August / September • Issue 4 • 2011

THE communiqué
Illinois Occupational Therapy Association

Kathy Van Leeuwen, OTR/L, CHT

Changing the future for patients with Dupuytren's contractures: Xiaflex

> Xiaflex, a collagenase injection, is the newest way to treat Dupuytren's contractures of the hand. ...While it sounds simple, this treatment is not without risk.

I recently had a charming 81-year-old patient in my hand therapy clinic. He had severe Dupuytren's contractures of his middle, ring and small fingers in both hands. His left hand had the addition of a thumb cord, restricting his palmar abduction to 30 degrees, not enough to span a coffee cup. When we finished our initial therapy session, he didn't shake my hand but fist-bumped me instead. At first, I thought it was cute that this old guy was making a cool exit but then I realized that there was no way he could have shaken my hand. His fingers were so flexed into his palm with Dupuytren's contractures that he couldn't possibly have opened to shake my hand. He had to quit the bowling league that he was in with his two sons because he couldn't get his fingers open enough to use his already custom-drilled ball. His thumb and index fingers were the only digits that provided any function for ADLs.

Dupuytren's disease is a process in which the palmar fascia just below the skin of the hand begins to abnormally thicken and contract into

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LaVonne St. Amand MPH,OTR/L

Social Media is Everywhere
Are you connected?

Today's communication methods give many choices. Most of us have access to texting; email; and the telephone whether it is a hard wired telephone or your cell phone. Many cell phones are like hand held computers. We are available much of the time and have choices to connect beyond belief.

Twitter; Facebook; yahoo; Myspace; LinkedIn and beyond. There are blogs, website communications, you tube and we could continue. Each of them offering their own customized way to stay connected to your friends; professional colleagues and family. Sites and methods of connecting with almost any topic or special venue. Pictures are posted that tell the world about events in our lives or simply make a statement based on feelings of the moment or the day. For the field of Occupational Therapy all of these venues or communication tools are generally referred to as "social media" and they are the trend of the day.

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AOTA State Affiliate

ILOTA Board

The Illinois Occupational Therapy Association of Illinois is the official representation of the OT professionals in the State of Illinois.

ILOTA acknowledges and promotes professional excellence through a proactive, organized collaboration with OT personnel, the health care community, governmental agencies and consumers.

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The Communiqué

The mission of the Communiqué is to inform Illinois Occupational Therapy Association (ILOTA) members of current issues, trends and events affecting the practice of Occupational Therapy. The ILOTA publishes this newsletter bimonthly.

ILOTA does not sanction or promote one philosophy, procedure, or technique over another. Unless otherwise stated, the material published does not receive the endorsement or reflect the official position of the ILOTA. The Illinois Occupational Therapy Association hereby disclaims any liability or responsibility for the accuracy of material accepted for publication and techniques described.

Deadlines and Information

Articles and ads must be submitted by the last day of the month prior to the month of publication. Contact the ILOTA office for more information and advertising submission forms:

7234 W. North Avenue, Suite 409
Elmwood Park, IL 60707
Phone: (708) 452-7640
Fax: (708) 452-764
Website: **www.ilota.org**

ILOTA Newsletter Editorial Committee

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ADVERTISING RATES

Vendor ads

Full page $535
Half page $425
1/4 page $315
1/16 page $205

Employment Ads

Full page $480
Half page $370
1/4 page $260
1/16 page $150

Continuing Education Ads

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Half page $205
1/4 page $150
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Typesetting Fees

Full page $100
Half page . . . . $ 60
1/4 page . . . . $ 35
1/16 page . . . . $ 15

Don't forget to renew your membership online at **www.ilota.org!**

Register for the 2011 ILOTA Annual Conference

Registration Is Now Open for the
2011 ILOTA Annual Conference
in Galena, IL
November 10, 11, and 12th

Conference Features:

- Thursday Afternoon: Pre-conference: ILLINOIS COMMISSION ON EDUCATION INSTITUTE
- Friday Morning: Keynote Address by Thomas M. Morrissey, a retired Sergeant with more than 30 years in the US Army Special Forces. On this Veteran's Day, we are honored to have Mr. Morrissey share his experiences with us. He was shot 8 times during his combat in Afghanistan and spent 3 years in rehabilitation.
- Friday Afternoon: Roundtable Discussions and Networking
- 28 educational sessions on a variety of topics…something for every occupational therapy practitioner
- The opportunity to receive 16 contact hours of continuing education at a fraction of the cost of many continuing education courses
- The Exhibit Hall where you can see new products, learn about charitable organizations, and talk with potential employers
- The Annual ILOTA Awards Luncheon and Business Meeting where you can share your voice and learn about what is new in the state
- The Association's annual fund raising event—the Silent Auction
- Opportunities to network with occupational therapy practitioners from the entire state of Illinois

Register online at **www.ilota.org**
Early bird registration discount ends November 4, 2011
Eagle Ridge room discount ends October 17, 2011

Legislative Update

September 2011 Legislative Report

Maureen Mulhall

The annual legislative veto session is scheduled to begin at the end of October. Veto session is designed to allow the General Assembly to take action on the bills that the Governor either vetoed or amendatorily vetoed during the summer. Of the 6,278 bills introduced in the spring 2011 session, 640 passed both chambers. Of those 640, the Governor signed 610 into law. Five of the remaining bills were budget bills that either had line item vetoes or reductions. That leaves only 25 substantive bills for the General Assembly to consider during the two veto session. Why in the world would legislators need 2 weeks to make decisions on only 25 bills? During the regular session they can work through that many bills in a single day.

Well, veto session has become more than just the time to deal with "vetoes." The "issues table" began being set in the summer with a rather open fight between the Governor, Mayor Emanuel, legislative leaders, and industry members interested in gambling expansion. The legislation that passed both chambers was a very carefully crafted house of cards. When the Governor started grumbling in late spring about his opposition to some of the elements being considering, Senate President Cullerton used a parliamentary maneuver to put the bill on hold, thus not giving the Governor the opportunity to take action on the bill. Senator Cullerton has expressed a willingness to look at the bill a second time with an eye towards compromise. Expect this to be a major topic during veto session.

Veto session issues continued to gain momentum after some controversial budgetary announcements initiated by the Governor.

These began with his announcement during the summer that union employees under his jurisdiction would not receive their pay raises this year. That proclamation has the Governor battling in court with the union. This was followed by the perhaps the more contentious announcement - the closure of seven state facilities and the possible layoff of over 1,900 state employees. Again, the Governor is battling the union in court on this issue as well. State facility closures impact much more than just the state employees however. The communities in which the facilities are located are greatly affected. But far more importantly are the hundreds, and perhaps thousands, of developmentally disabled and mentally ill citizens who will be displaced, let alone the closure of prisons. Where are all of these people to go?

The Governor indicated that much of this pain could be remedied if the General Assembly allowed him to reallocate $376 million that he reduced from the budget that the General Assembly sent to him in June. Some of that reduction was at the expense of the Regional Superintendents of Schools and transportation funding for students. Throughout the summer this particular reduction has been controversial – look for a resolution of this issue during veto session.

Currently budget estimates indicate that the state coffers have taken in nearly $2 billion over the estimates the 2012

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Research *Update*

The Canadian Occupational Performance Measure: An Outcome Measure

Lisa Knecht - Sabres, MS, OTR/L

Background

The expertise of an occupational therapist lies in his/her ability to appreciate the broad range of human occupations and activities that make up peoples' lives (AOTA, 2008). The Occupational Practice Framework (AOTA, 2002), defines occupations as activities that: (1) have unique meaning and purpose in one's life; (2) are central to one's identity; and, (3) influence how one spends time and makes decisions. Since occupational therapy practitioners focus on enabling people to engage (or re-engage) in the everyday activities which bring meaningfulness and purposefulness to their lives, the occupational therapy (OT) evaluation process must include an assessment of the daily activities the person either needs or wants to perform (AOTA, 2008).

