because sometimes patients want to learn things that we don't see as particularly bad at all. But know you're going to work with the patient in terms of doing things that they want to do. And so you get some relationship leverage in order to do things that you want to do because you think they will be really helpful for the patient. So, you know, I work in California here. We have a lot of individuals with head trauma who don't have much insight. And so you really can't have a conversation with many of the clients that we work with about improving their street crossing safety. But they'll walk with you to the 7-Eleven to buy a bag of chips. Right. So, it's a question of finding the goals that you can engage with the patients about and then setting up repetitive practice systems where you can do the same thing in the same way over and over again until it becomes an automatic behavior for the patient, particularly if you're working on things that are reenacted frequently.

It becomes that the patient can't get it wrong. Right. So, for example, I have friends, people who are many years post injury and who have been unable to bathe and dress themselves for years. We trained them to be independent bathing and dressing themselves in in sometimes just a few weeks. On a couple occasions, I had the opportunity to go back and talk with individuals ten, 15 years later. And I asked them how they learned how to bathe and dress themselves. And they looked at me like I'm a man and said, I've always done it like this. And they're doing it exactly the way that they were taught. So, when we saw it, we were doing it really in the post-acute care setting. And so what has been so exciting recently is the application of the neuro functional approach to people with severe brain injury during post traumatic amnesia. So, the period that follows a severe traumatic brain injury where the individual cannot remember any individual discrete event, so they will be frequently confused about why they're in the hospital.

They won't know that they've had a head injury and they won't remember any individual interaction. But they have with another person or with the therapist. But what has been demonstrated in a reasonably large, randomized controlled trial is that the application of this approach of having people practice AOTA's and simple AOTA's over and over again while in the hospital both improves their performance. And although this was not statistically significant, but it was if you actually eyeballed the data, it accelerated recovery and got individuals out of the hospital faster. Now, I should say that that was not statistically significant, but when you look at the numbers, it's a pretty clear trend towards that acceleration of hospital discharge. I had nothing to do with this study, it's pretty exciting. You know, you put yourself out there and there've been now three pretty large randomized controlled trials looking at the functional approach and its application and it's looking pretty good.

Then of course, it's only one habit training technique. There are, others. Right. So, what we did was just combine these behavioral methods of structuring practice with really a relational and a client centered approach.

MATT BRANDENBURG:
I love that. And that's so fascinating that these outcomes have been observed in different studies, and those components of being clients centered and setting up those repetitive practice scenarios are so important. What principles should practitioners really be considering and doing their best to follow when implementing these types of interventions?

DR. GORDON GILES:
Relationship is so important, right? And it's really hard because we really rush. But establishing a positive therapeutic relationship with the individual with whom you work and really thinking about the language that you use. So, in the neuro functional fights, we try and avoid any kind of language that is suggestive that the individual is impaired or damaged in some way. So, everybody needs to relax. Everybody needs to use some kind of structured way to remember what they need to do. So, we're really looking at non-confrontational language where the individual is not put in a position where they need to assert their independence in order to maintain their sense of self-worth. So, that the idea of relationship is, I think, really central of central importance.

MATT BRANDENBURG:
I love that. I love that emphasis of relationship and that the non-confrontational language can be so instrumental in helping someone to achieve the best outcomes possible. I know there's a question I've had when learning about these types of neuro functional approaches and that's trying to determine how you can ensure that you're helping a client to integrate thinking and their own performance skills and patterns into their daily routines, while not isolating or addressing components of cognition out of context. How how would you recommend a practitioner do that?

DR. GORDON GILES:
Well, you know, Matt, what we do is we really look at the tasks that the individual needs to perform. And so we are not again, we are not practicing remembering, for example, we're practicing doing a task that the individual needs to do. So, the clinical relevance for the client is often very apparent. Now, sometimes if the individual doesn't recognize that they have a problem, you need to do this, incidentally. So, for example, I can't say to a client, let's go practice crossing the street safely but I can say let's go to the 7-Eleven and buy a bag of chips. And then on the way, we're going to be practicing crossing the street safely, using exactly the same cues and exactly the same behavior as each time we cross. What we're doing is breaking down a functional task into the key decision points and then practicing those repetitively. Now, honestly, this can actually, for some of us that are occupational therapists really focus on the way that we change and adapt things. So, one of the things that is a little bit tricky in the neuro functional approach is, you know, once you set up the program, you just do it over and over again.

