Low Vision in Skilled Rehab

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Running the Gamut

This issue’s variety underscores again the wide-ranging nature of occupational therapy, across populations and practice settings. The cover story on page 8, for instance, shares some practical suggestions on helping address low vision issues geriatric clients may face in skilled nursing facilities. The latest continuing education article (p. CE-1), meanwhile, looks in-depth at suicide survivors and those at risk of suicide, including warning signs and how occupational therapy practitioners can identify appropriate clinical considerations and resources to help. Showing the profession’s geographic reach, the Around the World article on page 21 provides a quick take on the state of occupational therapy in Guyana and how one U.S.-based therapist has helped support occupational therapy’s emergence there. Finally, the On Campus article on page 23 reports on how one university in Florida, in the aftermath of Hurricane Irma, gained greater appreciation for the value of occupational therapy for disaster response.

As the year draws to a close, we’ve already well into planning issues for the coming year, in an effort to continually cover what’s new and interesting in the profession as well as provide a window into the much more extensive content on occupational therapy available on AOTA’s website, at www.aota.org. Any ideas about particular topics or issues we should be covering more or in addition? Send us a note to let us know.

The drawing to a close of the year also marks the end of the profession’s year-long celebration of its founding 100 years ago, which occupational therapy practitioners and students have contributed to all across the country, and even in a number of places outside the United States as well. Thank you to all for contributing your energy and great ideas for the Centennial, and remember, it’s still not too late to take part in this year’s celebration (visit www.OTCentennial.org) and help set the course for the next 100 years to come.
CMS Drops Proposal to Change Home Health Payment System

The Centers for Medicare & Medicaid Services (CMS) announced that it will not finalize a proposal that would have changed the payment system in home health agencies. AOTA had alerted members to this proposal, which it believed would cause reductions in the use of occupational therapy in home health agencies. AOTA submitted comments to CMS outlining its major concerns and urged members to do the same.

The decision to not finalize the proposed changes was a result of the comments CMS received in opposition to the new payment methodology. CMS announced that commenters were most concerned about the proposed change in the unit of payment from 60 to 30 days, and that such changes were being proposed for implementation in a non-budget-neutral manner.

As CMS continues to look at ways to change payment policies in home health, AOTA plans to meet with CMS officials to offer recommendations that ensure Medicare beneficiaries can receive medically necessary occupational therapy and other services when they need it.

For more information, visit https://goo.gl/2Qj5dq.

Update on Efforts to Repeal the Therapy Cap

At the end of October, the three Congressional Committees that oversee the Medicare Outpatient Therapy Cap announced that they had reached a bi-partisan bicameral (both House and Senate) agreement on a policy framework that would permanently repeal the therapy cap.

The draft policy, which must still go through the usual legislative process, would repeal the therapy caps but continue with some activities to ensure appropriate utilization: requiring an appropriate modifier (the KX modifier) certifying medical necessity and reasonableness, and continuing the current system of targeted review of claims over a $3,000 threshold. AOTA supports this framework for a permanent repeal of the Medicare therapy cap.

AOTA has been working with staff in the House and Senate, and the Committees have made repealing the therapy cap a priority. A study done through AOTA in early 2017 has been used by staff to make judgments about how to craft the policy. The proposal has not yet been introduced as legislation.

For the past 20 years, after the passage of the Balanced Budget Act in 1997, there has been a threat that consumers would be limited in the amount of occupational, physical, and speech-language pathology therapy they could receive under Medicare Part B. Congress has kept this limit or “cap” from going into effect, but should Congress fail to act by the end of 2017, a cap will go back into place. AOTA has worked alongside the American Physical Therapy Association, the American Speech-Language-Hearing Association, and a coalition of consumer organizations to repeal this.

For more updates and information on how to support the permanent repeal, visit www.aota.org/advocacy-policy/federal-reg-affairs.

Centennial Spotlight

Collaborating With NASA

In this photo from March 20, 1973, Celeste Thompson of Los Angeles, who developed a severe case of Poliomyelitis at 19 years of age, visited Capitol Hill to demonstrate a multi-channel proportional control unit developed for use in the NASA Marshall Space Flight Center’s Teleoperator-Manipulator Program by Rancho Los Amigos Hospital. Applications for this control unit can be adapted for people with artificial arms with powered hooks and for those with paralyzed arms. This proportional control system was part of NASA’s Technology Utilization program.

For more photos highlighting the past 100 years of the profession, visit www.OTCentennial.org.

PHOTOGRAPH COURTESY OF THE ARCHIVE OF THE AMERICAN OCCUPATIONAL THERAPY ASSOCIATION, INC.
2018 AOTA Award Recipients

OT Award of Merit
Ruth Zemke, PhD, FAOTA

Eleanor Clarke Slagle Lectureship Award
Ellen S. Cohn, ScD, OTR/L, FAOTA

Roster of Fellows
M. Irma Alvarado, PhD, OT/L
Cynthia S. Bell, PhD, OTR/L
Aaron M. Eakman, PhD, OTR/L
Katharine Preissner, EdD, OTR/L
Jessica Presperin Pedersen, OTD, MBA, OTR/L, ATP/SMS, RESNA Fellow
Lorie Gage Richards, PhD, OTR/L, FAHA
Susan Robosan-Burt, OTRL, FMOTA
Arline A. Schmid, PhD, OTR/L
Ashley Stoffel, OTR/L, OTR/L

Recognition of Achievement Award
Kerryellen Griffith Vroman, PhD, OTR/L
Amber L. Ward, MS, OTR/L, BCPR, ATP/SMS
Missi A. Zahoransky, MS, OTR/L
Debra S. Zelnick, OTR/L, OTR/L

Gary Kielhofner Emerging Leader Award
David S. McGuire, OTR/L

Outstanding Mentor Award
Meira L. Orentlicher, PhD, OTR/L, FAOTA

Health Advocate Award
Catherine Risigo Wickline, MS, OTR/L

Award for Excellence in the Advancement of Occupational Therapy
Marjorie E. Scaffa, PhD, OTR/L, FAOTA

Lindy Boggs Award
Karen M. Sames, OTR/L, OTR/L, OTR/L

Terry Brittell OTA/OT Partnership Award
Kimberly Breeden, MS, OTR/L
Nicole Rowe, BA, COTA/L

Outstanding Student Advocate Award
Nuriya Neumann, OTS

Emerging & Innovative Practice Award
Rachel Ashcraft, MS, OTR/L
Susan Bazyk, PhD, OTR/L, FAOTA

Patricia Jean Precin, PhD, PsyD, NCPsyA, LP, OTR/L, FAOTA

Academic News

Carolyn Baum, PhD, OTR/L, FAOTA, Elias Michael Director and Professor of Occupational Therapy, Neurology, and Social Work at Washington University in St. Louis, received a Distinguished Faculty Award from the university, in a ceremony for which Baum is the first occupational therapist to receive the award.

Students in the University of Washington’s Landscape Architecture Design Build Studio program working in collaboration with students from the 2016 Western Michigan University Department of Occupational Therapy Grand Rapids cohort were awarded the 2017 American Society of Landscape Architects (ASLA) Student Community Service Award of Honor for their work. The Garden of Earth and Sky was installed at the Puget Sound VA Hospital. Professor Daniel Winterbottom, RLA, FASLA, and Amy Wagenfeld, PhD, OTR/L, SCEM, FAOTA, accepted the award on behalf of the student cohorts at the ASLA Annual Meeting in October.

AOTA for You

Occupational Therapy Interventions for Adults With Low Vision
M. Warren & E. Barstow
This book provides an occupational therapy approach to all aspects of low vision, from evaluation to intervention and rehabilitation. $89 for members, $126 for nonmembers. Order #1252.

Early Childhood: Occupational Therapy Services for Children Birth to Five
B. E. Chandler
This book covers relevant federal legislation and the profession’s expertise in transitioning early childhood development into occupational engagement in natural environments. $69 for members, $98 for nonmembers. Order #1256.

To Order: http://store.aota.org (enter order # preferred) or call 800-729-2682
Tricare Reimbursement of OTA Services Advances in Congress

The House and Senate recently released legislative language that marks a major victory for occupational therapy assistant (OTA) services. The “must pass” National Defense Authorization Act for FY 2018 (NDAA), includes language that allows OTAs and physical therapists assistants to provide services under the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS), or TRICARE.

In May, AOTA had confirmed that Tricare would not cover services provided by OTAs, as they are not authorized providers under CHAMPUS. The same discrimination has been applied to physical therapist assistants. During the last several months, AOTA and the American Physical Therapy Association have advocated strongly for Congress to fix this policy.

The corrective language was included in the annual NDAA, which authorizes the existence of the U.S. Military and related programs, including TRICARE. Authorization bills for the National Defense must be passed every year. On October 9, the House and Senate released their compromise NDAA language, which included a section on “authorization of physical therapist assistants and occupational therapy assistants to provide services under Tricare.”

At press time, the House was scheduled to vote on the final bill in mid-November, with the Senate intending to vote on the bill by early December. This will clear the way for the bill to be signed by the President before the end of 2017. Once signed into law, the DOD will be required to update its policy manuals and regulatory guidance, and finally include occupational therapy assistants as TRICARE providers.

For more on this, visit https://goo.gl/6yGYWu.

Practitioners in the News

Lisa Davis, MA, OTR, and Marilyn Rosee, MS, OTR, presented to occupational therapy students at South London University on early November on the topic of “Wake Up Your Emotional Intelligence: Developing Professional Competencies for Professional Success.”

Helen Osborne, MEd, OTR/L, received the Alvarez Award from the American Medical Writers Association for her work promoting health literacy.

Roseann Schaaff, PhD, OTR/L, FAOTA, was featured in a Philadelphia Inquirer/Daily News article on a program that trains medical students on caring for a patient with autism.

Sally Wasmuth, PhD, OTR, of University of Indianapolis and Victoria G. Wilburn, DHSc, OTR, of Indiana University were interviewed by an ABC-TV affiliate channel (WRTV6) in Indianapolis, Indiana, on the value of occupational therapy for helping people with persons with addiction and in recovery (https://goo.gl/XaLkpC).

Questions?: 800-SAY-AOTA (members); 301-652-AOTA (nonmembers and local callers)
The Affordable Care Act (ACA), with all its benefits and requirements, is still the law of the land. The fifth open enrollment period is happening now, and plans are still required to cover rehabilitative and habilitative occupational therapy services. But a new proposal from the Trump Administration could roll back that requirement, even if Congress fails to repeal the ACA.

The health insurance marketplaces in every state, the financial help for low and moderate income enrollees, and the essential health benefits (EHBs) are all still in play. And, as of press time, so is the tax penalty for not having insurance. In most states, the 2018 open enrollment period runs from November 1 to December 15, half as long as last year, although a few states have extended their open enrollment periods.

This year the Administration cut outreach and enrollment assistance, so in most places there will be fewer advertisements promoting open enrollment, and fewer workers giving in-person help. But shoppers who can navigate the process might be able get a better deal than they did last year.

In October, the President shook up open enrollment by announcing that he would stop funding cost-sharing reduction payments (CSRs). CSRs, which reimburse insurance companies for lowering the out-of-pocket costs of lower-income marketplace enrollees, are different from premium tax credits, which go to a wider swath of enrollees to help with their premium costs. Insurers are still legally required to provide CSRs, even if the federal government is no longer reimbursing them for it, so eligible enrollees will still get plans with reduced deductibles and copayments. And many more will get more generous tax credits. When insurance companies increased their premiums to recoup the lost CSRs, many states loaded all the CSR-related increases onto silver plans, and because tax credit amounts are based on the cost of silver plans, tax credit–eligible enrollees will end up getting bigger subsidies. However, people who make too much to qualify for subsidies will bear the brunt of the CSR-related premium increases.

Just days before the start of open enrollment, the U.S. Department of Health and Human Services (HHS) released the proposed Notice of Benefit and Payment Parameters for 2019, the annual regulation that sets out the rules of the road for ACA marketplace operations. In it, HHS proposes to cede much of the federal government’s power over the EHBs to the states.

Currently, states fill in the details of the EHB package by selecting a “benchmark” plan that other plans must emulate. Under the new regulations, states would still have to offer the 10 EHB categories, but they would have more freedom to define what those categories cover. States could replace their whole benchmark with the benchmark from another state, or piece together a package made up of EHB categories from different states. Or states could select a brand new benchmark plan, as long as it isn’t more generous than the one they already have.

For more updates, visit https://goo.gl/lo0MWH.

Laura Hooper is AOTA’s Manager of Health Policy.
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GERIATRIC LOW VISION

By Kelsi Gagne and Cathy Peirce
Incorporating Low Vision Screening and Intervention Into the Skilled Rehabilitation Setting

Age-related low vision can severely hinder older adults’ independence and socialization, and it puts them at a higher risk for falls.