According to the Occupational Practice Framework (AOTA, 2008), the first critical step in any OT evaluation is to obtain an understanding of the patient's or client's occupational profile. In other words, it is imperative to gain a deep understanding of the person's occupational history and experiences, patterns of daily living, interests, values, and needs. Thus, it is essential to ascertain the person's concerns about performing his/her occupations and daily life activities, as well as his/her priorities for occupational performance. Utilizing a client-centered approach to evaluate one's activities of daily living (ADL's) and instrumental activities of daily living (IADL's) provides a natural means for the patient or client to identify his/her unique circumstances and context (Law, Baum, & Dunn, 2005). The Canadian Occupational Performance Measure (COPM) (Law et al., 2005) is one of the few OT evaluation tools which evaluates occupational performance in a client-centered manner.

The COPM is a semi-structured interview designed to have the client: (1) identify concerns regarding his/her performance during self-care, productivity, and leisure activities; (2) evaluate his/her performance and satisfaction relative to his/her self-identified problematic occupational performance areas; and (3) prioritize his/her problems in occupational performance in order to determine areas to focus on during intervention.

Thus, the COPM measures changes in a client's perception of his/her occupational performance over the course of occupational therapy intervention. Since the COPM was designed as an outcome measure, the scores are used for comparative purposes at reassessment. The COPM is an individualized measure (vs. norm referenced), so the client's scores are compared against their own assessment scores. Performance and Satisfaction for each identified problem are re-evaluated on a 10-point scale (changes of 2 or more points on the COPM are clinically important) (Law et al., 2005).

There is a plethora of research on the COPM, which has repeatedly demonstrated satisfactory to excellent reliability, validity, and usefulness of the COPM as an outcome measure (Carswell et al., 2004). Other benefits of the COPM are that it: helps with goal writing (e.g., goals are focused on occupational performance rather than on body function); ensures that the client is involved in the goal formulation process; helps with team conferences and ensures that conferences are focused on the client's needs; facilitates intervention planning and motivation of the client; facilitates evaluation of outcomes; and, outcomes are clear and evident to the client (Carswell et al., 2004).

Case Example: Lynda

Lynda* is a 45 year old married woman who is a mother and works full-time as a teacher. Lynda was seen for home health OT after having brain surgery to remove an acoustic neuroma. After surgery, Lynda exhibited many neurological deficits (e.g., dysmetria, ataxia, low muscle tone, fatigue, decreased balance, and decreased postural control), which significantly interfered with her occupational performance.

As seen below, Lynda was most concerned about being able to perform some of her basic ADL's, IADL's, and leisure interests. It was important for Lynda to be able to apply her make-up and style her hair because she wanted to go back to work and was concerned about her personal appearance. Being a wife and mother, it was important for her to be able to cook for her family. Additionally, Lynda wanted to be able to engage in her yearly hobby of planting flowers in her yard and she wanted to be able to join her family on

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Research Update

If you would like to contribute to the Research Update segment or know someone who would, please contact Carrie Nutter at codycheq@aol.com

Clinical Spotlight: Melissa Lane

Hello, my name is Melissa Lane. I am currently working as an Occupational Therapist on the Burn Unit at Loyola University Medical Center. I work with patients that have suffered from burns, frostbite, necrotizing fasciitis, toxic epidermal necroliysis, and other skin disorders. My first exposure to this population came while I was a student at LUMC. I was assigned the burn unit rotation for 3 months. During this experience I felt an intense level of compassion for my patients and realized that I wanted to help these individuals regain their independence. I was also drawn to the diligent level of work and dedication needed to treat this specific population.

As an Occupational Therapist on the burn unit, the majority of my duties involve evaluating patient needs and deciding the best treatment plan to ensure that the patients reach their goals. While in the hospital, we work on ROM, strengthening, increasing independence with ADL's, positioning, scar management, family training, and psychosocial concerns regarding returning to the community and work.

Once a patient has left the hospital, I visit them in the outpatient clinic to evaluate the progress made during their therapy. In many instances, the body is not the only thing that needs to be healed after these traumatic events. I take pride in treating the whole person by being supportive of patients and their families by discussing their thoughts, fears, and expectations of their recovery. Patients often worry about the difficulties broaching their disfigurements and returning to school/ work, their families, friends, and interpersonal relationships.

The things that I find most rewarding in this job are seeing a patient progress through their therapy and improve their quality of life. In many instances patients are unable to perform their daily activities, so it is extremely rewarding to watch them walk out of the hospital and re-engage in their daily routines.

I also have a strong working relationship with my co-workers. The Burn Team takes on a multi-disciplinary team approach and everyone from the Physicians to the technicians on the unit are always willing to lend a hand to promote quality of care. The Burn Team is a cohesive, knowledgeable, and supportive group.

There is constantly new research and information on how to better treat burn patients; in order to continually grow as a professional and an educator I spend a lot of time outside of work reviewing and learning new information.

I am currently a member of the American Burn Association and attend the annual conference. As an educator, I lecture to local universities to ensure students gain the most up to date knowledge on burn rehabilitation. I also lecture at local hospitals, rehab centers, and outpatient facilities ensure our patients receive the expected level of care upon discharge from our facility. I also am currently involved in a national, multiple-site research study in conjunction with the Department of Defense with an aim toward improved therapy outcomes.

In the future, we are aiming toward expansion of the burn team, specifically with additional PT/OT's to allow the patients to receive more client-centered care. We will continue to evolve our practice based on the most current research in the burn and therapy community. The field of occupational therapy has allowed me to utilize my talents in a challenging, yet rewarding career. •

Friday Afternoon Networking Social at The 2011 ILOTA Conference

When: Friday, November 11 during lunch
What: A unique opportunity to reconnect with colleagues, meet new individuals in the field, and learn about ways to give back by volunteering to help Occupational Therapy remain a vital part of the healthcare field.

For more information, see the flyer in your conference materials! And stop by for an exciting **raffle** opportunity at the ILOTA table!

Clinical *Spotlight*

Clinical Spotlight

If you would like to contribute or suggest someone for the Clinical Spotlight segment, please contact Carrie Nutter at **codycheq@aol.com**

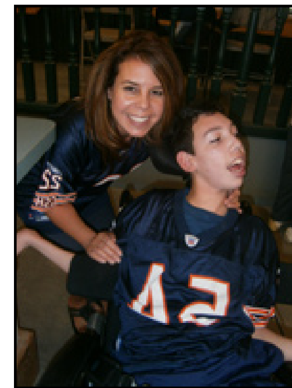
Photo *Opinions*

How has Occupational Therapy Impacted Your Family?

We value our colleagues' opinions and views! In each issue we will ask a different question. Some may be thought provoking and some may be more whimsical since as OTs we face both serious concerns and opportunities for creativity. We will feature responses and photos from 2-4 different clinicians or students in each issue. If you have an idea for a question or would like to be considered for a future issue, please contact us.

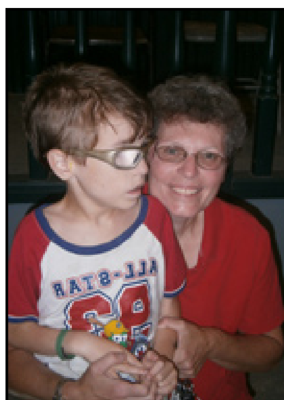
Variety of Therapy

Luis has participated in hippotherapy, occupational therapy, physical therapy and speech therapy. He has had private therapy at an outside facility since he was two years old. He received OT and PT in school until the age of 14. He has had outpatient therapy since he was five. I strongly believe the therapy has helped my child immensely. He has stronger head control and is able to grab things and be more attentive in social settings.