So, it can feel a little bit like skill loss that some of the feedback that I've got from people. But in the Australian study, when the therapists were actually interviewed after they had really learned the neural function approach and got into using it, what they said was they found that their relationship with the client was much stronger and that the engagement in the activity of rehab was also much better. So, it's a little bit of a different way of doing things. But therapists, once they got the hang of it, find it quite pleasant to do.

MATT BRANDENBURG:
But absolutely, it sounds like a wonderful intervention. And I love those key points of finding the relevance to the client, identifying key decision points and using the same cueing over and over. What tips could you give practitioners about maintaining that cueing hierarchy or using the same cues over and over? How would you recommend they do that efficiently?

DR. GORDON GILES:
So, one of the fun things about working with people with neurological impairments, right, is that everybody is different. So, we do a test analysis for every individual. One reason that we do this is that learning is difficult. Alright. So, learning is hard. So, you don't want to teach people, we don't teach people to do things in ways that are not natural for them. So, for example, an individual might bathe and dress themselves in a certain order. We're not going to change that order if that's the natural order that the individual has then we want to incorporate that into a program that allows the person to be successful. A lot of these programs with people with severe brain injury where we're working with both cognitive and (UNKNOWN) deficits, and so we're developing a program of trance, for example, that allows the person to be successful. And then once we've established that typically as a set of prompts that are written down and then just enacted by everybody who is working with that client.

So, we will write it down. Now, more recently, there's been a lot of work on automated smart cueuing systems. I have not been involved in that, but I've been really excited by these prompting systems that are, of course, portable, are adapted specifically for a client, and that can be then used for a period of time and then discarded once the client has actually developed the skill. So, that's really something that's exciting in terms of smart technology being employed, being applied to this kind of intervention.

MATT BRANDENBURG:
And that does sound very exciting, very interesting to look into more. You've already shared a couple great examples of, you know, going to 7-Eleven for a bag of chips that you're showering or grooming example as well. Is there another case study or personal example of when you have implemented an evidence informed approach that helped someone with cognitive deficits attain a positive health outcome that you could share with us.

DR. GORDON GILES:
Well, I'm not sure I can hit all of those Matt, but so one of the things that came to mind was a gentleman who was who had had a stroke and who was a small business owner. And that's always a mid-sized business and was trucking company. And he was the person who supervised the scheduling for his drivers. And so he had had a stroke, he was in acute rehab. And this is actually based on one of my graduate students who gave the client, administered to the client that we could count on planning activity. Right. So, in a week of calendar planning activity, the full adult version, an individual is given a blank calendar and is asked to enter 17 different activities into a weekly calendar. Now, they have to follow certain rules, and there are built in conflicts in these activities that they have to enter. So, they have to kind of manage these conflicts. So, this gentleman who, as I said, was managing a trucking company and has had a stroke, was given the weekly calendar planning activity completed in about 10 minutes while saying that this was something that he did all the time and it was no problem for him at all.

And he made a total hash of it. It was a disaster, and he had absolutely no insight into the fact that he'd made a total mess of it. And even with some encouragement and cueing to look back at it to see if he had made any errors, he was completely rejecting of the idea that he could have made any errors because this is something that he did. So, with his permission of course, the conversations were taking place with these family members and work colleagues that he could not, even though he thought he could, he would not be able to go back and without close supervision, be able to manage this company, at least in the state that he was at this time. So, this is I think we probably saved the business by administering the weekly time on the planning activity because you know that the thing is that the evidence that we have is that and this comes back to quality is that a lot of individuals who are potentially at risk for having functional cognitive deficits look pretty good. They told the story and can be missed the fact that they have even sometimes quite significant cognitive deficits and we overlooked.

Now, again, this is particularly the case when you're in a fast paced environment. The client may not be in the setting for that many days. And so. Screening is really important in terms of getting that quality that we're interested in. Now, of course, screening and assessment is not that age, but if you don't identify that the individual has a problem, then you can't intervene in order to improve those outcomes. And for us as a profession going forward, we're going to be judged, as I said at the beginning of this podcast, we're going to be judged by the outcomes that we can produce the clients. And so that is what is important. But first, you have to identify there is a problem. Then you have to decide how you're going to intervene in a way that is going to impact the client's ability to perform in the real world.