The eye naturally changes with the normal aging process, gradually beginning at 40 years of age (Kaldenberg & Smallfield, 2013). Macular degeneration, glaucoma, and diabetic retinopathy are the three most prevalent conditions affecting adults 65 years of age and older that cause diminished vision that hinders their daily occupations (Kaldenberg & Smallfield, 2013; Warren & Barstow, 2011). Age-related low vision can severely hinder older adults’ independence and socialization, and it puts them at a higher risk for falls. Occupational therapists need to incorporate low vision screening and intervention in the skilled rehabilitation setting to maximize their clients’ occupational performance by assisting those who have difficulty performing their activities or occupations of daily living successfully (American Occupational Therapy Association [AOTA], 2014).
A person can be labeled as having low vision when corrective lenses, medicine, or surgical procedures do not increase their ability to function in everyday tasks (National Eye Institute, n.d.). Low vision impairments can be classified into three levels: near-normal vision, low vision, or near blindness (Colenbrander & Fletcher, 1995). The World Health Organization further classifies low vision based on the Snellen chart for visual acuity, in which low vision starts at 20/80 and increases up to 20/1000, which is profound low vision (Colenbrander, n.d). A person with mild low vision (20/80) should have the ability to use a magnifier to read, whereas a person with profound low vision (20/1000) may use talking books because they can only spot read with a magnifier.

Low vision impairments have a costly effect on the health care system, and this cost will likely increase as the elder population steadily grows. In Maine, where we (the authors) are based, the direct cost of providing services for people over the age of 65 years with vision problems was estimated at $320 million a year, and the indirect costs (e.g., lost productivity) at $354 million (Prevent Blindness America, 2013). In the United States, low vision among people over 40 years of age leads to tens of billions of dollars in medical expenses, lost productivity, and other direct and indirect costs (Rein et al., 2006). Clearly, the prevalence of low vision in older adults indicates a need for increasing attention from the health care system and additional interventions to meet the needs of this growing population.

I (author Kelsi Gagne), as part of Nova Southeastern University’s Doctor of Occupational Therapy Program, focused my capstone project on determining the prevalence of older adults with low vision in a skilled rehabilitation facility in Maine and developed a strategic plan for better addressing low vision and providing adequate low vision occupational therapy—based interventions for this population. This article offers occupational therapists, particularly those employed in the skilled rehabilitation setting, with a model for examining the current state of low vision service delivery to the older adult population they serve and an approach to strengthening those services.

### Table 1. Prevalence of Low Vision at a SNF in Maine

<table>
<thead>
<tr>
<th>Residents’ Visual Acuity (N = 28)</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low Vision</td>
<td>12</td>
<td>43%</td>
</tr>
<tr>
<td>Normal Visual Acuity</td>
<td>14</td>
<td>50%</td>
</tr>
<tr>
<td>Legally Blind</td>
<td>2</td>
<td>.07%</td>
</tr>
</tbody>
</table>

As part of the capstone project, visual acuity screenings were conducted with the older adults residing at or participating in rehabilitation at this northeastern U.S. skilled rehabilitation facility (N = 28) throughout 4 weeks to demonstrate the prevalence of low vision at the facility. Two assessments—the Feinbloom, which measures distance acuity (Ormerod & Mussatt, 2012), and the MNREAD (University of Minnesota, n.d.), which measures near visual acuity—were chosen because of their cost efficiency and accuracy for assessing visual acuity, and because they are quick and easy to learn to administer, to confirm clients’ degree of vision loss and its effect on activities of daily living. Clients with a visual acuity score equal to or worse than 20/80 on the Feinbloom or the MNREAD were labeled as having low vision. The Feinbloom and MNREAD results confirmed that almost half of the clients (43%) had low vision in one or both eyes (see Table 1).

### Prevalence of Low Vision

Surveys revealed that all clients reported facing several difficulties completing their daily occupations because of their visual impairments. The affected occupations reported were knitting, driving, eating, watching television, reading, and seeing medications. Ten of the clients with low vision, or 36%, reported having...
difficulty functioning because of environmental barriers, including too much glare with windows and fluorescent lights, dark halls, reflections from white walls and other surfaces, and items being moved without their knowledge and being unable to subsequently find them.

**Barriers to Staff Addressing Low Vision**

Ten staff nurses and occupational therapists completed a questionnaire regarding barriers they experienced when addressing low vision with clients. Their responses revealed four main themes related to knowledge (e.g., “I have minimal training from school”), procedure (e.g., “We need a low vision screening process”), equipment (e.g., “We need more large-font books”), and environment (e.g., “The fluorescent lights are too bright”).

Subsequent to the content analysis of the questionnaires, a detailed analysis of strengths, weaknesses, opportunities, and threats was conducted and the Asset-Based Community Development (ABCD) model was used as a guide to develop a strategic action plan for addressing low vision. The ABCD model encourages community members to recognize, actively develop, and mobilize to meet their own community needs by determining and using their communities’ strengths (Mathie & Cunningham, 2003). Developing the strategic action plan clarified the role of the occupational therapist and other stakeholders in identifying low vision need areas and provided structure on how to improve low vision services for this geriatric population. Developing a strategic plan is time-consuming and labor-intensive, but there are many simple strategies occupational therapists can incorporate or ways to build on the assets already present in their settings to improve geriatric low vision services.

**Strategies for Addressing Geriatric Low Vision in the Skilled Setting**

**Strategy 1.** Encourage and initiate staff education on low vision. Staff education is vital to increase awareness, confidence, and knowledge in addressing low vision. One example of staff education would be inviting or requiring staff members to attend an in-service on low vision presented by the occupational therapy department or a low vision expert guest speaker, if current occupational therapists do not have this expertise and need further training. Sample in-service topics include (1) common low vision conditions, (2) prevalence of low vision, (3) environmental barriers for clients with low vision, (4) the role of occupational therapy in vision assessment and intervention, (5) the role of the interdisciplinary team in low vision screening and intervention, and (6) low vision referrals to occupational therapy.

**Strategy 2.** A low vision expert can provide training on available vision assessment tools and assist the department in developing a policy and procedure for low vision screening assessment and intervention. Education and training to improve the therapists’ competency in the area of low vision might include:

- Training on visual screening/assessment tools such as the Feinbloom, MNREAD, or Functional Vision Assessment (FVA; Perkins Scout, 2016).
- Education and training in using AOTA guidelines to guide low vision interventions. I have found

*“Surveys revealed that all clients reported facing several difficulties completing their daily occupations because of their visual impairments.”*
Low Vision in Older Adults: Foundations for Rehabilitation (Cole, Hsu, & Rovins, 2013) to be useful. Resources on AOTA’s website include many handouts and articles focused on low vision intervention (AOTA, n.d.). Additionally, low vision guidelines are clearly listed in the book, Occupational Therapy Practice Guidelines for Older Adults With Low Vision (Kaldenberg & Smallfield, 2013).

- Explore mentoring opportunities with experts in low vision. These opportunities can include job shadowing fellow occupational therapists or experts in low vision services at facilities or universities that offer low vision programs. Additionally, occupational therapists can collaborate with an optometrist or ophthalmologist to mutually gain knowledge in low vision and the role of each discipline. Collaborating with eye doctors can also increase referrals for occupational therapy low vision services. Envisions offers an annual multidisciplinary conference for all providers of low vision (www.envisionus.com). AOTA also offers several low vision resources, a new certification in low vision, and other forms of continuing education (visit http://store.aota.org and search “low vision”).

**Strategy 3.** Become knowledgeable in local and national low vision programs, providers, or services. Occupational therapists can create a low vision resource, such as a brochure or handout, to provide information on local and national low vision resources, so clients have options for further assistance and information that can empower them to independently use these services at discharge. AOTA offers a tip sheet on this topic, including a large print version, at https://goo.gl/g8cWXh. The information on your own flyer or brochure will enhance the discharge experience and ensure that clients have continual assistance as needed to succeed.

“Occupational therapy departments can purchase low vision adaptive visual aids to meet the needs of their clients.”

**Strategy 4.** Implement environmental changes in the skilled setting to decrease clients’ risk for falls and increase their independence. For example, the occupational therapist can work with the maintenance department to add contrast to clients’ rooms. Too often, we have white bathrooms with white call light buttons or strings and white toilet seats. Simply adding some contrast with color can make all the difference to a client with low vision. Dining menus in large font or on yellow paper with black ink can increase contrast. Looking at the lighting and windows to decrease the amount of glare in rooms is another helpful strategy. Most of the environmental changes can be done with simply a change of a lightbulb or a can of paint, which limits the labor and financial impact for the skilled facility. Such changes could also be a service activity for a local school.

**Strategy 5.** Occupational therapy departments can purchase low vision adaptive visual aids to meet the needs of their clients. Visual aids that can be easily used in intervention sessions or for client training include magnifiers, guides for reading and writing, large-font books, bump dots for labeling and marking items, and small bedside table lamps. Occupational therapy practitioners can also show people how to enlarge text on phones, tablets, or computers, if they are not already aware, as well as how to use text-to-speech readers on websites.
Strategy 6. Develop and initiate a Low Vision Program Committee. Recruit department representatives from each interdisciplinary team to be part of this group. This committee will meet to develop a strategic plan, set goals, and monitor the strategic plan’s implementation within an allotted timeframe to ensure goals and actions set by the committee are completed. Examples of potential committee members include representatives from occupational therapy, nursing, maintenance, the falls risk committee, and case management.

Strategy 7. Establish a system for occupational therapy referrals for low vision screening or assessment. Members of committees, such as the fall risk committee, who identify low vision as a risk factor, can make a referral to occupational therapy for low vision screening and follow-up. Moreover, all disciplines can be encouraged and instructed on how to identify and screen for clients with low vision to make appropriate referrals to the occupational therapy department for low vision evaluation and intervention.

Conclusion

Age-related low vision impairments are prevalent across the United States and will likely increase as the older adult population steadily grows. Because low vision affects function and ADLs, it is an important realm of practice for all occupational therapists to integrate into their practice and rehabilitation settings. Occupational therapists can take the lead in their practice settings to develop a strategic plan to provide intervention for low vision among older adults. 

References


constant struggle for occupational and physical therapists in an inner city level I trauma hospital is balancing a large volume of patients with significant needs while maximizing functional outcomes. At Sidney and Lois Eskenazi Hospital, a level I trauma center in Indianapolis, the therapy department historically prioritized medical ward patients over intensive care unit (ICU) patients to help expedite hospital discharges. Ventilated patients were seen as a lower priority because they were less medically stable and thus would not be able to participate well in therapy sessions.

Occupational therapy identified the need for more services for ICU patients as there was building evidence of better functional outcomes with early interventions for this population. The therapy team, including occupational and physical therapists, met to begin a literature review to determine the benefits of early interventions and assist with guiding the development of an ICU program. The review of literature revealed that early mobilization of ventilated patients resulted in expedited return to baseline functional independence, shorter duration of delirium, and reduced required ventilator days (Schweickert et al., 2009). Based on this research, in January 2015, Eskenazi Hospital staff initiated an early mobilization and ADL program in the ICU with the approval of the Director of Rehabilitation Services. The therapy and medical ICU team goal of this initiative was to demonstrate improved outcomes and decreased length of stay, thus saving health care dollars (Institute for Healthcare Improvement, 2012).

Caring for Medical ICU Ventilated Patients

With the constant changes in health care reimbursement, developing a multidisciplinary team approach to early mobilization and ADLs with ventilated patients was key to “lowering costs, improving patient experience, and managing the health of populations” (Moyers & Metzler, 2015, p. 500). To design a more collaborative approach, the therapy team sought champions from ICU nurses, respiratory therapists, and ICU physicians to develop an algorithm for ICU patient early mobilization on a ventilator. Once champions were identified, the team met to establish an early mobility algorithm that would be presented to the medical quality assurance team for approval before implementation. Inclusionary criteria were based on diagnoses, vitals, ventilator settings, baseline functional status, absence of delirium or agitation, and bridled endotracheal tube securement.

Once the algorithm was approved, the team developed discipline-specific roles when engaging patients in early mobility. For example, occupational therapists and physical therapists shared responsibilities for determining baseline functional status, determining a communication plan, and...
assisting with mobility. Occupational therapists also assessed upper extremity strength and some basic ADLs, while physical therapists addressed lower extremity strength and durable medical equipment needs for mobility. The nurse assisted with managing medical lines and assessing vitals. Finally, the respiratory therapists assisted with managing the ventilator and monitoring oxygen saturation. With all of that work done, the team of champions then disseminated the information to their respective staff through online education and competencies, team rounds, and one-on-one mentoring.

For the rehab team education, occupational therapists and physical therapists collaborated with respiratory therapists to receive ventilator education. The therapy team also completed ICU mobility webinars, learned to use the Richmond Agitation and Sedation Scale (RASS; Sessler et al., 2002) and Confusion Assessment Method in the Intensive Care Unit (CAM-ICU; Ely & Vanderbilt University, 2014) tools to identify patients’ levels of agitation or presence of delirium, and initiated rotations of therapists into the ICU. In addition, a member of the rehab team attended daily multidisciplinary medical ICU rounds for continued education of ICU physicians on the role of therapy in the ICU and to obtain patient orders for therapy.

For the first 3 months of the program, two occupational therapists and two physical therapists worked to further develop safe patient mobility techniques and staff education materials as well as improve teamwork and rapport with all ICU staff. After the first 3 months, an additional five therapists were gradually rotated into the ICU, with an ICU champion therapist for mentorship during their first rotation. To ensure continuity of patient care, the occupational therapy and physical therapy ICU rotations were staggered to ensure that one discipline was always up to date on the ICU patients.