Lurdes and Luis Aceves

OT Interventions Change Expectations



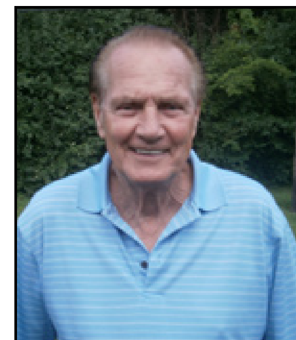
Mina and Kris Wright

Occupational Therapy services have been an integral part of the life of Kristofer Wright for many years. Throughout this time we have learned the importance of and experienced firsthand the benefits of this type of therapy. Kristofer has received occupational therapy services in a variety of settings including outpatient clinics, school, and hippotherapy for the past 12 years to treat severe hypotonia (low tone) which makes it difficult to move the muscles and almost impossible to perform fine motor skills. As a result he has been confined to a wheelchair and totally dependent on assistance for most of his life.

During Occupational Therapy sessions, various methods, such as ball work, play, and sensory activities are utilized to address hand strengthening, finger isolation, bilateral hand usage, and feeding skills. Kristofer has progressed slowly and steadily and can now perform many tasks he was never expected to. He has started to walk, can feed himself independently, and uses a computer and an electronic device to communicate. Much of this progress can be directly attributed to the occupational therapy he has received. We are grateful for OT as an intervention method and thankful to the therapists who are dedicated to the profession of Occupational Therapy.

Proud of Daughter's Chosen Field

My wife, Amy, always spoke highly of the field of occupational therapy and was proud that her daughter was an occupational therapist. When Amy became debilitated in April of 2009 by a stroke, she had many OTs working with her in the hospital, rehab. center and at home. She made some great progress after a few months of therapy but unfortunately had two seizures and her status declined a lot. Although she passed away in May of 2010, my family and I appreciated the help of all of the therapists.



Vic Nutter

Photo Opinions

If you would like to be featured in Photo Opinions or know someone who would, please contact Carrie Nutter at codycheq@aol.com

Xiaflex for patients with Dupuytren's contractures *(continued from page 1)*

palpable cords and nodules. The contraction of the fascia can progress over time and can extend into the fingers. This may cause the fingers to flex into the palm. The severity of the disease can vary greatly from just firm lumps in the palm to extreme flexion of MPs and PIPs of multiple fingers. The origin of this disease is unknown; however, Dupuytren's is more common among people of Northern European heritage and in men over 40. The dysfunction caused by Dupuytren's contractures can be debilitating and can significantly impair ADL function. Simple movements such as putting a hand in a pocket to retrieve a wallet or sliding a hand into a glove can become impossible.

My gentleman had 3 choices:

1. Do nothing and continue modifying every ADL over time.
2. Surgically remove the nodules and cords, or
3. Xiaflex injection into the cords with manipulation.

When the disease process becomes severe enough to impact ADLs or work function, treatment is available to deal with the contractures. Until recently, palmar fasciectomy and needle aponeurotomy were the most common procedures to remove/break the thickened palmar cords in a person's hand. Palmar fasciectomy is an open procedure in which the cord is surgically excised from the palm. If the skin remaining is not adequate to cover the wound bed, the opening may be left to close by secondary intention or with a skin graft. Skin grafting requires skin from another site, creating a second wound area.

Needle aponeurotomy uses a needle-like blade to puncture the cord to weaken it and allow mechanical force to break the cord. This is an outpatient procedure performed in the office with local anesthesia. Needle aponeurotomy is typically utilized in the early stages of cord contracture.

Both procedures create their own scar tissue and risk injury to tendon and nerve tissue which may be connected to or contracted closely with the Dupuytren's cord. Therapy is utilized after both procedures for splint fabrication, modalities to minimize scar development and further contracture and exercise to promote maximum range of motion. Depending on the severity of the wound, the scar tissue and the pre-operative limitations, therapy can be quite extensive.

Xiaflex, a collagenase injection, is the newest way to treat Dupuytren's contractures of the hand. It uses a medicine made of a mixture of proteins injected into the Dupuytren's cord to break down the collagen in the cord. This weakens the cord to allow the surgeon to manually extend the finger, "breaking" the cord. The hand is injected by a qualified surgeon and manipulated the following day to straighten the finger. The cord can be injected along different points and the injection can be repeated up to three times over several weeks, if needed, to achieve maximum extension.

After manipulation, the patient is provided with a splint to maintain the achieved extension. The splint is worn consistently for several days except during hygiene. If good extension is maintained at that point, the patient may then wean out of daytime wear and use it just at night. If more range is achieved, the splint can be adjusted for more extension.

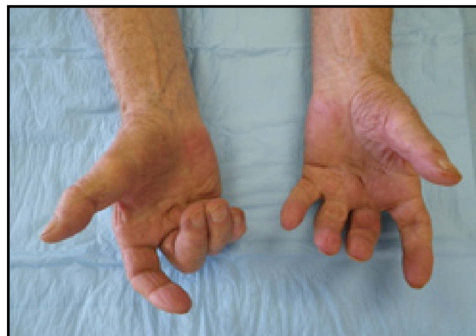
Some patients receive therapy for a short period to regularly adjust their splint as their tissue stretches and to provide exercises to maximize full extension and return to function. With milder contractures, many times therapy is needed only for the initial splint fabrication.

While it sounds simple, this treatment is not without risk. The medication breaks down collagen in the palmar cords. This means it can also break down collagen in tendons and ligaments. Tendon rupture after injection is a possibility, giving strong reason to seek out a surgeon practiced in the administration of the injection. Because this is an office procedure, the anesthesia risks are minimized and the costs are more reasonable. Because it is non-surgical, infection risks are lower also.

Collagenase injection has made a significant difference in expected healing time after the procedure as well as therapy time and involvement.

My 81-year-old patient chose the Xiaflex injection to begin regaining his hand function. On Tuesday, his surgeon injected the palmar cords to his middle, ring and small fingers. On Wednesday, the doctor was able to manipulate the ring and small fingers into extension at the PIP and MP joints; however, the middle finger PIP joint was still severely flexed at approximately 90 degrees. The surgeon also injected the thumb cord and was able to achieve more abduction after manipulation. After the manipulation appointment on Wednesday, the patient immediately came to me in therapy for a custom, fabricated splint. He was to wear the hand-based digit extension/thumb abduction splint at all times except hygiene and gentle exercises 4-5 times per day.

The patient was reasonably compliant with the program. He chose to remove his splint more often during the day to perform activities but was able to stretch back out to put it back on. Because this gentleman had 2 severely contracted hands, placing one in a splint left him quite unable to perform even basic ADLs independently. He chose to remove the splint more often and tried to maintain the extension by stretching. After 6 weeks, he underwent a second injection to straighten the PIP of his middle finger. This was effectively extended to approximately -35 degrees at best. His splint was adjusted to increase the middle finger extension position. The patient attended two more therapy appointments after that and decided to continue independently. He had the splint and the exercises protocol. Photos of his outcome are below.



My patient still does not have perfect extension as you can see. He has stopped wearing the night splint after 3 weeks and chooses to perform his exercises when he "feels stiff." His left hand shows enough MP and PIP extension to perform all ADLs including mowing the lawn independently. He can grasp a glass or coffee mug with his left hand again. Despite imperfect follow through, this gentleman has a

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Jodie Auliff, OTR/L

Occupational Therapy and Driving Evaluations

My name is Jodie Auliff. I graduated from St. Ambrose University (Davenport, Iowa) in 1994. I have been at Alexian Rehabilitation Hospital since 1997. I have been an evaluator with the driving program for the past 15 years at Alexian Rehabilitation Hospital. I am the lead outpatient occupational therapist. I treat individuals that fall under the general/neuro diagnosis as well as the orthopedics/hands diagnosis. I am also one of the low vision therapists. My interests include traveling, kayaking, hiking, biking, camping, scuba diving and snorkeling with my husband. I have three cats, which are my babies.