MATT BRANDENBURG:
Absolutely. I love that. Gordon, thank you for sharing that example and a follow up. What did the intervention look like for this individual who had experienced the stroke?

DR. GORDON GILES:
Well, for this particular individual, the first line of defense was actually to stop him from doing this without supervision. So, the idea was that this family that were also involved in the business would then divide up the activities so that there were things that he could do that were independent and would make him feel OK about himself but would not destroy the company. And so really, it was environmental and social support that was central here to having this work for the client and for the other people who are involved in his life.

MATT BRANDENBURG:
Absolutely. That's a wonderful example. Thank you again for sharing that. Gordon, you also the Eleanor Slagle Award recipient for 2018, kudos for that. In your lecture titled Neurocognitive Rehabilitation Skills or Strategies, you share some additional aspects of your background and personal experiences with functional cognition. And I did want to ask you about that lecture and if there's anything you'd like to say or summarize for our listeners on that today.

DR. GORDON GILES:
Well, it was incredibly nerve wracking. I knew that I was probably never going to spend as much time preparing for it all ever again. So, it took me about six months to put it together, and so many people helped me. It was so great. My colleagues at Sonoma University, people at the University of Wisconsin allowed me to pilot it. And so it was a lot of fun doing it. So, but it was part of it, we kind of back to quality because one of the reasons that I was so excited about having the opportunity to do the Eleanor Slagle lecture was the idea of putting some of this information out into the world about functional cognition and how you make decisions as to what kind of intervention you're going to provide for a client. So, you know, there's lots of evidence from all kinds of disciplines that from the inception of an idea that people believe will improve outcomes, to actually having it adopted by people throughout a profession can take, you know, decades. And so a lot of what we have been trying to do within the Quality Advisors Group is really look at ways to interact with AOTA membership to kind of spread the word that functional cognition is a construct that can be really helpful for occupational therapists, that we can address functional cognition as part of a quality toolkit.

It's one of the benchmarks that we need to hit along with for seniors, for example, activities of daily living AOTA's, vision, fold, prevention and fear of quality, fear of falling and participation notes. One of the things that would indicate if we can get some uniformity across occupational therapy providers and, you know, no one's ever going to tell occupational therapists what tools they need to use or what they need to do. But if we can get some uniformity in at least addressing some of these issues and people who are at risk of having deficits in these areas, as it's just something that occupational therapists check in on, that it's definitely a step in the direction of having uniform quality across occupational therapy providers and giving us more of a chance to really improve outcomes.

MATT BRANDENBURG:
I love that the importance of improving and uniform being a quality among our profession. And you've mentioned a number of resources that I would love to link our listeners to. One being you Slagle lecture. And if you could send me a link to the menu task and maybe some of what you touched on with the automated prompting devices. I can make that available for listeners in our episode description as well.

DR. GORDON GILES:
Sure. I would also grow people's attention to the quality toolkit on the AOTA, the lovely revamped AOTA website. So, there's quite a lot of material on the energy website. As I said, the quality toolkit and you just put in the magnifying glass functional cognition, a lot of stuff comes up.

MATT BRANDENBURG:
Perfect. I love that will encourage our listeners to check that out as well at aota.org. Gordon, this has been a wonderful interview. Thank you so much for sharing your knowledge and your expertise in this area. And I have just one question for you now. This is our concluding Golden Nugget segment. Gordon, if you could give one piece of advice or share one piece of knowledge with OT practitioners, what would you say?

DR. GORDON GILES:
Gosh. Well, you know, I'm kind of going to reject the question, Matt, and I'm going to talk about evidence based practice. And I would say that if you're going to adopt functional cognition as part of your professional practice, what you really need to be able to do is to develop a peer group of supporters in the place that you work to encourage and share resources and knowledge. And the reason I'm saying that is that there's evidence that really helps. There's a recent survey in The Australian journal OT on functional cognition and what helps people actually incorporate functional cognition into that, into their professional practice. So, getting like minded people around you to help support your practice.

MATT BRANDENBURG:
I love that setting up a community and setting yourself up for success by so doing. That's a wonderful piece of advice. Gordon, it's been a true pleasure having you on the show. Thank you again so much for your time.

DR. GORDON GILES:
Well, thank you for the opportunity there.

MATT BRANDENBURG:
Absolutely.

SPEAKER:
Thanks for listening to Everyday Evidence. Tune in next time for more evidence based practice, insights and applications.