### Implementing the Interprofessional Approach

In designing the new model of care, therapy focused on a team approach between occupational therapy and physical therapy to maximize patient care in the ICU. This had historically been a physical therapy–dominant area of patient care; however, the physical therapy staff was enthusiastic about improving patient care in the ICU with occupational therapy’s assistance. Collaborative therapy sessions focused on improving range of motion, full body strengthening, advancing independence with basic ADLs, and earlier mobilization. The therapy team collaborated with other representatives nursing, respiratory therapy, and ICU physicians to determine the appropriate activity level and when to progress to functional mobility, based on the patient’s medical and respiratory status. The entire team evaluated the patient using the RASS to assess agitation/sedation and the CAM-ICU to assess for delirium. Per our ICU algorithm, we determined that the patient must be CAM-ICU negative and have a RASS score between -1 and +1 to proceed with out-of-bed mobility while ventilated.

Each discipline had its own responsibilities in the early mobilization of ventilated patients. Nursing responsibilities included assessing patients’ state of arousal and vitals as well as monitoring medical equipment, lines, and medications. Respiratory therapy monitored oxygen saturation, airway, and the ventilator. The occupational therapy/physical therapy team worked with ICU physicians to upgrade activity orders and clarify any medical precautions. The therapists worked with the patient to develop a communication signal (e.g., thumbs up or thumbs down for continuing with mobility progression).

Before beginning mobility, therapists set up the environment with a bedside commode, rolling walker, and wheelchair with an overhead lift sling available to maximize patient safety. The therapists progressed mobility from supine range of motion, to sitting, then standing, and finally to commode/chair transfers and walking with the ventilator. The patient had to maintain stable vitals and require only minimal assistance with the transfers to progress through the functional mobility stages. The occupational therapists also engaged the patients in early ADLs, such as dressing, bathing, and toileting as well as upper extremity strengthening. Through this collaborative process among multiple disciplines, all groups involved found a new appreciation for each other’s role in early mobilization.

### The Results and Future Projects

Data was collected 3 months pre- and post-implementation of the occupational therapy and physical therapy teams in the ICU. We collected data on length of hospital stay, the amount of time from when a therapy evaluation was ordered to when it was completed, number of overall therapy sessions provided per patient in the ICU, and discharge locations. During the first 3 months of the program’s implementation, overall patient length of stay decreased by 2 days, occupational therapy orders were received 0.5 days more quickly, and 4% more patients were discharged to home instead of to a rehabilitation facility. We continue to refine and improve the ICU mobility program with hopes of continued improvement of patient outcomes and satisfaction. In the future, we plan to develop an activity protocol to advance all ICU patients from bed to ambulation and further address delirium prevention.

Through this process of interprofessional collaboration, we gained better camaraderie and respect across disciplines, leading to better patient care and outcomes.

### References


The number of times people change jobs over the course of their careers, or change careers entirely, may be tricky to pin down precisely, but studies over the past 20 years or so show that most people change employers at least every 4 years, and even more frequently than that when they are younger (Bialik, 2010). Like members of many other professions, occupational therapy practitioners change their jobs often. Part of this may stem from the various practice settings the profession offers. After graduates meet the certification and licensure requirements, the profession of occupational therapy offers a variety of areas in which to practice, such as hospitals, skilled nursing facilities, outpatient centers, pediatric centers, schools, clinics, home health agencies, and mental health facilities.

After graduation, occupational therapy practitioners are most often generalists; thus, many remain unsure of what practice area(s) to enter. Many times, after practicing for several years in one area of practice, they realize they would prefer a change. Reasons for this may include a lack of passion in their current practice area, along with a better understanding of their workplace preferences, strengths, and talents.

How can new practitioners decide where to start their careers? The Occupational Therapy Practice Framework: Domain and Process, 3rd Edition (Framework; American Occupational Therapy Association [AOTA], 2014), and the Model of Human Occupation (MOHO; Forsyth et al., 2014), which help form the basis of occupational therapy students’ understanding of the profession, can also be helpful for recent graduates seeking the right niche as entry-level practitioners.

The Framework describes employment interests and pursuits as “identifying and selecting work opportunities based on assets, limitations, likes, and dislikes relative to work” (AOTA, 2014, p. S20). Similarly, it notes the importance of client factor values, such as honesty with self and others, tolerance toward others, and obligation to provide service, which also can be helpful for practitioners in thinking about work options. Using MOHO allows practitioners to focus on their thoughts and feelings with personal causation, values, and interests. According to Cole and Tufano (2008), when a person chooses, organizes, and performs occupations that are meaningful, they display function. Therefore, for new practitioners, finding the right niche at the beginning of their career is a meaningful occupation that is paramount for optimum functioning in life.

Considering Options

More concretely, finding the right mentor and taking advanced courses to enter a specialized field are some basic external supports new practitioners can consider for getting a job; however, these strategies do not consider the intrinsic factors that make one an occupational being.
Here are some personal internal strategies that new practitioners can consider in finding the right niche at the start of their careers:

- Articulating one’s interests, pursuits, and reasons for accepting a job, in order to manage expectations
- Using one’s passion and intrinsic motivation as a starting point for exploring practice areas
- Being cognizant of one’s strengths and skills, and how these could apply to various practice areas
- Developing a strategic plan for the next 5 years, with concrete short- and long-term career goals, and being prepared to adjust as necessary to achieve them
- Considering taking short-term assignments to meet expenses, or taking a position that matches some of your interests, while continuing to search for the right niche
- For long-term assignments, accepting new challenges to avoid monotony or routine

Not being swayed only by the salary and benefits of some job offers, and focusing on the actual position

Having a career plan as an entry-level practitioner to find the right niche can be very rewarding. Some of the benefits include:

- It will inspire you to continually further your professional growth.
- You will experience more job satisfaction.
- You will be happier and have less stress at work, which will improve your productivity, relationships with your coworkers, and health and wellness.
- It will strengthen your longevity and sustainability in the job.

Conclusion

As I reflect on my own career, in which I’ve found my niche as a full-time academician in one of the master’s programs at Stanbridge University, in Irvine, California, after working in skilled nursing facilities, integrated school settings, adult-day-care centers, and home health settings over a period of 2 decades, I know that doing what you are passionate about makes a difference. I believe “choosing your niche” is all about self-awareness and education, both of which can be inculcated as occupational therapy students are getting ready to practice. Finding the job that fits one’s knowledge, skills, and personality can result in having more energy and motivation in performing any job-related task.

References

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People thinking about a forthcoming job interview often focus on the personal aspects: handshake, eye contact, and other techniques to improve the potential to make a good impression. But successful job interviews also entail the prospective employee asking the right questions to understand whether an organization is the right fit for them, including understanding an organization’s ethical values.

For prospective employees interested in working in a skilled nursing facility (SNF), the following are some important aspects to think and ask about when interviewing a potential employer.

Engage in a self-reflection regarding personal standards, ethics, and values. I encourage you to review the American Occupational Therapy Association’s (AOTA’s; 2015) Occupational Therapy Code of Ethics (2015) as well as state statutes, regulations, codes, and laws pertaining to practicing occupational therapy in your state. You should be familiar with guidelines and reimbursement regulations relating to Medicare and Medicaid (or other state-sponsored insurance programs). The Standards of Practice for Occupational Therapy (AOTA, 2015) is another great resource for understanding ethical and legal practice to consult before your interview.

Some specific areas of exploration include understanding your scope of practice; professional responsibilities as an occupational therapist or occupational therapy assistant, respectively; and the requirements related to the supervisory relationship. Now ask yourself, what professional standards need to be followed? What personal ethics have I committed to follow as an occupational therapist or occupational therapy assistant? You should have a clear understanding of ethical, legal, and regulatory obligations related to the practice area and setting.

Research the company. You may find tidbits of information that could be quite important. For example, how many locations does the company operate? What is the administrative hierarchy and reporting structure, if available? Is this a rehabilitation staffing company or does the facility employ its own therapy personnel? This type of information could affect how they deal with productivity, screenings, evaluations, referrals, and personnel issues, among other things.

Talk to other practitioners who work there, if possible. Get an idea of what a typical day is like, what the workload is, what type of interaction occurs between staff and supervisors/administrators, and what opportunities for feedback and input exist. Talking to the other therapy staff, such as physical therapists or speech-language pathologists,
can help give you an idea of the teamwork and interprofessionalism that is present.

**Arrive a little early to the interview and look over the facility.** In the waiting area, for example, see if you can get a sense of the culture and “feel” of the facility. Do people generally seem happy? Angry? Abrupt? Helpful? Additionally, if invited back for a second interview, consider asking whether you can observe a therapy session in process and evaluate the environment (including tools) to further understand the rehabilitation culture of the facility. The facility should have the capability to include interventions and activities that are occupation based in addition to other therapeutic and preparatory activities. If you are in a rehabilitation hospital or a SNF, look for anything that would encourage or promote actual, or close-to-actual, activities, such as cooking, doing laundry, or washing dishes. If you do not see this, you can ask the interviewer whether there is a potential for occupational therapy to include such activities.

**Ask questions about productivity.**

1. **What are the productivity standards?** The answer to this question is a good basic indicator of the company’s values. If productivity is required to be above 80%, consider asking follow-up questions: What is included in the productivity requirement? Is this direct billable time only? Is there time for required, indirect, client-related tasks, such as team meetings or documentation? This level of productivity may be OK, depending on the company. Productivity levels in the 90% or above range are generally not feasible when following required service delivery and billing standards, as set forth by Medicare and other third-party payers, given the realities of treating older clients, the time required for indirect tasks (e.g., documentation), and the physical set up (unless aides are available for transport and session prep/clean up). For example, Medicare does not consider transporting a client from his or her room to the therapy gym to be skilled services because others could do the same thing; therefore, that time is not billable (Centers for Medicare & Medicaid Services [CMS], 2012). As a therapist, you should have the flexibility to determine when skilled care begins based on client need and your clinical judgment, rather than having the company pressure you into starting services prematurely or not permitting discharge even when goals have been met.

2. **What are the ramifications for not meeting productivity standards?** Some companies use productivity standards as a target but realize those numbers are not realistic in all cases. The interviewer should indicate the policy clearly. Think about talking to some of the therapists who work there about the pressure to meet productivity standards and the consequences when they do not do so.

3. **Does the company have a mentorship program? How much interaction would I have with the mentor?** This question is especially important for new graduates. If the company has a specific mentoring program, they will be investing in you as part of the team. If there is no mentoring program, or nothing specific, use caution and ask what resources may be available, including time for independent learning. Many new occupational therapy practitioners who work in isolation may be more vulnerable to taking shortcuts when things get overwhelming.

4. **How are resource utilization group levels determined at this facility? How many skilled, Medicare A clients are currently considered “ultra”?** Some SNFs put all new clients on the highest level regardless of their actual condition and need for services.

“**A good company will let the therapist do the screenings to determine therapy needs.”**

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This is a major red flag, as indicated by CMS (2012). This is also a good time to understand the nature of the facility. If it is a SNF that is known for taking more complicated clients, ultra-high may be the most appropriate if the clients are able to tolerate, and benefit from, therapy. To have more than 75% of client load in a sub-acute rehabilitation setting at the same level would be highly questionable.

5. How many Medicare B clients are on caseload? How long do they typically stay on caseload? How are therapy referrals generated for long-term-care (LTC) residents? This set of questions can provide important information about how the company uses Medicare Part B benefits. A good company will let the therapist do the screenings to determine therapy needs. Other companies may pressure therapists to classify long-term residents as requiring services and will cycle the Medicare Part B (long-term) residents through therapy repeatedly to capture the therapy money. It is, however, common to have LTC residents on caseload. The percentage of residents receiving therapy and how long they have been on the therapy caseload will indicate appropriate use of Medicare Part B benefits. Some common reasons for long-term residents to be on caseload include a recent fall that resulted in a change in functional status; residents with degenerative disorders, such as Parkinson’s disease or multiple sclerosis, which require some skilled intervention to decrease the progression of the disability; or a change in functional status that requires adding mobility aids or durable medical equipment.

6. If a client arrives to the facility under Medicare Part A and I determine that they are not in need of therapy, what would your response be? Occasionally, people are sent to a rehabilitation facility or SNF under Medicare Part A, but they are either too functionally independent or they are so low functioning that they could not participate in or benefit from therapy. A good company will let you decide who is and is not eligible for occupational therapy services without pressure, based on your clinical judgment.

7. Although receiving feedback is important, would you support my autonomy to make rehabilitation decisions that I believe best fit a client’s needs? This question is tricky to ask, but it can be important as it will gauge respect for the therapist’s clinical judgment, considering the specific needs of the client. Some companies buy expensive equipment that they expect to be part of the therapy process. Your plan of care and intervention plan, developed collaboratively with the client, should determine the services provided, not the company’s desire to use equipment that was an expensive purchase to increase revenue.

Conclusion
Preparing for a job interview can be overwhelming, especially for new graduates. Most are anxious to have a good job and to provide quality occupational therapy to those in need. Be prepared for the interview so you will obtain good insight into the organization to which you are applying. Asking the right questions is important to finding the right fit for a job as occupational therapy practitioners. The best way to ensure client outcomes are at their best is by providing interventions based on the client’s goals that align with our ethical and professional standards for appropriate practice. Selecting an employer that will help us work to the best of our ability will improve services and outcomes for clients.

The author wishes to thank Ann Burkhardt and Sarah Ulfers for their assistance with this article.

References

Steven S. Bowen, OTR, OTRL, CAPS, is an Assistant Professor in the Department of Occupational Therapy at Drake University in Des Moines, Iowa. His primary work experience is in skilled nursing facilities and home health. Bowen previously served for 3 years as the Lobbyist for the Nebraska Occupational Therapy Association and is currently a Legislative co-Chairperson for the Iowa Occupational Therapy Association.
Recently spent 11 months as a Peace Corps Response volunteer, tutoring occupational therapy students at the University of Guyana (UG) in Georgetown, Guyana.