The outpatient occupational therapy department at Alexian Rehabilitation Hospital is located in Elk Grove Village. We have an outpatient sister clinic located in Schaumburg. The program offers rehabilitation for general/neuro diagnosis and ortho-pedic/hands diagnosis. The occupational therapy specialty programs include the low vision program and the driving program. We have three occupational therapists that are trained in administering the driving evaluations. We contract out for the on the road portion. Our on the road driving instructor is not your typical instructor for new drivers or teenagers. He mainly works with adults who have previous driving experience and have experienced a medical condition that now may interfere with their driving abilities.

Facts about driving

- Drivers receive 98% of visual information through peripheral vision.
- A 60 year old driver needs 10x the light required by a 20 year old.
- Per the AAA, we make 20 major decisions for each mile we drive.
- Older drivers have fewer collisions because they drive less & at less dangerous times.
- In a 2 car fatal collision where 1 driver is 65 years old, the older driver is 3.5 times more likely to be killed.

FYI: Link for medical/vision issues in Illinois:
http://www.cyberdriveillinois.com/departments/drivers/drivers_license/medical_vision.html

Quick reference for license renewal

22 – 74 years old
-Renew every 4 years
-Every 8 years if Safe Driver Renewal
-Vision screen each time you come
-Written test every 8 years (depending on traffic convictions)

75 – 80 years old
-Renew every 4 years
-Vision screen each time you come
-Written test every 8 years (depending on traffic convictions)
-Driving test

81 – 86 years old
-Renew every 2 years
-Vision screen each time you come in
-Written test every 8 years (depending on traffic convictions)
-Driving test

87 years & older
-Renew every year
-Vision screen each time you come in
-Written test every 8 years (depending on traffic convictions)
-Driving test

Driving evaluations are an instrumental way to help determine if someone is safe to continue driving, whether it is for physical, visual, or cognitive reasons. The evaluation lasts for three hours and is split up into three different sections.

The first hour is in the clinic with an occupational therapist. The therapist evaluates upper and lower extremity range of motion, upper and lower extremity strength, upper and lower extremity muscle tone, grip strength, fine motor coordination, reaction time, vision, memory, attention, upper and lower extremity sensation, transfers, functional ambulation, street signs, and situational driving questions.

The state of Illinois has specific vision requirements that the individual must pass. The individual must have far acuity of 20/70 for daytime driving and 20/40 to drive at night. Peripheral vision for a binocular driver must be 140 degrees and a monocular driver needs 105 degrees. The occupational therapists also evaluate other vision areas. These include: fixation, tracking, saccades, convergence, contrast sensitivity, color perception, lateral phoria, vertical phoria, depth perception, and fusion.

The next hour and a half is out on the road, where the driving instructor evaluates handling of the car and ability to safely drive. This section includes: pre driving assessment, general driving skills, turns, parking, backing, stopping, changing lanes, vision, and cognition. The evaluation concludes with a sit down meeting to go over the results and recommendations that will be made to the doctor.

Individuals may pass with no restrictions and ability to return to normal independent driving, pass with restrictions, fail, or require further training sessions to practice their skills or to practice with adaptive equipment if needed. Some examples of adaptive equipment could be spinner knobs, hand controls, cross over turn signals, left foot accelerator, pedal block, outside blind spot mirror, panoramic mirror, etc. The occupational therapist may also recommend further therapy with occupational, physical, or speech therapy. The final recommendation to the physician is

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Animal Assisted Therapy At Lutheran Home: A Pawsitive Experience

Maximillian C. Zugaj, OTS
Jody L. Benson,MS, OTR/L

"In an age of research when it is tempting to reduce human emotions to biochemical reactions and to rely heavily on the technology of medicine, it is refreshing to find that a person's health may be improved prescribing contact with other living things. Members of the health and allied professions must continue to combine resources, work together in the spirit of cooperation, and never forget to **'cure when possible but comfort always.'***"*
—Michael J. McCulloch, MD (1981)

Today, Animal Assisted Therapy (AAT) is being incorporated into a number of healthcare and community settings across the country because it is viewed as a valuable treatment approach for individuals of all ages (young children to those nearing the end of life). AAT is being paired with traditional treatment approaches because many patients have shown to make greater improvements in psychological and physiological domains on account of this addition to their treatment regime. Incorporating animals into treatment, however, is not a new concept; canines have been used as a therapeutic tool as early as 1699 when they were introduced with children as a tool for developing responsibility and providing emotional support. AAT now uses a variety of animals in addition to dogs, such as cats, monkeys, birds, horses, and dolphins (Delange). AAT is also used in a wide range of treatment strategies both for assessing deficits and working toward clinical goals. Treatment goals may include: increasing a patients range of motion, strength, endurance, balance, mobility and sensation. Goals are not just limited to being physical; they can also address cognitive, perceptual, psychological, and social deficits. Having this availability to treat patients in a wide variety of ways truly makes AAT a holistic therapy. Research has also shown that the use of animals in therapy can reduce stress, increase patient motivation, and raise self-esteem. In addition, a number of studies have shown that animal-assisted therapy promotes emotional comfort and decreases loneliness, anxiety, and physical stress responses. (Calvert 1989; Barker and Dawson 1998; Churchill et al. 1999; Friedmann, Thomas and Eddy 2000; Friedmann and Son 2009)

One such facility which incorporates AAT into its regular treatment sessions is Lutheran Home, a skilled nursing facility located in Arlington Heights, IL. It has always been very accepting in allowing patients to bring their dogs for visitations while admitted here at the short term care facility. This animal friendly facility has a full-time therapy dog named Mak who is a golden retriever certified as an assistive therapy dog. Having spent time at Lutheran Home with Mak, it doesn't take long to see the influence that he has on patients. He greets everyone with the same friendly welcome whether he's known you for weeks or is just meeting you for the first time. Not any dog can be a therapy dog. It takes a special temperament and rigorous training including: obedience training, completed applications, veterinary screenings, temperament tests, completion of training sessions, participating in AAT programs and the completion of a probationary period of 3 months. Tests include the Canine Therapy Corps certification test and the Canine Good Citizen Test, which are pass/fail examinations testing various canine characteristics. These include handling exercises with strangers, attention demanding restrictions, exercises demonstrating a client's verbal control over the dog, exercises testing a dogs control with another canine present, startling exercise, distraction tests using various medical equipment such as walkers and wheelchairs and various other vigorous exercises. Some certification organizations which offer training include: Delta Society, Therapy Dogs International, The Service Animal Registry of America and Bright and Beautiful Therapy Dogs. There are many different organizations and programs which offer certification but these are the most common and widely recognized. Mak is certified through both Therapy Dogs International and through the Service Animal Registry of America (S.A.R.A.) which legally allows him share his gift and take part in the therapeutic treatment of Humans.

Mak's great therapeutic value is evident through the patients' boosted morale in building patients self-esteem hence increasing their motivation towards therapy. Mak gives patients a cathartic effect decreasing symptoms such as pain, or simply evoking a positive response from those patients that might be more difficult to motivate through traditional therapies. Caring for a dog is an intrinsically motivating activity for many patients who may otherwise be resistant to traditional therapeutic techniques or exhibit psychological symptoms such as depression. It also allows therapists to implement other unique methods of treatment. Caring for a pet is an IADL which could be incorporated into a patient's treatment and goals. Having Mak around has allowed Occupational therapists at Lutheran home to incorporate treatments such as proper body mechanics when placing dishes on the floor, walking a dog, grooming, or playing fetch as part of their functional therapeutic activities. These IADL's address dynamic sitting/standing, reaching, balance, fine motor, upper extremity strength, and endurance alongside benefits attributed to social interactions with the animal.

Having Mak as a tool to address these factors has motivated patients to participate in their treatment plans and opens the door to becoming more open to future treatment sessions addressing concurrent diagnoses such as depression and anxiety which might not otherwise be addressed. Addressing these secondary diagnosis allows for a more holistic based approach as opposed to simply treating the initial diagnoses.