A small country by South American standards, but almost as big as Great Britain, Guyana is largely forested and has a diverse population made up of people of African, Indian, Chinese, Portuguese, Amerindian, and European origin. It is the only English-speaking country in South America, although the dialect is definitely a local variety, largely incomprehensible to the new arrival.

UG initiated a 4-year bachelor’s degree course in medical rehabilitation about 5 years ago. Prior to that, just two physiotherapists had completed degrees at UG. Students spend 3 years studying the basics of physical rehabilitation and its application to physiotherapy and occupational therapy. During their final year, they specialize in one of these disciplines. This approach provides the skills needed to address a client holistically, addressing all their rehabilitation needs. UG also offers bachelor’s degrees in speech-language pathology and audiology.

Occupational therapy is not entirely new to Guyana. For the past 20 years, the Ministry of Public Health has been training rehabilitation assistants, who receive 1 1/2 years of training covering the three allied health disciplines. But Guyana has only one professional occupational therapist, a graduate of the UG program last year; five more students will be graduating this year. There are more physical therapists in Guyana, and they are mainly in urban areas. The Ministry of Public Health has made a commitment to provide more rehabilitation services in rural areas. Thus, these new occupational therapists may find themselves in a rural hospital with no other therapists, and their cross-sectoral skills will be very useful.

The World Federation of Occupational Therapists (WFOT) has established a task force to provide UG with technical support as the occupational therapy program develops. WFOT members have also been involved in setting up a mentoring system for the new graduates, ensuring that they will have access to an experienced therapist who will communicate with them on a regular basis, providing advice on unfamiliar situations that will arise as they start their professional careers.

Using Available Resources
As a Peace Corps Response volunteer, my 11-month contract covered two semesters, to work with the fourth-year students.
I was provided with course outlines by my predecessor. I revised these, focusing on problem-solving techniques (the previous course outlines had more emphasis on details of medical conditions). I also arranged and supervised clinical placements for my students—five fourth-year students and one third-year student. Students were placed at Georgetown Public Hospital, Palms Geriatric Center, and Ptolemy Reid Pediatric Rehabilitation Center. We did not have any clinical placements in psychiatric centers because the only psychiatric hospital is about 100 miles from Georgetown.

Teaching occupational therapy in Guyana involves working with available resources. My office was a wooden classroom with a whiteboard; clinics had basic exercise machines, activities of daily living facilities, and different types of games. Most specialized equipment, such as thermoplastics or splints, had been donated and were not replaced when they ran out. So we managed as best we could, using toys made locally, making button hooks out of paper clips, and using flour and water dough for hand strengthening exercises. This experience was good preparation for the students’ future professional lives, because resources at rural clinics are likely to be even more limited.

The students were all motivated and interested. Time management is a challenge because time has a flexible meaning in Guyana; a rainstorm is an adequate excuse to be absent from any event, and being on time means arriving anywhere up to an hour after the stated time.

UG is seeking occupational therapists who would like spend from a few weeks to a year teaching occupational therapy skills in Guyana. Anyone interested should contact Reverend Holder at ketannah@gmail.com or Dr. Maria Sheena Villareal at msvillareal2013@yahoo.com.

David Thomforde, MS, OTR/L, has been an Occupational Therapist for almost 30 years, working in the United States, India, Sierra Leone, Madagascar, Guyana, Uganda, Mexico, the Philippines, and China. He earned his bachelor's degree in psychology from Haverford College in 1975 and his master’s degree in occupational therapy from Western Michigan University in 1982.

Students Calvin Lawrie and Afeeza Khan examine the fit of a wrist cockup splint along with lecturer David Thomforde.

The social and economic costs associated with medication nonadherence have prompted requirements and quality initiatives to promote medication adherence and to reduce the risk of medication-associated problems for the population receiving home health services. For home health agencies to meet these requirements, all skilled clinical professionals have additional responsibilities to monitor medications and implement efforts to promote medication adherence.

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Students Calvin Lawrie and Afeeza Khan examine the fit of a wrist cockup splint along with lecturer David Thomforde.
On Campus

Hurricane Irma
The Lived Experience of an Occupational Therapy Program

Brigitte Belanger
Sarah Fabrizi
Edwin Myers

Occupational therapy educators challenge students to think creatively and to remain adaptable to prepare them for success in a challenging health care environment, and sometimes those challenges come up sooner than expected, and in the most unexpected ways. Hurricane Irma provided an opportunity to model adaptability and community engagement to benefit faculty, students, and community partners at Florida Gulf Coast University (FGCU), in Fort Myers, and throughout southwest Florida.

Pre-Impact
On Wednesday, September 6, as the storm approached the region, students began preparations to leave the campus and seek shelter. On Thursday, September 7, the National Weather Center was predicting Irma would strengthen to a category 5 hurricane—the highest category possible—and make landfall in southwest Florida, with a potential for 10- to 15-foot storm surges. A sense of urgency and panic set in throughout our community as local gas stations and stores ran out of basic supplies. Faculty and students hurried to make preparations, which included packing, securing valuables and property, boarding up homes, and evacuating the area, or gathering supplies to hunker down. FGCU’s Alico Arena was opened to the public as a shelter.

Impact
Hurricane Irma came through Florida on Sunday, September 10, and left a path of destruction that stretched from the Florida Keys to Jacksonville. More than half of the state was without power in the aftermath—the largest power outage in the history of Florida Power and Light (Griffin & Johnston, 2017). Estimates placed the outages in Florida at as many as 13 million households. Record flooding left many homes and roadways underwater. Wind knocked down trees and street signs, and scattered debris. Residents who had sheltered in place were unable to leave their homes, while those who had evacuated were stranded in shelters because of gas shortages and impassable roadways. The
The university remained in close contact with faculty and students through email, providing important updates; however, Internet service was scarce or absent in many areas. Other universities, as well as other programs—such as the University of Florida’s Occupational Therapy Program and student organization—reached out to offer support. FGCU would eventually resume classes on September 20, with students having missed 9 days of class.

Immediate Post-Impact
Faculty returned to FGCU on September 18 and immediately began implementing changes to make up for lost time. When students returned, this opportunity was a chance to share stories about their experiences before, during, and after the storm. This mindful reflection enabled them to process their own emotions. Telling individual stories was an occasion to share wisdom, build resilience, and prepare to help others.

Irma wreaked academic havoc on, among other things, the carefully scheduled programming developed for the Assistive Technology (AT) course. This course places great emphasis on establishing professional contacts in the AT industry. Many AT experts are scheduled as guest speakers throughout the semester, along with multiple field trips. The schedule delay resulted in extended class periods, additional class days, and shifting the order of assignments. Students demonstrated resiliency and resolve as they adapted to every change in the schedule.

Faculty decided to introduce the role of occupational therapy in disaster response in the context of the students’ community practice seminar. Two American Occupational Therapy Association (AOTA) Official Documents and one American Journal of Occupational Therapy article were added to the course’s reading list: AOTA’s Societal Statement on Disaster Response and Risk Reduction (AOTA, 2017); The Role of Occupational Therapy in Disaster Preparedness, Response, and Recovery (AOTA, 2011); and “Hurricane Sandy, Disaster Preparedness, and the Recovery Model” (Pizzi, 2015).

Students learned about the concept of disaster response and occupational therapy’s role in mitigating occupational dysfunction, highlighting the special skills occupational therapy practitioners possess that can make them valuable assets in times of crisis. This new avenue led students to ask about ongoing community projects and to identify community partners who were in need of support. A shift occurred. Students began to look outward. They used their own experiences and coping strategies to gain perspective on vulnerable groups and potential immediate and long-term effects of the hurricane on community partners.

Recovery
The FGCU Occupational Therapy Program partners with Lighthouse of the Blind of Southwest Florida and the Naples Botanical Garden for various projects to advocate for the role of occupational therapy in community settings and provide service learning opportunities for students. The effects of Irma hit both organizations hard. Realizing the amount of help required for these organizations to return to regular operations, students mobilized on a single day’s notice. Two groups of students provided more than 100 service hours of work. The students then returned in smaller groups over the following week, providing an additional 50 hours of service through the Student Occupational Therapy Association. No course content was missed, and both organizations saved thousands of dollars in expensive clean-up costs.

Several class projects and research endeavors were in jeopardy as Hurricane Irma decimated the local landscape. One research group had to quickly redesign an intervention activity when Irma destroyed the previously planned ropes course. The students demonstrated great flexibility and adaptability by seeking and developing alternative interventions that would meet the requirements of their projects while providing much needed storm recovery assistance to community agencies. Students were challenged to develop innovative solutions, and empowered to design their own projects. Like faculty, students needed to reevaluate what the objectives and goals were. Outcomes that were meaningful pre-Irma didn’t necessarily have the same priority post-Irma. With support from both faculty and peers, students collaborated to identify and participate in meaningful tasks that supported the rebuilding of community and the return to a new normal.

Reconstruction
Hurricane Irma has altered the landscape for many in our community. Our students and faculty have become aware
of a much greater need and more opportunities to contribute, and have begun conducting needs assessments in the hope of participating in rebuilding our community in the years to come.

Faculty focus has been on supporting students as they reconstruct a sense of normalcy. Disasters happen, most times without much warning. Occupational therapy is needed as a profession, both globally and in the United States, to collaborate in planning for dealing with the aftermath of these events. This is especially true for populations and individuals considered vulnerable and at risk. Additionally, the need for individuals and groups affected to have their stories heard, get immediate needs met, and return to a routine that supports recovery is apparent.

Conclusion
After a disaster, occupational therapy practitioners can use professional skills to support all stages of relief. After Hurricane Irma, occupational therapy faculty at FGCU pulled together to adjust the curriculum and meet the needs of students, offering them a chance to develop resilience, gain experience and self-confidence, and engage in meaningful activities in the community. The opportunities to participate in community projects was the natural denouement of students’ increased awareness, resulting in greater community engagement (AOTA, 2011). This event will lead to notable changes in our curriculum that we hope will benefit students, faculty, and the community.

References

Brigitte Belanger, DSc, OTR/L, recently retired from the U.S. Army and joined the Florida Gulf Coast University (FGCU) Occupational Therapy Program as an Assistant Professor. She has a strong interest in nontraditional practice settings and looking for opportunities to enhance occupational therapy’s role with underserved populations, and she has served since 2014 on the Roster of Accreditation Evaluators.

Sarah Fabrizi, PhD, OTR/L, is an Assistant Professor with the FGCU Occupational Therapy Program. She has more than 10 years of experience working with a variety of clients, including those in adult rehabilitation and the pediatric neonatal intensive care unit, early intervention, prescribed pediatric extended care, outpatient, and private practice.

Edwin Myers, OTD, OTR/L, is an Assistant Professor with the FGCU Occupational Therapy Program. He has practiced for more than 26 years in various settings, including skilled nursing, inpatient rehabilitation, home health, outpatient settings, and hospital. He is the current Florida representative for the Representative Assembly.

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by Underlying Sensory and Motor Abilities by Lucy Jane Miller, PhD, OTR, FAOTA and Sarah A. Schoen, PhD, OTR. This course is a recorded Pre-Conference Institute that was hosted by AOTA at the 2017 AOTA Annual Conference & Centennial Celebration. Earn .45 AOTA CEUs (1.25 NBCOT PDUs/1.5 contact hours). Order #OL4974, AOTA Members: $29.95, Nonmembers: $44.95. http://store.aota.org

Online Course
Hand Rehabilitation: A Client-Centered and Occupation-Based Approach, 2nd Edition by Debbie Armini, EdD, OTR/L, FAOTA. AOTA’s newly updated Hand Rehabilitation course familiarizes occupational therapy practitioners with a client-centered and occupation-based approach to intervention that is easily incorporated into the hand rehabilitation setting. Earn .15 AOTA CEUs (1.88 NBCOT PDUs/1.5 contact hours). Order #OL4975, AOTA Members: $29.95, Nonmembers: $44.95. http://store.aota.org

Online Course
Early Development of Neuromuscular Disorders in Early Intervention Settings (Module 4 of the Early Identification Series) by Rameana M. Bendixon, PhD, OTR/L; Kris Barnewelt, PhD, OTR/L; Series Editor: Kris Barnewelt, PhD, OTR/L. This course provides an overview of neuromuscular disorders (NMDs) in infants, toddlers and young children. These disorders vary greatly and manifest themselves through a combination of symptoms based on lower motor and sensory nerve dysfunction. Identification of the initial symptom(s) may be the key element in diagnostic success. Earn .15 CEU (1.88 PDUs/1.5 contact hours). Order #OL4975, Member: $65, Nonmembers: $99. http://store.aota.org

Online Course
Emergent & Early Literacy: The Role of Occupational Therapy Practice in Schools by Gloria Freile Clark, PhD, OTR/L, SCSS, BCP, FAOTA et al. Literacy is embedded within a child’s daily activities giving reading, writing, listening, speaking. Without these basic means of communication, all aspects of occupational participation can be impacted. Occupational therapy practitioners have a critical role in literacy including supporting the development of literacy and providing professional development at a systems-level; evaluating a child’s ability to participate in literacy activities; and providing intervention to enhance participation in literacy activities. This course will offer occupational therapy practitioners working with children the knowledge and skills on emergent and pre-literacy development that can be integrated into OT evaluations and interventions. Earn .15 AOTA CEU (1.88 NBCOT PDUs/1.5 contact hours). Order #OL4979, AOTA Members: $34.95, Nonmembers: $49.95. http://store.aota.org