...Continued on Page 12

Social Media (continued from page 1)

It is a wonderful opportunity for people to stay connected with everyone having such busy and full lives. They also provide the experience of meeting new people that have the same "passions" or interests that you have. Many provide educational experiences; games; surveys; drawings; prizes and other catchy ways to draw you in. Those of us in the profession of Occupational Therapy can and should take advantage of all the tools which connect us to our profession for learning; gathering information and sharing information and simply letting off steam. Many new treatment interventions, evidence based practice and other tid bits of information that can assist us in our professional lives are at our finger tips.

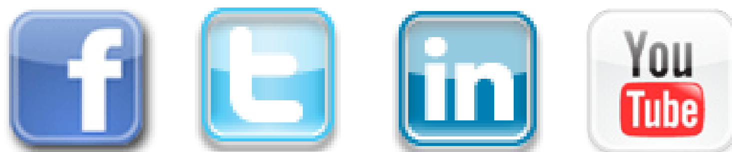
Along with all of the advantages like, gathering work / job information and references, meeting people and the possibility of finding new job positions by networking or staying connected to the various professional websites; face book pages and linking up to twitter about your job or position, there is a red flag or caution sign we should all be aware of.

It is so easy to connect and pass along our personal information as well as talk about anything. But sometimes "caution" needs to prevail. Remember, HIPPA the Health Portability Information Act? Remember privacy and the ethical and legal guidelines that tell us not to discuss our work situations outside of the appropriate and with the appropriate persons. Ahhhhh... sometimes it is so easy to forget and simply talk up a storm and never remember what information we are giving out not only to one person but in these social media environments we are giving this information to the world... a public domain place that remains forever in many cases.

Caution when giving out personal contact information and posting it in a public domain. We hear about the many different ways it has been used to harm people. Our first thought does not go in that direction, when posting or giving out information. We are thinking only of the moment in which we are sharing with personal friends or colleagues.

Caution number three is remember, your colleagues at work, your supervisors, professors and potential employers or present employers look at these sites. It is said that many places check these out before hiring people today. Your job hopes could be "smashed" with one posting.

Every couple of months I look for avenues of communicating or connecting and it is amazing to me just how many new ones are out there. Below is a list but for certain, not an exhaustive resource listing of places you can use for professional information and communication related to Occupational Therapy. Take advantage of these many social media options . It only takes a few minutes and the benefits are well worth it!



www.OT connections.org

www.aota.org/twitter

http://OTconnections.aota.org/forums/i/10504.aspx

www.aota.org/youtube

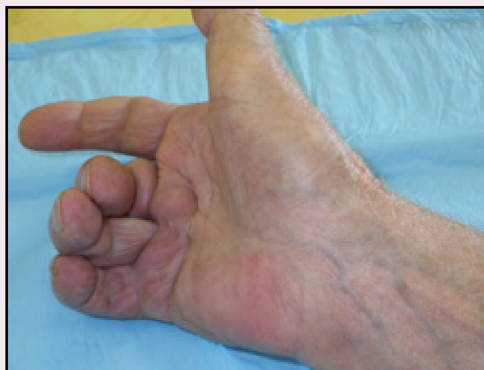
www.aota.org/facebook

www.nbcot.org

www.nbcot.org/facebook

If you have a favorite list serve or other social media site or source that would be beneficial to share, send them to **lstama@midwestern.edu** and we will gladly post them in future newsletters. •

Xiaflex (continued from page 7)



very successful result and is now waiting to schedule his right hand injections. He is hoping to have enough extension to join the bowling league with his boys again.

Meanwhile, I am looking forward to shaking his hand instead of fist-bumping.

Xiaflex, the collagenase injection, has revolutionized the treatment for a disease process that has no known cause or cure. As occupational therapists, we are obsessed with function and independence. Dupuytren's disease has been a debilitating progressive problem that robs a person of his or her independence in ADLs and work tasks. The previous treatments have been costly, complicated, and time-consuming. This new treatment has brought a choice that minimizes risk and maximizes hand function. People who were unable to grab the steering wheel or to don gardening gloves can now return to their lives and their life's work. •

Canadian Occupational Performance Measure *(continued from page 4)*

weekend bike rides. The chart below represents Lynda's initial and discharge scores (self-assessment of her performance and satisfaction) on her areas of concern/goals related to her occupational performance.

Initial Evaluation Performance/Satisfaction		Reassessment Performance/Satisfaction	
Applying Make-up:	0/0	Applying Make-up:	8/8
Hair Care:	0/0	Hair Care:	8/8
Cooking:	2/2	Cooking:	8/8
Gardening:	0/0	Gardening:	8/8
Riding a Bike:	0/0	Riding a Bike:	5/6

Case Example: David

David* is a 65 year old retired man who had a LCVA which resulted in global aphasia and dense right hemiparesis. David was seen for home health OT after an intense course of in-patient rehabilitation services. Both David and his wife were concerned about David's inability to take care of himself and his apparent "depression" over his inability to partake in his leisure interests. The chart below represents David's initial and discharge scores on his areas of concern/goals related to his occupational performance.

Initial Evaluation Performance/Satisfaction		Reassessment Performance/Satisfaction	
Toileting:	4/4	Toileting:	8/8
Showering:	4/4	Showering:	8/8
Dressing:	4/4	Dressing:	8/8
Riding a Bike:	0/0	Riding a Bike:	8/8
Date Night:	3/4	Date Night:	6/6

The above two case examples illustrate how the COPM can be used as an outcome measure. Since changes of 2 or more points on the COPM are considered to be clinically important, this data demonstrates that these two clients made significant improvements in their level of satisfaction, as well as their ability to perform their self-identified problematic areas of occupational performance. Both of these clients were seen for 3-4 weekly OT home health visits which focused on improving occupational performance via remediation, compensation, and adaptation. •

*Please Note: Names have been changed to ensure anonymity of the clients.

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Occupational Therapy and Driving Evaluations *(continued from page 8)*

very individualized and will vary from person to person.

Individuals must have a current driver's license or learner's permit and an order from their physician to participate in the evaluation.

For more information please call Alexian Rehabilitation Hospital drivers program at 847-640-3119. The occupational therapists also have many presentations on driving geared to either occupational therapy students, other professionals (case manger, physician, therapy clinics, etc.), park districts, senior centers, libraries, YMCA, etc.

If interested in having one of the occupational therapists come present, please contact **Jodie Auliff** at 847-981-3592. •

Animal Assisted Therapy *(continued from page 9)*

Having Mak in the facility also encourages patients and their families to bring their own dogs to visit which positively affects the patient's emotional well-being. Having a dog around has shown to positively influence patient mood and productivity during rehabilitation (Marieanna C. LE ROUX1). A dog will love a person in an unconditional way giving some patients who may not have many visitors a sense of identity and belonging. It may even encourage a lonely patient who seeks companionship to consider adopting a dog. Having Mak around allows for the discussion of what kind of pets the patient may have and the care that will need to be provided to the animal when the patient is discharged back home. This allows the dog to be used as an adjunct to treatment sessions related to goals focusing on IADL's.

AAT is still a relatively new field of study with limited research in the subject area. The future looks promising as more facilities like Lutheran Home begin to incorporate AAT into their treatment sessions. Lutheran Home is just one example of the positive impact that AAT can have when used in congruent with a traditional treatment approach. AAT helps to teach us about others by how they interact with animals while offering a wide variety of health and treatment benefits. AAT can and does have considerable benefits to offer and should not be overlooked as a possible tool within our extensive resources within occupational therapy. •

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Don't Forget! 2011 ILOTA Conference November 10, 11, 12 in Galena, IL
Occupational Therapy: Overcoming Adversity, Transforming Lives
Keynote Speaker: Retired Sergeant Major Thomas M. Morrissey

Meeting Clinical Education Needs in a Tough Economy

Gary Solomon, MBA, MS, OTR/L, CHT

As the Education Division Director for the American Society of Hand Therapists (ASHT), I face the challenge of trying to develop high quality clinical programs for members while realizing that continuing education and travel reimbursement are significantly limited for most therapists. The tug of war between realizing the value of continuing education programs, and the understanding of the costs involved in bringing programs to fruition has made our division examine alternative delivery models which are cost effective for participants and ASHT.