Online Course
SIS Quarterly Practice Connections 05 - Community Participation/Mobility. Community participation and mobility are often central to a person’s autonomy and independence. This issue of the SIS Quarterly Practice Connections focuses on how occupational therapy facilitates community participation and mobility for clients, whether through driving to the store or appointments, attending school or work, or participating in other activities they have identified as meaningful. Earn 1 CEU (1 NBCOT PDU’s/1.25 contact hours). Order #CGS5305, AOTA Members: $20.99, Nonmembers: $24.99. http://store.aota.org

CE Article
Occupational Therapy’s Role in Social-Emotional Development Throughout Childhood by Mary Anderson, OTD, OTR/L, and Sarah Grinder, MOT, OTR/L. This article examines the basic constructs of SEL, the domain of occupational therapy in SEL, and areas for intervention in SEL development. Earn 1 AOTA CEU (1 NBCOT PDU/1.25 contact hours). Order #CEA40417, AOTA Members: $24.95, Nonmembers: $24.95. http://store.aota.org

Online Course Promoting Medication Adherence: An Occupational Therapy Approach to Education and Intervention by Jaclyn Schwartz, PhD, OTR/L. This on-line continuing education course examines the core concepts of medication management for adults in physical and psychosocial rehabilitation settings. Earn 1 CEU (1.25 NBCOT PDUs/1 contact hour). Order #OL4979, AOTA Members: $24.95, Nonmembers: $34.95 http://store.aota.org

Online Course Every Day Ethics: Core Knowledge for OT Practitioners and Educators, 3rd edition, by Deborah Yarett Slater, MS, OT/L, FAOTA. This important course provides a foundation in basic ethics information that gives context and assistance with application to daily practice for students, clinicians, educators, researchers, and those in other occupational therapy-related roles. Seven overarching learning objectives address critical information for occupational therapy personnel, including recognition of the role of ethics as part of our professional responsibility. Content also addresses what is actually meant by ethics, with a focus on key ethical theories and principles that assist in analyzing and resolving situations that present ethical challenges. Earn .3 AOTA CEU (3.75 NBCOT PDUs/3 contact hours). Order #OL4975, Members: $35, Nonmembers $65. http://store.aota.org

Online Course Pediatric Constraint Induce Movement Therapy: Modules 1 and 2 by Andrew Persch, PhD, OTR/L, BCP. This continuing education program will provide you with information necessary to help you get started completing a PCMT program with your pediatric clients. This course defines PCMT, provide an overview of the evidence that informs practice and describes assessments and components of documentation of service delivery. Total credit earned (both courses must be completed) .3 CEUs (3.75 PDUs/3 contact hours). Order #OL4932, Members: $59, Nonmembers: $99. http://store.aota.org

Online Course Designing Occupational Therapy Services in a Primary Care Setting: Successful Strategies & Lessons Learned by Dragna (Anna) Kopalek, PhD, OTR/L, Heather Jarvis-Oyster, OTD, OTR/L. This course describes the role of occupational therapy in a primary care setting and provides insight into establishing OT services in a medical setting. Earn .15 CEUs, 1.5 Contact Hours, 1.88 NBCOT PDUs. Order #OL4989, AOTA Members: $24.95, Nonmembers: $34.95. http://store.aota.org

Online Course Hand & Upper Extremity Essentials 2.0: The Fundamentals by Wendy Hoogsteden, MHS, OTR/L. This course provides beginner to advanced OT practitioners with information on the anatomy and kinesiology of the upper quarter. You will learn neuransynaptic concepts as related to hand and upper extremity rehabilitation. The course covers basic theory and application of physical agent modalities (PAMs) used in physical agent modalities (PAMs) used in upper extremity rehabilitation as well as an overview of splinting of the upper extremity. Earn .7 AOTA CEUs (8.75 PDUs/7 contact hours). Order #OL4983, AOTA Members $79.00, Nonmembers $200.00. http://store.aota.org

CE Article Rethinking Safety for Older Adults by Claudia E. Dakes, PhD, OTR/L. This article will review the literature regarding safety to help practitioners better understand the complexity of these issues and communication to help bridge the gap between our perceptions and older adults’ perceptions of safety. Earn .1 AOTA CEU (1.25 NBCOT PDU/1 contact hour). Order #CEA40417, AOTA Members: $24.95, Nonmembers: $34.95. http://store.aota.org

Online Course Occupational Therapy Practice Guidelines for Adults with Traumatic Brain Injury by Steven Wheeler, PhD, OTR/L, CBS and Amanda Acord-Virts, MOT, OTR/L, CBS. This course is based on the Occupational Therapy Practice Guidelines for Adults with Traumatic Brain Injury and provides an overview of the occupational therapy process for this population. The purpose of this course, in the role keeping with the purpose of the Practice Guidelines, is to help occupational therapists and occupational therapy assistants, as well as the individuals who manage, reimburse, or set policy regarding occupational therapy services, understand the contribution of occupational therapy in providing services to adults with TBI. Earn 15 CEU (1.88 NBCOT PDUs/1.5 Contact Hours). Order #OL4976, AOTA Members: $24.95, Nonmembers: $34.95. http://store.aota.org

AOTA Documentation Series: Module 3 - Documentation Essentials for Medicare Part A in SNFs by Melissa Colm Bernstone, OTR/L, FAOTA and Consultant/Subject Matter Expert: Nancy J. Beckley, MS, MBA, CHC. This intermediate level module is designed to provide a bird’s eye overview of the updated regulations that, together with the care delivery model, help identify how the overall payment system works under the MDS 3.0, specifically reimburse- ment under Medicare A, including required RUGS-IV assessments, and how therapy services are delivered and captured for Medicare A beneficiaries. Earn 2 AOTA CEUs (2.5 NBCOT PDUs/2 contact hours). Order #OL4977, AOTA Members $34.95, Nonmembers: $44.95. http://store.aota.org

Online Course Ethics Topic-Duty to Warn: An Ethical Responsibility for All Practitioners, 2nd Edition by Deborah Yarett Slater, MS, OT/L, FAOTA. This course assists participants in under- standing their professional, ethical, and legal responsibilities in the identification of safety issues in ADLs and IADLs as they evaluate and provide intervention to clients. Includes not only lecture format but also interactive case studies and resources to enhance learning on this topic. Earn .1 AOTA CEU (1.25 contact hours)

OT PRACTICE • NOVEMBER 27, 2017

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Continuing Education Opportunities

Online Course
Ethics Topic—Duty to Warn: An Ethical Responsibility for All Practitioners, 2nd Edition by Deborah Harett Siter, MS, OTR, FAOTA. This course assists participants in understanding their professional, ethical, and legal responsibilities in the identification of safety issues in ADLs and ADLS as they evaluate and provide intervention to clients. Includes not only lectures but also case study and historical accounts to enhance learning on this topic. Earn .1 AOTA CEU (1.25 NBCOT PDUs/1 contact hour). Order #OL4951. AOTA Members: $24.99, Nonmembers: $39.99. http://store.aota.org

Online Course
Introduction to Evaluation and Treatment of Children with Eating and Feeding Disorders by Donna Reigstad, MS, OTR/L. This beginner to advanced beginner course is for pediatric therapists interested in developing the foundational skills to provide comprehensive evaluation and treatment within an interdisciplinary setting. Participants in this course will develop skills in the development of normal and abnormal aspects of oral motor skills and swallowing, and examine the development, psychosocial and cultural factors affecting children’s eating and feeding skills. Earn .5 AOTA CEU (5.0 NBCOT PDUs/5 contact hours). Order #OL4680. AOTA Members: $75.00, Nonmembers: $120.00. http://store.aota.org

Online Course
Sis Quarterly Practice Connections #3 - Measurement/Assessment. Earn CE credit with the SIS Quarterly Practice Connections! Issue for this course, which draws from the content of SIS Quarterly Practice Connections #3 – Measurement/Assessment, you will learn to describe benefits of using assessments and various forms of measurement in occupational therapy practice; identify specific assessment tools that are used in occupational therapy for various populations and practice settings; and explain how OTs can use assessment results to develop holistic, occupation-based intervention plans. Earn .1 CEU NBCOT PDUs (1.25 contact hours). Members/Nonmembers: $20.99, $24.99. http://store.aota.org

Online Course
A Contemporary Occupational Performance Approach to Pediatric Self-Regulation Part I: Theoretical Framework and Evaluation Considerations by Meredith Gronski, OTD, OTR/L, and Theresa Henry, MSOT, OTR/L. This course will present an evidence-based theoretical foundation for authentic practice with children and youth who struggle with emotional and behavioral regulation. This course will offer an encompassing framework for evaluation from an occupational performance perspective, focusing on assessment tool selection and developing a comprehensive, yet targeted measurement model. Earn .1 CEU (1.25 NBCOT PDUs/1 contact hour). Order #OL4961. AOTA Members: $24.99, Nonmembers: $34.99. http://store.aota.org

Online Course
A Contemporary Occupational Performance Approach to Pediatric Self-Regulation Part II: Self-Regulation Intervention Framework and Strategies by Meredith Gronski, OTD, OTR/L, and Theresa Henry, MSOT, OTR/L. This course will present the most effective treatment strategies from a comprehensive foundation of evidence-based practices, all within the context of the PEEP (Person/Environment/Occupational Performance) framework, from Part 1 of this 2-part course. The primary focus of this course will be on client-centered, environmentally-relevant interventions that lead to productive occupational performance across the continuum from early childhood to adolescence. Earn .1 AOTA CEU (1.25 NBCOT PDUs/1 contact hour). Order #OL4931. AOTA Members: $24.99, Nonmembers: $34.99. http://store.aota.org

Online Course
Applying the OT Practice Guidelines for Adults With Neurodegenerative Diseases by Katharine Pressmer, EdD, OTR/L. Evidence-based practice is integral to successful client outcomes. This course is intended to assist occupational therapy practitioners in providing evidence-based assessment and interventions to adults with neurodegenerative diseases (NDDs). This course facilitates the use of the practice guidelines by presenting the information in a multimedia format and walking the learner through case studies that illustrate important concepts in the guidelines. Four interactive case studies are presented that address the following NDDs: Multiple Sclerosis (MS), Parkinson’s Disease (PD), Amyotrophic Lateral Sclerosis (ALS), and Transverse Myelitis (TM). Earn .15 CEU (NBCOT 1.88 PDUs/1.5 contact hours). Order # OL4896. AOTA Members: $34.95, Nonmembers: $49.95. http://store.aota.org

Online Courses
Occupational Therapy: Across the Parkinson’s Disease Continuum Series – designed and created in collaboration with the Parkinson’s Disease Foundation. These online courses are designed by expert occupational therapy practitioners in the field of Parkinson’s to help their colleagues to ensure best practice care for people living with the disease. These courses will provide practical, evidence-based knowledge across the continuum of Parkinson’s care to help occupational therapists evaluate and treat individuals in all settings — including in home care, community rehabilitation and long-term care practice settings. Earn 2 AOTA CEUs (2.5 NBCOT PDUs, 2.0 contact hours). Members/Nonmembers: $19.95. Module 1: Overview of Parkinson’s Disease (Order #OL4960); Module 2: Assessment in Parkinson’s Disease Intervention (Order #OL4961); Module 3: Occupation Therapy Intervention for Parkinson’s Disease (Order #OL4962); Module 4: Parkinson’s Disease: Emerging Research, Resources, & Beyond (Order #OL4963). http://store.aota.org

Online Course
Organizational Ethics: Occupational Therapy Practitioners in the field of Parkinson’s to help their colleagues to ensure best practice care for people living with the disease. These courses will provide practical, evidence-based knowledge across the continuum of Parkinson’s care to help occupational therapists evaluate and treat individuals in all settings — including in home care, community rehabilitation and long-term care practice settings. Earn 2 AOTA CEUs (2.5 NBCOT PDUs, 2.0 contact hours). Members/Nonmembers: $19.95. Module 1: Overview of Parkinson’s Disease (Order #OL4960); Module 2: Assessment in Parkinson’s Disease Intervention (Order #OL4961); Module 3: Occupation Therapy Intervention for Parkinson’s Disease (Order #OL4962); Module 4: Parkinson’s Disease: Emerging Research, Resources, & Beyond (Order #OL4963). http://store.aota.org

Online Course
Social Skills for Children with Autism Spectrum Disorder (ASD) by Sharron J. Gutman, PhD, OTR/L, FAOTA and Emily L. Michaud. This course will illustrate the theoretical basis and guidelines for the SIMPLE Intervention and its use through written and video demonstrations. Instructions for 11 warm-up and 10 role-play activities are embedded in the course. Video clips are provided to demonstrate many of the activities. The SIMPLE Intervention can be used in the school system or in private practice. Earn .2 CEU NBCOT PDUs/2 contact hours). Order #OL4897. AOTA Members: $49.95, Nonmembers: $64.95. http://store.aota.org