Cuts in continuing education funding for many therapists unfortunately comes at a time when the programs are needed most. In the hand therapy specialty area, I see many clinicians placed in clinics where they are the sole occupational therapist. This practice pattern has developed from increased productivity demands from employers, as well as patients' decreased willingness to travel more than a few miles to obtain therapy services. Continuing education programs are not a luxury, but a necessity as the amount of on-site mentoring has decreased. Therapists often do not of the luxury on relying on a more experienced set of eyes to aide in decision making and must find methods to accelerate their professional development and clinical decision making skills.

Continuing education programs are also a key component of integrating evidence into clinical practice. Therapists can no longer afford to have a disconnect between research done by "academics" and what happens in clinical practice in the "real world". Programs which focus on how to make clinical decisions based on the best available evidence are a key component to professional survival. We must be able to vigorously defend the purpose and rational behind clinical interventions in order to be appropriately reimbursed for high quality services provided.

As times have changed, those of us charged with trying provide educational programs must also change. Embracing technology and making continuing education programs easily accessible is a necessity. ASHT is working to look for new opportunities to minimize travel costs and bring continuing education to therapists, rather than waiting for therapists to come to education.

"Travelling Courses" create the opportunity for a facility to host a speaker and bring the content to the participants. ASHT currently offers a "Hands on Orthotics" course where facilities can work to design a course to meet participants' specific needs. The instructor arrives at the host facility with all supplies, and is able to lead a workshop without participants needing to incur travel costs. This model of continuing education also can assist in providing a consistent knowledge base for many therapists in a facility. At ASHT, we hope to develop further courses in this model.

Webinars and online learning experiences are also becoming valuable methods of delivering educational content to therapists. Live webinar presentations allow the participants to directly interact with nationally renowned speakers from the comfort of their own home. Technology allows the presenters to upload video and presentation media, encourage audience response and participation, and deliver an interactive experience for therapists. The ASHT webinar series creates cost effective learning experiences without the need to miss work or travel.

I still believe it is essential to travel to a course annually to interact with therapists from other regions and discover different perspectives to the clinical challenges we face. Whether employer reimbursed, or not, part of being a professional requires a commitment which may involve personal financial involvement. The ASHT annual conference delivers presentation of the latest evidence supporting treatment as well as instructional courses designed to meet the needs of therapists from new graduate to highly experienced clinician.

A balanced but aggressive portfolio of continuing education will help therapists become more effective regardless of their specialty area, and be able to thrive in a challenging economic environment. With clinician and employer taking joint responsibility for professional development, patients will continue to greatly benefit from high quality therapy services delivered in a cost effective manner. •

A Message From the ILOTA Home Health SIS

How have the new Medicare guidelines affected home health Occupational Therapists and Occupational Therapy Practitioners? Are PTs doing "OT" work? Have you lost referrals? Please join us at the SIS Home Health Round-table Discussion in Galena on 11/11, Friday, @12:45! See you after lunch at the Exhibitor Hall!

Student *Voice*

A Very Unique Opportunity

Allison Stoner, MS, OTR/L
Aspire Children's Services

Salt Lake City, Utah. Everyone was asking me, "Why are you going there?" And if they were the pushy type, "Why are you leaving Chicago to go there?" They all asked the question of me like it was almost rhetorical, there really could not be a reason that I wanted to leave Chicago and go live in Salt Lake City for 3 months.

I would calmly, but not always patiently answer, "Its a very unique opportunity." I stand by that to this day. At that point, I'm not sure I realized how much of a unique opportunity it was. But I was committed, and after New Year's my dad and I loaded up my car and drove across the lots and lots of nothingness and small gas stations that make up the middle of America. I had never been to Utah before.

The next question I got from people was "Why does Salt Lake City have so many refugees?" The answer to this one, I found out after I arrived. The United Nations High Commissioner for Refugees places refugees in cities that have available resources. This is why refugees are not commonly placed in cities like Chicago, the Chicagoans are already using all the available resources. Consequently, cities like Salt Lake, Minneapolis, and Atlanta, become chosen destinations.

This unique opportunity was being sponsored by the University of Utah. Several of their OT students had done it for a few years and now they were opening it up to students from other schools. I was to work with one other student from California, Katie Cotter, and a professor, Yda Smith, who would supervise us. We worked with three different community organizations, each a little bit different, but all of them happy to have us. Each organization provides services for recent immigrants and refugees. One organization, University Neighborhood Partners Hartland, was run entirely by the University of Utah, students did the work as part of the their clinicals and community placements with professors overseeing them. Another was Hser Ner Moo (HNM) a community center in an apartment complex. Both of these organizations work with kids and families providing various educational opportunities, afterschool programs, and other services that are needed. The third was an international organization that provided support for two years that included helping refugees finding an apartment and enrolling them in English classes and work programs, to help them adjust to life here.

At our first meeting with Yda, I bubbled over with excitement. I was remembering the history of occupational therapy lecture we had gotten from one of our professors during one of our first classes at UIC. She had told us about the Hull House, and how occupational therapists then were helping to teach people skills so they could find employment. I burst out, "We are going back to the grassroots of occupational therapy!" And in fact, we really were.

While we were there, as is typical in many psychosocial settings, we taught lots of groups. A normal week contained college prep classes, computer classes, and pre-driving classes at both Hser Ner Moo (HNM) and UNP Hartland. Our college prep classes were fun. Katie and I made sure that all of the high school seniors in our college prep classes filed FAFSAs. We helped them search for scholarships and edited their essays for grammar. Computer class consisted of typing practice, teaching them how create an email account and check it. We also taught them how to use Word; so many wanted to be able to type letters to their family members back in their home country. Pre-driving was a class about the rules of the road. We taught people the rules so that they could take the written test and get their driving permits. In a city with limited public transportation, our clients were very motivated to drive.

A separate grant funded PAR FORE. This group was for at-risk adolescent males. The guys in our group were from Somalia and Burundi in Africa. A golf pro and a few other students from the University of Utah taught them how to play. Katie and I planned life skills lessons, usually relating the life skills to golf, or sports in general.

Another group we helped with was the Karen Women's Organization. They are a lovely group of women who weave. This occupation was incredibly important to their culture. Many had not even brought their weaving supplies with them from Thailand. Yda had spent a few years working with them, and when we arrived she had found them a grant so they could teach the younger girls and teens how to weave, a woodworker willing to make their tools and a craft house willing to house them. Katie and I helped with some of the organizational stuff to help further the organization. I created lots of excel charts for attendance, expenditures, and hours worked, to help document and keep track of the grant money. Katie and I interviewed the women, and took their pictures

...Continued on Page 15

Student Voice

If you would like to be featured in Student Voice or know someone who would, please contact Carrie Nutter at codycheq@aol.com

Student Voice (continued from page 14)

and photos of their products so they could sell their goods on a new website created by the city.

We also helped people individually. At Hartland, we held "open hours" where we would help anyone who came in with questions. We called the Department of Family of Services for people, we deciphered mail, and helped them set up resumes and email accounts. Working with the international organization, we attended weekly problem solving meetings, and would take on any client that had a problem we could help them with. This ranged from medication management, parenting skills, household management, job searching and resume building, to using public transportation. We literally helped people do any occupation that they found valuable. It was exhilarating, and awesome to watch how it empowered our clients and allowed them to take ownership of their lives here in the U.S.

We were able to witness lots of changes in our clients while we were still there, but the great thing is that Yda keeps us posted on our results as well. She emailed us in May that one of the seniors had gotten a full tuition waiver from the local community college. Another man, who came in to Hartland several times for help with his resume and job applications, got a job with one of the last applications I helped him complete. He had confided in me that if he didn't get this job, he would have to go back to Mexico, where he had more connections for work, leaving his wife and 3 kids here. He had stopped by Hartland in April to say thanks.

I think all occupational therapists have a drive to help people. I feel so fortunate that I had this opportunity, my first 3 months of fieldwork, where I actually helped people in ways that were life altering. Bottom line-I'd do it all over again in a heartbeat. I urge current students to explore those unique opportunities, to push the envelope, to put themselves out there. All that will happen, at least in this field, is you'll help people and in the process learn a lot about yourself.

About the Author

Allison E. Stoner received her Bachelor's degree from Augustana College in Biology and Psychology, and recently received her Masters of Science in Occupational Therapy from the University of Illinois at Chicago. She is currently employed at Aspire Children's Services as a pediatric occupational therapist in Hillside, Il.

Dementia Capable Care:

Two-Day Foundation and Dementia Therapy Applications Course

Over 5,000 professionals, including many occupational therapists and COTAs, have attended this course and learned advanced evaluation and treatment skills, effective treatment planning using the Allen Cognitive Levels and Theory of Retrogenesis, how to document and code for maximum reimbursement, and more. This course was formerly known as *Dementia Therapy: Achieving Positive Outcomes for the Person With Dementia*.

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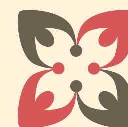

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DS121

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Legislative Update *(continued from page 3)*

budget was based on. Speaker Madigan issued a statement shortly after the Governor's facility closure announcement indicating that he might be amenable to discussing a reallocation; however under no circumstances would there be any consideration to approve expenditures beyond the level that was approved by the legislature at the end of May. Any new dollars are expected to be used to pay down the state debt.

Other issues that will be hot during veto session include the Governor's amendatory veto re: who can receive legislative scholarships and "Smart Grid" legislation.

Reapportionment Maps in Court

A federal court decision on the validity of the Illinois state and federal reapportionment is expected sometime in November. In the meantime, candidates for the state legislature have begun making plans, preparations and announcements to run in the newly designated districts. Some prospective candidates, incumbents in particular, are grappling with very difficult decisions regarding residency. In a redistricting year the Illinois Constitution allows a candidate to run from any district that contains any part of their former district. The catch is that if you run and win then you have to move into the district you were elected from by May 1 of the following year. The thought of uprooting families and selling homes has caused many over the years to retire, and a number of incumbents have made such announcements with a number probably yet to come.

Legislative Turnover

The following legislators have announced their intentions to retire at the end of their current terms rather than seek re-election: Sen. John Millner (R-West Chicago), Sen. Susan Garrett (D-Lake Forest), Rep. Kimberly du Buclet (D-Chicago), Rep. Lisa Dugan (D-Kankakee), Rep. Connie Howard (D-Chicago), Rep. Joe Lyons (D-Chicago), Rep. Karen May (D-Highland Park), Rep. Kevin McCarthy (D-Orland Park), and Rep. Jerry Mitchell (R-Sterling). In addition to these changes, Rep. Dan Reitz (D-Steeleville) has already retired and was replaced by Rep. Jerry Costello. Rep. Ron Stephens (R-Troy) resigned and was replaced with Rep. Paul Evans. Finally, Rep. Mark Beabien (R-Barrington Hills) passed away this summer and was replaced with Rep. Kent Gaffney.

Term Limits???

There is often an erroneous perception that once elected legislators never leave willingly, rather they stick around one election too long and suffer defeats or are carried out. This perception is often the basis for the cry for term limits. While that is true for some, the numbers show that there is a great deal of turnover in legislative seats during the course of each ten year period from one reapportionment to another. While sitting incumbents are still deciding whether or not to begin the process of putting their names on the ballot for the upcoming 2012 election cycle, a cursory review shows that there has been a fairly large legislative turnover since January, 2003, the date when legislators elected under the current maps were sworn into office.

Fifty-nine senators took the oath of office in 2003. How many are still serving today? Twenty seven … which represents a turnover of 54%. While a few did leave for other elective offices, most of the 32 departures simply completed their service by way of election defeat or retirement.

The turnover rate in the House is just as telling. Seventy of the 118 House members who took the oath of office in January, 2003 are no longer serving today, a turnover of 59%. Of those 70, seven moved across the rotunda to the Senate, but the other 63 left via deaths, defeats or retirements.

The departure numbers cited above do include legislators who have vacated offices by death or resignation this summer, but do not include those who have announced their intentions to retire at the end of their terms. Additionally, there will be a further winnowing of some incumbents because the new legislative maps have forced head-to-head primary election fights, and a few others that may not survive the general election next November. When the dust clears after the election season and legislators gather in Springfield in January, 2013 to begin the legislative session expected that at least 60% of senators and 65% of representatives were not around ten years prior.

These numbers should be very meaningful to those who promote and engage in advocacy because it fractures the presumption that legislative membership is a constant and never-changing. It verifies that there is always a new coterie of legislators to educate and to tell our story to.

Veto Session Dates

The General Assembly will convene on October 25, 26, 27 and November 8,9,10 for its veto session.

HOME CARE SERVICES

Is your life out of balance? Let OSF Home Care Services get you back in perspective with a position in one of the regions where we provide care to patients in their homes. Our focus on Mission makes all the difference. We serve our patients with the greatest care and love every day.

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Contact:
Cindi Hoggard
E-mail: cindi.s.hoggard@osfhealthcare.org

ILOTA Springfield Lobby Day: How Did it Impact You?

As the Fall season approaches leaving the ILOTA board and committee members busy planning for this year's conference, the past spring season sprung the ILOTA Advocacy and Political Action Committee into action. On April 6th, 2011, representatives of the ILOTA board, ILOTA members, our state association's lobbyist, and students gathered to introduce the new Illinois 97th General Assembly to the occupational therapy profession. ILOTA's lobby day was intended to educate many of the new legislators and to offer thanks to those incumbent legislators who have supported the profession and our clients. Thanks to the coordinated efforts of Kim Langley, ILOTA's Director of Advocacy, and the hard work from the students and staff at Southern Illinois Collegiate Common Market, ILOTA was well represented and welcomed at the State Capitol.

Maureen Mulhall, ILOTA's lobbyist, assisted us in beginning our venture with a run down of the Senate and House session schedules for that day. Groups were dispersed to all the legislative member's offices to drop off mementos and information regarding occupational therapy prior to the start of the day's sessions. Occupational therapy practitioners and students were able to make personal visits to their respective district legislatures regarding the importance of occupational therapy and the impact of our services.

We were also able to observe the legislators on the House floor and noted a few legislative bills that were relevant to the occupational profession and would impact our future service delivery. Specifically, we witnessed House Bill 1530 pass it's third reading sponsored by Representative Lou Lang from the 16th District. This bill will impact practitioners who treat populations such as those with autism, habilitative conditions, mental and/or substance abuse conditions. HB 1530 states that the "…medical coverage benefits provided through a group or individual policy of accident and health insurance or managed care plan shall be subject to the parity requirements of the provision concerning mental health parity". HB 1530 is currently awaiting a signature from the Governor once the Fall sessions begins.

In the Senate, Senate Bill 1557 was due for it's second reading that day. This bill provides "…coverage under the Act for medically necessary physical therapy and occupational therapy when that therapy is ordered for the treatment of autoimmune diseases or referred for the same purpose (rather than at any time medically necessary physical therapy and occupational therapy is ordered or referred)". Although it was scheduled for discussion that day, the bill did not come to the floor until two days later, passed and is also currently awaiting review and the Governor's signature. Just think, who would have known or been aware that in just the one afternoon we were at our State's capitol, legislative action was directly impacting our professional services and our clients?

So, if you are still wondering how does this impact me, here are some question(s) and actions to consider:

- Is Representative Lang your House Representative? Or, are any of the legislators who sponsored or supported the passing of HB1530 your district legislators? If so, thank them for supporting HB1530 since it expands the coverage under medical insurance plans for mental health and behavioral services we as OT's provide to our clients.

- Do you serve clients with auto-immune disorders such as HIV AIDS? If so, thank your local representative for recognizing the importance of occupational therapy services as medically necessary for the overall health and well being of individuals with these chronic conditions. Or, are there other populations vulnerable to having limited access to our services whose voices need to be heard by your local legislator?