Webcast
Home Modification Webcast Series. Learn how upcoming changes in post-acute policy will change the value proposition of occupational therapy from one of maximizing reimbursement to creating value for all stakeholders—patients, family, payers, and providers. Earn 1 to 1.5 AOTA CEUs (1.25–1.88 NBCOT PDUs/.5–1.5 contact hours) per completed webcast. AOTA Members: $24.95, Nonmembers: $34.95. Enabling Design: A Person-Centered Approach (Order #WA1226); Occupational Therapy’s Role in Navigating a Patient Transition from Hospital to Home (Order #WA1225); Fundamentals of Pediatric Home Modifications (Order #WA1224); Setting up a Home Modifications Business (Order #WA1223); From Inspiration to Installation: The Search for Creative Ideas to Solve Home Modifications Challenges (Order #WA1221). Meeting the Psychosocial Needs of Clients (Order #WA1220). http://store.aota.org

Earn CE Credit With AJOT Articles! Learn about tested treatment strategies by reading AJOT articles in your area of practice. Become an evidence-based practitioner and demonstrate your knowledge by passing the course exam. Articles have been selected for their relevance to practice, fresh ideas, and strong evidence supporting treatment and the distinct value of OT. Earn .1 AOTA CEU (1.25 NBCOT PDUs/1 contact hour). Order #OL4950, AOTA Members: $24.99, Nonmembers: $39.99. http://store.aota.org

AJOT CE: Effectiveness of Occupational Therapy Interventions for Adults With Fibromyalgia: A Systematic Review, Order #CEAJOT40 0416

AJOT CE: Effectiveness of Occupational Therapy Interventions for Adults With Rheumatoid Arthritis: A Systematic Review, Order #CEAJOT41 0416

AJOT CE: Evaluation of Hand Forces During a Joint-Protection Strategy for Women With Hand Osteoarthritis, Order #CEAJOT42 0416

AJOT CE: Lifestyle Redesign® for Chronic Pain Management: A Retrospective Clinical Efficacy Study, Order #CEAJOT43 0416

AJOT CE: Facilitating Wellness in Urban-Dwelling, Low-Income Older Adults Through Community Mobility: A Mixed-Methods Study, Order #CEAJOT44 0416

AJOT CE: Supporting Participation for Children With Sensory Processing Needs and Their Families: Community-Based Action Research, Order #CEAJOT45 0416

AJOT CE: Effects of a One-to-One Fatigue Management Course for People With Chronic Conditions and Fatigue, Order #CEAJOT46 0416

AJOT CE: Caregivers’ Perspectives on the Sensory Environment and Participation in Daily Activities of Children With Autism Spectrum Disorder, Order #CEAJOT47 0416

AJOT CE: Integration of Medication Management Into Occupational Therapy Practice, Order #CEAJOT48 0416

November 27, 2017 • www.aota.org
**University Of Pittsburgh**

**SENIOR FACULTY POSITION – ASSOCIATE/FULL PROFESSOR**

**ARE YOU a leader or emerging leader in research, education, and practice? Consider joining the faculty of one of the nation’s leading public research institutions.**

**WE NEED:** An occupational therapist, with an earned research doctorate, a license (or eligible for) to practice occupational therapy in Pennsylvania, a history of funded research, and a minimum of 5 years of teaching experience to:

1. Implement a research agenda; 2) teach in our professional and research doctoral programs. Rank and salary are dependent on qualifications. Expertise in health services research is preferred.

**TO APPLY:** Applications accepted until positions are filled. For information, contact Dr. Elizabeth Skidmore (skidmore@pitt.edu). Letter of application, curriculum vitae, and names and addresses of three professional references should be sent to: Christie Jackson, 5012 Forbes Tower, University of Pittsburgh, Pittsburgh PA 15260; 412-383-6620; cmr77@pitt.edu.

**Creighton University**

**School of Pharmacy and Health Professions**

**ASSOCIATE/FULL PROFESSOR**

**SENIOR FACULTY POSITION –**

**Two 12-month tenure-track, teaching-research faculty positions, rank commensurate with experience**

**Qualifications:**
- Earned research doctorate (e.g., PhD, EdD, DSc, ScD); Licensed or eligible for occupational therapy licensure in Nebraska preferred; other research-related professions eligible to apply; Teaching experience of at least 3-5 years preferred, experience in distance and hybrid programs preferred; Clinical expertise and proficiency in an occupational therapy practice area preferred; Active research program or demonstrate potential for scholarship, funding, and publication

**Responsibilities:**
- Teaching, scholarship, and service to the department and the university; Primary teaching responsibilities in research and/or evidence-based practice courses in the OTD program; Serving as a research mentor for group student research projects and engaging in a research program; Student advisement

**One 12-month non-tenure track, clinician-educator faculty position, rank commensurate with experience**

**Qualifications:**
- Earned doctorate (e.g., OTD, EdD, DSc, ScD); Licensed or eligible for occupational therapy licensure in Nebraska preferred; Teaching experience of at least 3-5 years preferred, experience in distance and hybrid programs preferred; Clinical expertise and proficiency in physical rehabilitation preferred

**Responsibilities:**
- Teaching, scholarship, and service to the department and the university; Primary teaching responsibilities in physical rehabilitation and/or other courses in the OTD program (e.g., ethics, evidence-based practice, management); Serving as a research mentor for group student research projects; Student advisement

Due to occupational therapy departmental growth, these unique and exciting opportunities await the appropriate candidates. We are looking for doctoral-prepared individuals who enjoy a progressive and dynamic environment to join our active, creative, and engaged faculty of 20; dedicated to expanding the scope of occupational therapy practice and education and challenging our students to actively reflect the University’s unique Ignatian values. Our is nationally recognized for its leadership and innovation in occupational therapy doctoral education. The Department has strong administrative and institutional support for its programs and creative initiatives.

The Department of Occupational Therapy is seeking self-motivated and productive individuals who are looking to advance their career and become part of a vibrant and transformational program. The doctoral-prepared faculty member will have an exceptional opportunity to influence the future of occupational therapy doctoral education through a number of successful initiatives including our entry-level campus-based pathway and our three entry-level hybrid campus-online programs in Omaha, Anchorage, Denver, and the more recent launch of our international Master of Science in Occupational Therapy and the Master of Science in Rehabilitation. In addition, we are experiencing continued growth in our highly successful post-professional doctoral program and several international collaborative and outreach programs such as the Institute for Latin American Concern and the China Honors Interprofessional Program.

Omaha is a friendly city in the heart of a metropolitan area of over 1 million. It is a wonderful place to live where unemployment is low, cost of living is below the national average, educational attainment is high, and a variety of cultural and recreational attractions exist. For more information, please visit: http://www.visitomaha.com/.

Application review will begin immediately and continue until the position is filled. Expressions of initial interest will be treated in strict confidence. To learn more about the university, school and program, please visit: http://www.ot.creighton.edu. Candidates should submit a letter of application, curriculum vitae, and three personal references to:

Vanessa Jewell, PhD, OTR/L
Chair - Search Committee
Department of Occupational Therapy
School of Pharmacy and Health Professions
Creighton University
2500 California Plaza
Omaha, NE 68178
Phone: (402) 280-5946, Fax: (402) 280-5692
email: vanessajewell@creighton.edu

Creighton is a Jesuit, Catholic institution that encourages applications from qualified individuals from all backgrounds who believe they can contribute to its distinctive educational tradition.

Creighton University is an Affirmative Action, Equal Opportunity Employer.

**RehabCare Group East, Inc.**

is currently recruiting full-time Occupational Therapists to provide services in at multiple facilities in Redmond, WA with occasional coverage in Everett, WA and Seattle, WA. US or foreign Master’s Degree in Occupational Therapy. Must possess a State of Washington occupational therapy license.

To apply, please e-mail your resume to Dan Miller at dan.miller@rehabcare.com
Position Description: The University of Texas at El Paso (UTEP) College of Health Sciences Department of Rehabilitation Sciences invites nominations and applications for a full-time, tenure-track or tenure-eligible position in a growing Master of Occupational Therapy (MOT) Program. This is a 9-month academic year appointment with the possibility of summer teaching. Responsibilities include teaching, advising, research/scholarship and service activities within the department, college, university, and profession. Unique opportunities for interdisciplinary research in underserved and multicultural populations are available. The anticipated appointment date is September 2018.

Qualifications: Candidates must (1) have a doctorate in occupational therapy or a related field, (research doctorate preferred, clinical doctorate considered), (2) be eligible for Texas occupational therapy licensure, (3) be an active member of the American Occupational Therapy Association, (4) have a minimum of two years of experience in clinical occupational therapy practice, (5) have experience in teaching, research, or grant writing, (6) demonstrate a commitment to, or potential for, teaching excellence at the university level, (7) demonstrate skills or potential to develop proficiency in instructional technology, and (8) have the ability to work effectively with faculty, staff, and students from diverse ethnic, cultural, and socioeconomic backgrounds. Preferred qualifications include (1) a record of active participation or leadership roles in occupational therapy, (2) a record of research and/or publications, and (3) experience in grant writing and/or project management.

Application Instructions: Review of applications will begin immediately, and applications will be accepted until the position is filled. Applicants should submit: (1) a cover letter describing qualifications and interest in the position, (2) an up-to-date copy of a curriculum vitae, and (3) names and complete contact information for three professional references. Candidates will be notified before references are contacted. For more information, please contact Program Director Dr. Christine C. Chen at cchens5@utep.edu.

To view the full position announcement and apply, please visit www.utep.edu/employment.

In keeping with its Access and Excellence mission, the University of Texas at El Paso is committed to an open, diverse, and inclusive learning and working environment that honors the talents, respects the differences, and nurtures the growth and development of all. The University of Texas at El Paso is an Equal Opportunity/Affirmative Action employer. The University does not discriminate on the basis of race, color, national origin, sex, religion, age, disability, genetic information, veteran status, sexual orientation or gender identity in employment or the provision of services.

UNIVERSITY OF TEXAS AT EL PASO

Write for OT Practice!

See author guidelines at www.otpractice.org.
TWO FULL-TIME FACULTY POSITIONS

A great opportunity for early career faculty, applicants are invited to apply for two 12-month, full-time Assistant/Associate Professor Open rank positions to join our innovative entry-level Master of Occupational Therapy program at the University of New Mexico, a research intensive university. The positions are available due to the retirement of two founding faculty members. We are also entering a period of growth, opportunity and transition as we have moved into our new state of the art teaching lab and are beginning to create a new entry-level curriculum for an occupational therapy doctorate. We are seeking faculty who would be excited and ready to be a part of our team in creating the new curriculum.

A focus on occupation will continue to be the foundation of the curriculum, which includes a strong problem-based learning (PBL) component. The Occupational Therapy Graduate Program is housed administratively within the Department of Pediatrics; however, we emphasize teaching across the lifespan. The UNM Health Sciences Center offers opportunities for interprofessional education and collaborations with centers such as the Project Echo® (Extension for Community Healthcare Outcomes), Memory and Aging Center, Clinical and Translational Sciences Center, and the Brain and Behavioral Health Institute.

The UNM Occupational Therapy Graduate Program is located in the vibrant and culturally rich city of Albuquerque, which lies in the high desert ecosystem of central New Mexico. The city spans the Rio Grande River and is bordered by the Sandia Mountains on the East and a string of five inactive volcanoes on the West. A number of Native American communities exist near the city. In addition to the world renowned Albuquerque International Balloon Fiesta, Albuquerque boasts easy access to skiing, golfing and countless hiking and biking trails.

Responsibilities will include collaborating with faculty in teaching and administering the Master's program, course development, curriculum development for the new entry level OTD, engaging in scholarly activity, grant writing, mentoring graduate students, and serving on program and university committees. Rank and tenure status will be commensurate with educational background and experience.

Minimum Qualifications:
• Doctoral degree or verified completion of doctoral degree by start date
• At least one year of teaching graduate students
• At least one year of Occupational Therapy practice experience
• Evidence of scholarly activity
• Eligibility for Occupational Therapist licensure in New Mexico

Preferred Qualifications:
• Research doctoral degree
• Evidence of teaching excellence, graduate student mentoring, and curriculum development
• Evidence of scholarly activity with at least one peer-reviewed article
• Evidence of obtaining grant funding

For best consideration, applications must be received by December 15, 2017; however, the position will remain open until filled. A complete application must contain a cover letter, CV and 3 references with contact information. This position is subject to criminal records screening in accordance with New Mexico law and clearance by the New Mexico Department of Health is required as a condition of employment.

The University of New Mexico is an Equal Opportunity/Affirmative Action Employer and Educator. Regents’ Policy Manual - Section 6.7: Disclosure of Information about Candidates for Employment, which includes information about public disclosure of documents submitted by applicants, is located at http://policy.unm.edu/regents-policies/section-6-6-7.

For complete details of this position or to apply, please visit this website and reference posting number req2881 unmjobs.unm.edu.

For additional application information, you may contact Lynda Easter, Search Coordinator, at leaster@salud.unm.edu.

For more job information, contact Dr. Carla Wilhite, OTD, OTR/L, (505) 272-3324, cwilhite@salud.unm.edu.

QUALIFICATIONS

Earned doctorate with evidence of research, publications and grant activity; eligible for license as an occupational therapist in the state of Indiana; at least three years of full-time academic appointment.

Salary and benefits are competitive; Academic rank, tenure, and salary are dependent upon academic qualifications, clinical experiences, previous academic teaching, experience, program management experience, and scholarship accomplishments.

Appointment/Start Date: July 1, 2018

Application Process: Applicants must include resume or curriculum vitae, a letter of application, transcripts, and three letters of support. For questions related to the position, contact the Search Committee Chair Carmen Dielman cdielman@iusb.edu. For best consideration, please apply by November 15, 2017 and continue until the position filled.

https://indiana.peopleadmin.com/postings/4678

Indiana University South Bend’s 2014 – 2020 strategic plan includes a commitment to advance diversity and open-mindedness and to create a civil, welcoming, and caring culture for all. Of over 7,500 students, 24% self-identify as minority. The population of Hispanic students has exceeded 10% and IU South Bend has seen significant increases in the admission of African American students. Women, minorities, individuals with disabilities, and veterans are strongly encouraged to apply. Candidates who have mentored minorities or other underrepresented groups are encouraged to highlight such efforts in the application.
Social Media Spotlight

Tricks for New Practitioners

We asked our Facebook friends to share their best tricks for new occupational therapy practitioners. Check out some of their advice:

“Always have ready a well-rehearsed definition of occupational therapy—how it is different than PT, and why your patient needs it. Advocate for the profession!”
—Stephanie Holder

“At my Fieldwork, the hospital is implementing a “got your back” plan. Therapists there keep an eye out for each other’s ergonomics during therapy and patient transfers, and keep an eye on patients’ ergonomics as well. If they see something, they say something. Doing so can literally save someone’s back!”
—Ashley White

“Keep in mind that the first duty of an occupational therapist is to identify what it is that the patient wants and facilitate that. What they want doesn’t have to be “normal” or sensible or approved by others.”
—Sheila Joss

“Self-care: If we can’t look out for ourselves, we can’t look out for others. So many times, clinicians (myself included) just power through—sometimes we just need that mental health day. Don’t be afraid to take it. You’ll come back ready to work and be your best!”
—Rachael Wallens

“Remember to keep the patient first and listen to them. As a new practitioner, everyone feels like they know nothing, but just fake it ’till you make it. No one knows your insecurities besides you.”
—Ashley Nicholson

#OTCentennial
On This Day

Throughout 2017 we’ve been sharing “on this day” posts about OT’s history. See a timeline of major events at www.aota.org/events-timeline.

1. On September 14, 1937: First Lady Eleanor Roosevelt spoke at an AOTA conference.
3. On July 30, 1965: Medicare was established and OT was included.

OT Connections

— Your colleagues in Work & Industry are discussing a new official document in AJOT on facilitating work participation and performance. www.aota.org/otc/work-doc

— Backpack and bag safety is a relevant topic year round for adults who carry heavy purses and briefcases. Continue the discussion on proper bag use. www.aota.org/otc/bag-safety

— Student Occupational Therapy Association (SOTA) advisors are discussing challenges and strategies for support. www.aota.org/otc/sota

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Suicide Awareness and Occupational Therapy for Suicide Survivors

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This CE article was developed in collaboration with AOTA’s Mental Health Special Interest Section.

ABSTRACT
Suicide is a public health crisis. In 2015, within the United States, 44,193 individuals completed suicide, and an additional 1.4 million individuals attempted suicide (Centers for Disease Control and Prevention, 2017a).

Although much remains unknown about the underlying cause of suicidal ideation, behaviors, attempts, and completions, research has indicated contributory (not causal) risk factors and associated warning signs. Because of the multiple complexities associated with treating those at risk (including those who have lost someone to suicide), a holistic approach that recognizes the complexities of the individual, such as the approach of occupational therapy, is crucial.

Occupational therapy practitioners from all practice settings need to be aware of the risk factors and warning signs to respond appropriately. Moreover, occupational therapists can enhance their evaluation and treatment approaches by applying models of practice and frames of reference, activity analysis, and through examining the Occupational Therapy Practice Framework: Domain and Process (American Occupational Therapy Association, 2014).

LEARNING OBJECTIVES
After reading this article, you should be able to:
1. Identify known risk factors associated with suicide
2. Describe appropriate steps to take in addressing suicidal behaviors
3. Differentiate grief experienced by suicide survivors from other types of grief
4. Identify appropriate clinical considerations and resources to enhance the occupational therapy approach when working with individuals at risk for suicide (including suicide survivors)

INTRODUCTION
Suicide is defined as “the act or an instance of taking one’s own life voluntarily and intentionally” (Suicide, 2017). Medical examiners or designees report their findings associated with the cause of death and record these findings on the death certificate. This means that the medical examiner or designee, to whatever degree possible, may be involved in determining the “intentionality” of the act that resulted in death. Therefore, not all deaths that are directly because of the deceased’s actions are considered suicide. An opioid overdose, for example, that unintentionally results in death might not be considered suicide. The cause of death noted by a medical examiner or designee is also noted by other entities and compiled for reporting and research purposes (for example, by the Centers for Disease Control and Prevention [CDC]).

Throughout this article, the terms completed suicide or death by suicide are used instead of committed suicide. The word committed in this sense may imply judgment of the person or act. Therefore, the words are purposefully and thoughtfully chosen, particularly in view of the stigma associated with suicide. The term suicide survivor refers to an individual who has lost someone to suicide.

The statistical data that follows has primary application to the United States; however, suicide is also a global health issue. The World Health Organization (WHO; 2017) reported that in 2015, approximately 800,000 deaths by suicide were reported worldwide. In 2015, within the United States, a reported 44,193 suicides occurred (CDC, 2017a), making suicide the country’s 10th leading cause of death. In addition, 505,507 individuals received medical care for self-inflicted injuries in 2015 (CDC, 2017a). Researchers estimate that for every person who has completed suicide, approximately 11 to 25 individuals have attempted suicide (CDC, 2017a; National Institute of Mental Health [NIMH], 2016). Data from the Substance Abuse and Mental Health Services Administration’s 2015 National Survey on Drug Use and Health found that within the previous year, “9.8 million adults (18 years of age and older) seriously contemplated completing suicide, 2.7 million actually made plans, and 1.4 [million] had an actual attempt” (NIMH, 2016).

A more specific, brief summary by the CDC (2017a), based on data from 2015, found suicide to be the second leading cause of death among 15 to 34 year olds, after death caused
by unintentional injury. Suicide is the third leading cause of death among 10 to 14 year olds, the fourth among 35 to 44 year olds, the fifth among 45 to 54 year olds, and the eighth among 55 to 64 year olds. Statistical data are also available regarding the prevalence of suicide among various ethnicities and races, the means and methods used in the completed suicides of 2015, and the economic burden associated with suicide (CDC, 2017a).

**Risk Factors**

Through research, risk factors have been identified that are associated with completed suicide. The presence of any of these risk factors does not imply absolutely that a suicide would be attempted. The factors do, however, indicate where caution needs to be used. Wherever possible, steps should be taken to reduce the number and/or intensity of risk factors.

The CDC (2017b) notes that risks factors include but are not limited to:

- Family history of suicide; family history of child maltreatment; previous suicide attempt(s); history of mental disorders, particularly clinical depression; history of alcohol and substance abuse; feelings of hopelessness; impulsive or aggressive tendencies; cultural and religious beliefs (e.g., belief that suicide is a noble resolution of a personal dilemma); local epidemics of suicide; isolation; a feeling of being cut off from other people; barriers to accessing mental health treatment; loss (relational, social, work, or financial); physical illness; easy access to lethal methods; and/or [an] unwillingness to seek help because of the stigma attached to mental health and substance abuse disorders or to suicidal thoughts.

Again, these risk factors are considered to be contributory, not causal.

Suicidal ideation, suicidal behaviors, and suicide attempts are considered to be psychiatric emergencies. However, occupational therapy practitioners need to be aware of these contributory risk factors potentially present in clients, regardless of practice setting and area (i.e., not only in mental health practice settings). Research findings associated with an increase in the prevalence of suicidal ideation, suicide attempts, and completions among those who experience physical illness, disease, or trauma, further underscore the importance of occupational therapy practitioners’ awareness of contributory risk factors. Kashiwa, Sweetman, and Helgeson (2017) addressed the high rate of suicide among veterans, as well as the contributing risk factors experienced by veterans. Individuals who have experienced bullying have also been identified as being at risk for suicide (American Occupational Therapy Association [AOTA], 2011; CDC, 2014). McIntosh and colleagues (2016) provided information on suicide rates as grouped by identified occupation and also offered interesting commentary as to potential contributing factors, including, in some instances, the exposure to various environmental pathogens. Research has also examined associated increased prevalence of suicide and chronic pain (Wilson, Kowal, Henderson, McWilliams, & Pelquin, 2013), lupus (Tang, Lin, Chen, Chen, & Chen, 2016), stroke (Pompili et al., 2012), traumatic brain injury (Fisher et al., 2016), spinal cord injury (Cao, Massaro, Krause, Chen, & Devivo, 2014), Parkinson’s disease (Lee et al., 2016), amputation (Jammillo, 2015), Type I diabetes (Siddharth & Yatan, 2014), posttraumatic stress disorder (Selaman, Chartrand, Bolton, & Sareen, 2014), and rheumatic disease (Shim et al., 2017). This is by no means an exhaustive list. Whether contributing factors (e.g., mental illness) might be present before the onset of the client’s condition, risk factors are consequential to the client’s condition, or a traumatic life event or accident occurs (e.g., a life experience resulting in posttraumatic stress disorder, a disabling car accident), occupational therapy practitioners need to be aware of contributing factors to suicide and be able to provide an appropriate response.

A few comments need to be made regarding suicide survivors—those who have experienced the loss of someone to suicide. Suicide survivors are also sometimes referred to as suicide bereaved.

Research estimates regarding the number of survivors for every individual death by suicide vary, ranging from an average of six (Berman, 2011) to 115 (Spinno, Kameg, Cline, Terhorst, & Mitchell, 2016). The severity of the impact may be influenced by the relationship to the deceased (e.g., spouse, sibling, child, friend, co-worker, client), the circumstances surrounding the suicide, and the aftermath of the suicide (Cerel, Jordan, & Duberstein, 2008; Cerel, Maple, Aldrich, & van de Venne, 2013; Erlich, 2016; Grad, Clark, Dyregrov, & Andriessen, 2004; Mitchell, Sakaida, Kim, Bullian, & Chippetta, 2009; Rostila, Saarela, & Kawachi, 2014). Suicide survivors may experience the stigma associated with suicide, resulting in isolation (Grad et al., 2004; Hanschmidt, Lehning, Riedel-Heller, & Kersting, 2016). There may be a sudden change or end of a life role secondary to the loss (e.g., loss of the role of spouse, parent, sibling, child, client). Survivors may experience psychological and somatic declines that affect psychological, cognitive, and physical health status as well as a decline in the ability to carry out responsibilities (e.g., family, employment) (Rostila et al., 2014; Terhorst...
& Mitchell, 2012). More specifically, Rostila et al. (2014) discussed "adverse health effects" associated with being a suicide survivor, including increased risk for suicide, cardiovascular disease, and "pathophysiological changes in the sympathetic nervous system, the hypothalamic-pituitary-adrenal (HPA) axis, and the immune system" (p. 920). Research also indicates that survivors of suicide grieve differently than survivors of death by other means and are at risk for complicated grief, which may persist for years, including shame, guilt, feelings of responsibility for the suicide, and feelings of rejection (Bailley, Kral, & Dunham, 1999; Brower, 2017; Gall, Henneberry, & Eyre, 2014). Mitchell, Kim, Prigerson, and Mortimer-Stephens (2004) further indicated that suicide survivors’ complicated grief may be associated with cardiovascular issues, cancer, immune disorders, and unhealthy behaviors (e.g., increase in smoking, negative change in eating habits). Given the range of potential health complications associated with being a suicide survivor, occupational therapy practitioners need to be aware of other potential indicators that an individual may be suicidal. The AFSP (2017) has provided information regarding warning signs that an individual might be contemplating suicide, namely:

Changes in behavior (such as increased use of alcohol or drugs, recklessness, withdrawal and/or isolation, looking for ways to complete suicide, giving away possessions), changes in mood (displays of depression, anxiety, loss of interest, rage, irritability, humiliation), and what a person says (talking about killing oneself, being a burden to others, feeling trapped, having no reason to live, being in unbearable pain).

Occupational therapy practitioners should be aware of any of these indicators that are expressed by clients and immediately follow the protocol as established by the employer or facility for such an emergency. Typically, the protocol will include steps to keep the client, one’s self, and others safe; how to summon emergency support if necessary; and how to ensure the treatment includes communication with one another (and emergency personnel, if necessary). Documenting the client’s words or actions and the occupational therapy practitioner’s response will likely occur within the occupational therapy note or through another method (such as an incident report, or client concern report). These documents are typically part of the client record and should be considered legal documents, with the hallmarks of accuracy, clarity, and factual relevance. Occupational therapy assistants should immediately report any concern or change in client status to the occupational therapist in the event that further evaluation or modification of the treatment plan is warranted. Methods of communication to part-time and/or per diem employees should also be established so that they are aware of the client’s status.