- Are there other bills currently being introduced that will affect you? How would you find out? First and foremost, your State association, ILOTA, has tried to make this as convenient for you as possible by listing monthly all the relevant State bills on the website under "Government Affairs". This list is compiled by our lobbyist and provides brief descriptions of the Sate bills. For instance, HB2856 will require that the Department of Human Services "…develop and maintain an updated list of all of the State-approved public or private early intervention service providers in each local service area. Provides that the list shall be available on the Department or designated entity's website to allow free access to the list by eligible children and their families." Are you an EI provider that should be on that list? Do you feel a list should be made available?

Now, this brings us to this question, if you have been convinced that you, as an occupational therapy practitioner, are indeed impacted daily by the legislative laws that are passed in Illinois, what would you like to do to get involved?

Here are some suggestions:

- Become informed and involved by visiting the ILOTA website (**www.ilota.org**) to find information regarding current legislation under the "Government Affairs" tab.

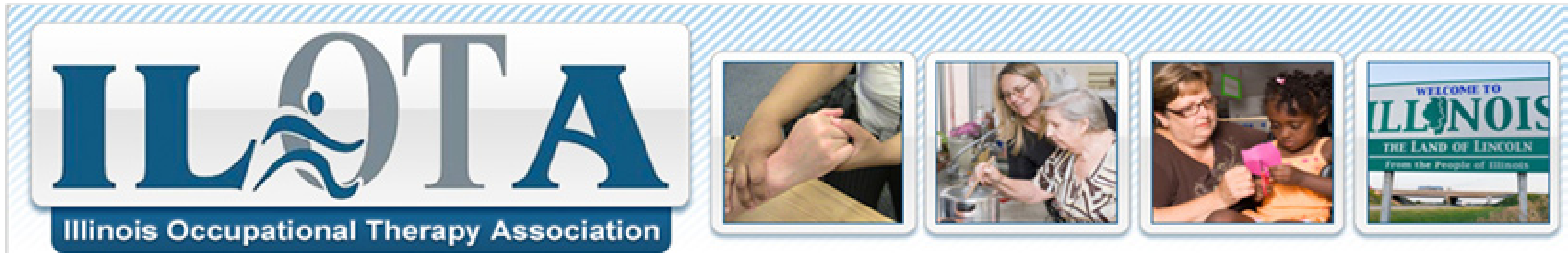
- Contact the ILOTA Executive Board Director of Advocacy, **Kim Langley**, to find out how you can participate in advocating for the profession or to alert the Board regarding issues/legislation that impact the profession. Kim can be reached via email at: **ilotapublicpolicy@yahoo.com**, or call (618)926-0292.

- Introduce yourself to your local legislator as a constituent and as an occupational therapy practitioner.

- Contact **Monika Robinson**, IOTPAC Committee Chair, to find out about volunteer opportunities to attend political fundraisers, identify legislators who support the profession, and/or donate to the IOTPAC Fund. Monika can be reached via email at: **mrobinsonot@gmail.com**. More information on IOTPAC can be found in this issue of the Communiqué.

- Help plan and get involved in the next Lobby Day! Contact ILOTA for more information at: **office@ilota.org .**

ILOTPAC
Illinois Occupational Therapy Political Action Committee
Frequently Asked Questions



What is a PAC?

A Political Action Committee (PAC) is an agent of an interest group, such as Illinois Occupational Therapy Association, and one whose function is to influence the outcome of an election campaign; ensuring the candidate, who is supportive of the goals of the interest group, wins.

PACs contribute to candidates who are sympathetic to their cause and to those who are likely to win the election and who have power and influence in the legislative process. The Illinois Occupational Therapy Political Action Committee, a separate entity from the Illinois Occupational Therapy Association, has contributed to campaigns of legislators who are on key committees that would affect Occupational Therapy.

What does IOTPAC do for Illinois Occupational Therapy Practitioners?

IOTPAC was created in 1985 by former IOTA president Lynne Barnes of Urbana. IOTPAC relies heavily on the volunteer efforts of ILOTA members throughout the State to attend political events and inform the Committee regarding potential candidates to support. IOTPAC helps give the profession a voice in assisting legislators to become elected and who will pass bills and regulations that affect the daily practice of occupational therapy practitioners

As an example, on a very cold and snowy day last winter, a small group of volunteers canvassed for the then incumbent Republican Representative of the 17th District, Elizabeth Coulson's 10th Congressional District campaign. IOTPAC supported Representative Coulson, a licensed physical therapist, due to her prominent advocacy efforts for the profession and the populations we serve. She kept us abreast of legislation that affected OT practice, and sponsored a bill that protected OT credentials in early intervention.

By contributing to IOTPAC, you have support to contact your local legislator, you increase the image of the profession, your facility, your area of practice, and of you as a healthcare practitioner supporting our clients' needs. You can also influence healthcare policy development in Illinois. If you have any questions regarding volunteering, supporting legislators, attending political events, or suggestions, please contact Monika Robinson.

Where, who and how does the IOTPAC receive & use its funds?

1. You can contribute to the IOTPAC when you renew your ILOTA membership.

2. Facilities and individuals can contribute to the IOTPAC.

3. Send a check or money order to IOTPAC, 7234 W. North Ave., Elmwood Park, IL 60707.

4. IOTPAC donations are NOT tax deductible and CANNOT be made anonymously. A copy of our reports filed with the State Board of Elections are available on the Board's official website (**www.elections.il.gov**).

5. IOTPAC funds are used to attend political events/fundraisers to support legislators and for campaigning.

If you have any questions regarding donations, use of funds, or supporting IOTPAC please contact:

Monika Robinson, OTR/L
Committee Chair, IOTPAC
Email: **mrobinsonot@gmail.com**

Gail Fisher, MPA, OTR/L
Treasurer, IOTPAC
Email: **gailsfisher@aol.com**

Join the Gerontology Listserv!

As you may know, in April 2009, ILOTA launched a Gerontology Listserv. As SIS Chair I have been on a campaign to recruit as many COTA's, OT's, and OT Students as possible to help make this new listserv a success. The purpose of the listserv is to provide a forum for occupational therapy practitioners and students who work with older adults to talk about issues of interest and concern, pose questions, provide feedback, and increase interest and communication among OTs in Illinois.

Listservs are a convenient, online way to network with other occupational therapy practitioners in your area of practice. A special thanks to ILOTA member Howard Kaplan who has been most helpful in setting up the Gerontology Listserv.

Please forward email addresses from anyone interested in joining the Listserv to **caroleschwartz333@yahoo.com**. Once we sign them up, they will receive a welcome message – and they're off! They can then ask those burning questions, provide feedback and advice, share therapy strategies and novel ideas.

I believe the more activity we can generate on our Listservs the more members we can attract to ILOTA! •

Submit Articles to the Communiqué

We want your articles!

Each issue of the Communique seeks to highlight areas of Occupational Therapy Practice. We appreciate our readers' wide-ranging experiences.

Each issue features a different theme:

Jan/ Feb/March: Education and Research
April/May: Gerontology, Home Health, and Low Vision
June/July: Pediatrics and Assistive Technologies
Aug/Sept: Physical Disabilities, Hand Therapy, Driving Rehabilitation
Oct/Nov/Dec: Mental Health and Work Hardening

Do you have an article that does not fit the themes already listed? **Send it.** We welcome articles from diverse and novel perspectives.

Article Guidelines:

- Articles should contain title, introduction, body, summary, and references when appropriate.
- Theme articles might include photos and/or graphics.
- Approximately 350-1000 words
- Authors are requested to submit a professional biography, maximum 35 words.
- Passport type photo recommended.
- For the next issue, articles should be submitted by **November 15**!

SUBMIT ARTICLES TO: codycheq@aol.com

The Communiqué editorial committee reserves the right to edit any material submitted.