Role of OT in Suicide Awareness and Working With Survivors

As seen in the information presented thus far, occupational therapy practitioners may be treating individuals at risk, including survivors, regardless of setting or area of practice. Kashiwa et al. (2017) presented a compelling discussion regarding the need for occupational therapy practitioners to examine their professional roles and responsibilities in addressing suicide awareness and prevention with the veteran population (and others). Although Hewitt and Boniface (2014) indicated that many occupational therapy practitioners think they are “ill-prepared to address suicide-related issues” (p. 13), they have many professional tools available and need to consider their therapeutic approaches, both in assessments and interventions, based, at minimum,
on models of practice, frames of reference, and the Occupational Therapy Practice Framework: Domain and Process (3rd ed.; Framework; AOTA, 2014). The Framework and other models of practice can help practitioners develop a clinical approach that sustains the holistic views of occupational therapy. Additionally, although frames of reference assist practitioners in specific focuses of practice, the Framework and various models of practice provide a greater perspective that will many times include the dynamic interactions of environment, culture, occupation, and personal life roles of the client. In connection with this, Gutman (2005) provided several occupational therapy treatment suggestions, with a primary focus on client and family education. She highlighted the importance of client and family awareness of symptoms related to psychiatric conditions, exacerbations of those conditions (including the negative effects of drugs and alcohol), and understanding the importance of compliance with medication management. She also discussed the value of “contingency plans,” which outline steps to take if the client has an exacerbation of symptoms. Contingency plans are particularly useful if the client can participate in creating the plan, as a means, in some sense, to self-direct appropriate action in the event of a relapse. The Framework defines prevention as “education or health promotion efforts designed to identify, reduce, or prevent the onset and reduce the incidence of unhealthy conditions, risk factors, diseases, or injuries” (AOTA, 2014, p. S44). Gutman's suggestions are certainly in alignment with this definition.

Addressing the occupational needs of the client is a core characteristic of occupational therapy (Lamb, 2016). To that end, occupational therapy practitioners need to apply all their knowledge of human condition and activity analysis within a therapeutic environment and through the therapeutic use of self to most effectively address the client's engagement/re-engagement. Although occupational therapy interventions might involve various functional activities (e.g., dressing, bathing, cooking, managing medications), occupational therapy practitioners must look deeper than the client's performance of the activity (i.e., functional status or components that affect functional status, such as decreased range of motion or strength, or attention span) to understand what meaning the activity has to the client and the client's consequent level of engagement. Functional status and/or performance components offer important information regarding the client's ability and potential; however, the client's interpretation of meaning is critical to sustained engagement.

Velde and Fidler (2002) asserted that:

An activity encompasses a number of elements that contribute to defining the nature and characteristics of the activity. These include form and structure, action processes, properties, discernable outcome, and real and symbolic meaning ... It is important to distinguish activity from occupation. While occupation is defined and understood as the dynamic, complex process of being engaged in “doing,” it is not a synonym for activity; rather, it connotes the dynamic process of doing. It is the phenomenon of mind and body being occupied. (p. 5)

This is relevant because individuals who contemplate suicide are literally contemplating, if not already experiencing, a dis-engagement. Even for those clients who are seeking physical rehabilitation through the occupational therapy process, practitioners need to take into account the effects of reduction in the client's ability to engage in meaningful occupation when full rehabilitation may not take place. Fine (1999) described the ability to find meaning in “one's self, one's activities, [and in] the broader world of people and things around us, [as an invaluable ‘gift’ that allows for] adaptation and growth for both the individual and society” (p. 12). Fidler and Velde (1999) also placed value on the symbolic importance of purposeful activity and occupation, and the importance, as occupational therapy practitioners, of assisting the client in sustaining the engagement, or the “doing” of those activities (Fidler & Velde, 1999; Velde & Fidler, 2002). In such instances, when a client no longer views themselves as able to meaningfully engage, occupational therapy practitioners need to be able to navigate through the symbolic meaning of the occupation and assist the client in adapting and renegotiating either the manner or level of engagement or the meaning of that engagement. To provide the appropriate occupational therapy intervention, practitioners must understand the relevance of various activities to the client's personal sense of meaning and interests, and more broadly, the relevance to the client's personal and societal relationships.

Through therapeutic use of self, thorough client-centered activity analysis, and applying occupational therapy models of practice, the occupational therapist can address the client's strengths and risk factors as well as physical, cognitive, and psychological components that might interfere with or facilitate engagement in meaningful activity and occupational performance. By applying these tools and approaches, occupational therapists can determine whether the goal is “health promotion, rehabilitation/restoration, remediation, health maintenance, adaptation, or prevention” (AOTA, 2014, p. S33). Educating the client to actively participate in identifying this overall goal as well as establishing
the appropriate steps is critical to successful intervention. Assisting the client in developing awareness of self (e.g., personal signs and symptoms of exacerbation of depression or the awareness of low self-esteem); knowledge (e.g., identifying coping strategies and resources); and perhaps even a health and wellness plan (e.g., self-care, exercise and diet, community engagement) are all preparatory activities. The occupational therapy process for clients should also include having the client actually perform the tasks or activities associated with the plan that has been developed. In so doing, practitioners are better positioned to respond to the client’s level of engagement and the perceptions of the client on the larger relevance and meaning of their engagement as part of “health promotion, rehabilitation/restoration, remediation, health maintenance, adaptation, or prevention” (AOTA, 2014, p. S33).

These concepts associated with the occupational therapy process apply to suicide survivors as well because of the identified potential complexities of physical and mental health challenges experienced by survivors following a loss as well as the survivor’s own risk for suicide.

ADVOCACY

Occupational therapy practitioners can advocate for methods that support suicide prevention awareness, research, and services. Many avenues are available for participation, such as supporting state and national occupational therapy political action committees; participating in lobbying efforts and town hall meetings; and participating in various volunteer organizations, such as the AFSP. Occupational therapy practitioners can also be leaders by developing and maintaining professional competencies; providing advocacy through documentation and reporting; and addressing third-party requests (e.g., medical review) in a thorough, accurate, and compelling manner. Such efforts can also provide a powerful example to clients of relevant methods of advocacy while discussing the need for services and appropriate resources. Given the number of risk factors and warning signs, as well as the potential for an extended, complicated grief process, occupational therapy practitioners should consider the benefits of advocating for occupational therapy services to be made available as part of the primary care process as well as potential for providing follow-up services.

Occupational therapy practitioners can advocate for required education on the topic of suicide awareness and prevention, as has occurred in several states (including Washington and Kentucky) to maintain state licensure for occupational therapy practice.

Occupational therapy practitioners can also be advocates by engaging in evidence-based practice and research. Searching for evidence and discussing the evidence with colleagues and other health care professionals can help establish the clinical basis and rationale for services. Participating in qualitative and quantitative research through compiling assessment and outcomes data and providing case studies (in accordance with facility research protocols and requirements) will further develop the body of knowledge and potentially help substantiate the need for and value of occupational therapy services.

AOTA (2017) provides strategies and tools to support practitioners in addressing and advocacy for mental health services. These tools include resources that assist practitioners in developing their own evidence-based practice as well as tools that can be used to educate others on the value of occupational therapy in addressing mental health.

CLINICIAN AS SURVIVOR

What would happen if an occupational therapist or occupational therapy assistant at some point in their career or personal life became a suicide survivor? The statistical information presented at the beginning of this article, as well as the information related to contributory risk factors, gives evidence that a great number of people are at risk. Whether occupational therapy practitioners work in the mental health practice area, or pediatrics, or physical rehabilitation, there will be clients who are at risk. Even if an individual is receiving treatment, they may still go on to complete suicide.

It is vital that occupational therapy practitioners take the necessary steps to address the effects of a suicide professionally and personally. Occupational therapy practitioners are not immune to the effects of a traumatic loss, such as suicide. Although blame, guilt, and anger might be a part of the “normal” grieving process associated with loss to suicide, prolonged and unresolved grief carries its own risks of psychological and physical harm. Seeking support is a crucial step professionally and personally. Attending to personal health and wellness to maintain an appropriate sense of balance through traumatic loss is also important. Through the grieving process, this balance is challenged. As Fielden (2003) noted, the transformation through grief related to a loss by suicide may include “ebb and flows” and “spirals inward and outward” (p. 83) until the survivor reaches a point of a renegotiation and understanding, where new beginnings can occur.

Fine (1999) also stated that “there is a unique human need to understand and give meaning to our experiences” (p. 12). Occupational therapy practitioners will also likely seek understanding and meaning in experiencing a loss by suicide. Of course, many aspects of occupational therapy concepts
and the Framework can also be personally applied. However, practitioners should not hesitate to seek out help from others who are trusted and qualified (e.g., physicians, family members, friends, religious/spiritual leaders, mental health professionals).

CONCLUSION
Statistical data and the known risk factors indicate that occupational therapy practitioners will likely encounter those who are at risk of suicide and those who are suicide survivors. They need to be aware of the identified risk factors and warning signs to respond appropriately.

Occupational therapy has a role in addressing the needs of those who are at risk for suicide or are suicide survivors. Applying models of practice, frames of reference, activity analysis, and the Framework can facilitate evaluation and treatment approaches that focus on the re-engagement of the client by addressing the factors that interfere with engagement, and potentially adapting to facilitate engagement in other ways or in other activities that are equally meaningful and purposeful to the client.

Although much research is still needed to understand the complexities and mechanisms that lead to suicide, occupational therapy practitioners need to continue to examine and enhance approaches to occupational therapy services for those at risk and for those who are survivors as well. Occupational therapy can have a positive effect in assisting clients to find ways to sustain their engagement and find meaning in their lives.

REFERENCES


How to Apply for Continuing Education Credit

A. To get pricing information and to register to take the exam online for the article Suicide Awareness and Occupational Therapy for Suicide Survivors, go to http://store.aota.org, or call toll-free 800-729-7262.

B. Once registered and payment received, you will receive instant email confirmation, with password and access information to take the exam online immediately or at a later time.

C. Answer the questions to the final exam found on pages CE-7 and CE-8 by November 30, 2019.

D. On successful completion of the exam (a score of 75% or more), you will immediately receive your printable certificate.

Final Exam

Article Code CEA1117

Suicide Awareness and Occupational Therapy for Suicide Survivors

November 27, 2017

To receive CE credit, exam must be completed by November 30, 2019

Learning Level: Intermediate

Target Audience: Occupational therapists and occupational therapy assistants

Content Focus: Professional Issues and Process of OT

1. In 2015, the number of reported deaths by suicide within the United States was:
   A. 800,000
   B. 44,193
   C. 21,000
   D. 50,000

2. In 2015, approximately how many people in the United States made a suicide attempt?
   A. 15,000
   B. 3 million
   C. 1.4 million
   D. 800,000

ADDITIONAL RESOURCES

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<th>Resource</th>
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<tr>
<td>Emergency Response (where available) at 911</td>
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<tr>
<td>National Suicide Prevention Lifeline: 800-273-TALK (8255)</td>
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<tr>
<td>National Alliance for Mental Illnesses Helpline: 800-950-NAMI</td>
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<td>American Foundation for Suicide Prevention: <a href="http://www.afsp.org">www.afsp.org</a></td>
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<tr>
<td>American Occupational Therapy Association: <a href="http://www.aota.org">www.aota.org</a></td>
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3. Suicide is the second leading cause of death among 15 to 35 year olds, second only to:
   A. Homicide
   B. Traumatic brain injury
   C. Unintentional injury
   D. Cancer

4. As identified through research, risk factors for suicide include all the following except:
   A. History of suicide attempt
   B. Family history of suicide
   C. Presence of mental illness
   D. Active community engagement

5. If an individual exhibits suicidal behaviors during a treatment session, the first course of action would be:
   A. Provide an occupational therapy assessment to identify the underlying causes of the behaviors
   B. Provide the client with alone time so they can process their feelings and/or behaviors
   C. Remove the client from any object or means that potentially could be used to inflict self-harm (or could be used to harm others) and seek emergency support personnel
   D. Document the behaviors and provide a report at the upcoming weekly staff meeting

6. Current research indicates that an individual’s attempt to complete suicide is:
   A. Likely a response to multiple factors that need to be addressed
   B. Because of a single isolated life event
   C. Can always be known
   D. Not serious if the person did not actually complete the suicide

7. The cause of an individual’s intention to complete suicide:
   A. Can be determined through a blood test
   B. Can be determined through a brain scan
   C. Can be pre-determined through genetic testing
   D. Cannot yet be determined, in that no definitive diagnostic methods are available

8. Currently, research indicates that the most effective method(s) of treating individuals with mental health conditions that put them at risk for suicide is/are:
   A. Electroconvulsive therapy
   B. Long-term institutionalization
   C. A combination of medication and psychotherapy
   D. Medications only

9. Occupational therapy practitioners will encounter individuals who have suicidal ideation, made an attempt to complete suicide, or are an identified suicide survivor:
   A. In the mental health practice setting only
   B. In the pediatric practice setting only
   C. In physical rehabilitation only
   D. In any and all practice settings

10. The individual who will determine the meaning of an activity to a client is:
    A. A significant other or spouse
    B. Other immediate family member (parent, sibling, child)
    C. The client
    D. The occupational therapist or occupational therapy assistant

11. An occupational therapist who uses a holistic approach in working with clients will consider:
    A. Dressing, bathing, and functional mobility only
    B. Paper-and-pencil activities to address self-esteem issues only
    C. Components of activity and occupational performance as well as the larger context of meaning to or for the client and the effect on the client’s “world”
    D. Only the components listed on the evaluation or treatment plan form

12. Occupational therapy practitioners who use a holistic approach will consider:
    A. Applying activity analysis, models of practice, frames of reference, and the Occupational Therapy Practice Framework: Domain and Process
    B. Only what is required by the client’s insurance or payer
    C. Only what is required on the evaluation or treatment plan form
    D. Only aspects of client care that are specific to the setting