OTD670 Case Study – Steve
Total 100 Points
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Case Steve Part I:

Brainstorm a list of questions you have about Steve. Where will you find the answers?

- Obtain a complete medical history
    - Did he have any health concerns or diagnoses prior to stroke including cardiovascular issues, trauma, etc.?
    - Is this his first stroke?
    - What was Steve's visual acuity/did he use corrective lenses prior to his stroke?
    - Do his current vitals line up with his vitals prior to his CVA?
- Does Steve have a history of smoking, substance abuse, and/or alcohol consumption?
- Prior daily health status
    - Eating habits/diet?
    - Exercise/physical activity?
    - Sleep schedule/rest?
- What medications (if any) has he been taking recently or in the past? If so, have there been any noticeable side effects?
- How much total time had passed before thrombolytic drugs were administered? Was there a reason that this did not occur within the recommended 3 hour window?
- Where did the stroke occur in his brain? What kind of stroke is it? What kind of symptoms can be prepared for/predicted as a result of this kind of stroke?
- What were Steve's baseline levels of functional cognition, physical ability/endurance, visual acuity/perception, and independence prior to his CVA?
- What are Steve's current levels of functional cognition, physical ability/endurance, visual acuity/perception, and independence immediately following his CVA?
    - What is Steve's L side ROM, strength, endurance as compared to his R side?
- What is Steve's home environment? Does he live with anyone? Who can support him?
- What occupations are important to Steve?
- What are his priorities/goals within the acute care/ICU setting?

The answers to our questions will be found through a comprehensive review of his medical charts/electronic medical records, communication with his attending physician and current healthcare team, and an occupational profile. The occupational therapy practitioner will complete the occupational profile by collecting information from Steve, his wife, and his children (if they are authorized to provide input, and the occupational therapy practitioner is authorized to utilize that information).

What type of stroke has Steve experienced?

Steve's CVA is most likely an ischemic stroke. The medical team administered thrombolytic agents (probably tPA), which indicates ischemic stroke; thrombolytic agents are used to dissolve clots and improve blood flow to the parts of the brain experiencing blood/oxygen deprivation.

Where was the stroke in the brain?

It is suspected that the stroke occurred within the left middle cerebral artery; left hemisphere of the brain. Potential areas of the brain affected include: the lateral fissure, inferior frontal temporal lobe, lateral frontal lobe, and parietal lobe. Additionally, strokes most often occur within the middle cerebral arteries, and Steve's presentation of right side

hemiparesis/sensory loss, loss of expressive language, and inattention solidify this hypothesis.

What were his risk factors?

- Age, 60 years old
- Gender, male
- Race (?)
- Diet (?)
- Weight, 300+ lbs
- Potential genetics/family history
- Frequently flying for business
- Strenuous physical activity (shoveling snow)

In what areas do you expect deficits? Strengths? How will you determine these?

Deficits:

- profound flaccid right hemiparesis
- expressive aphasia, communication skills
- inattention (complex attention issues)
- sensory loss on right side (hot/cold, sharp/dull, light touch, stereognosis)
- impaired function in ADLs/IADLs
- impaired rest and sleep
- impaired work ability
- impaired leisure and social participation
- impaired mobility
- potential impaired vision (neglect, field loss, visual-perceptual deficits)
- impaired functional cognition (executive function, social cognition, learning, memory)
- apraxia and/or ataxia
- hypertonic and hypotonic antagonist and protagonist muscles

Strengths:

- strong support system (family, coworkers, small community)
- has meaningful/purposeful/motivating occupations (work, refinishing furniture, yard work, caring for pet)
- left side strength and ROM for UE/LE, as well as sensory function
- receptive language and comprehension intact (can potentially even exhibit effortful speech)

Deficits and strengths will be determined through occupational profiling, skill specific assessments (sensory, motor, cognition, visual-perceptual), the examination of psychosocial factors, and functional evaluations (ADLs and occupational performance).

What prognosis is anticipated?

Strokes can have a wide range of impact depending on the size, location, type, and whether the stroke damage is localized or globalized in the brain. Additionally, medical intervention, access to early intervention (thrombolytic drugs), and rehabilitation services can improve patient outcomes. A patient's awareness of deficits increases positive outcomes. Although he initially experienced profound flaccid right hemiparesis, expressive aphasia, inattention, and

no withdrawal to pain on the right side, Steve has displayed enough tolerance to meet inpatient rehabilitation requirements after 8 days in acute care. Steve's current prognosis is fair, which makes him a good candidate for inpatient rehabilitation.

What are priorities for occupational therapy intervention? Identify specific Areas of Occupation (Table 1) with rationale. These can be several specific areas under one category.
Priorities for Steve's ICU occupational therapy interventions are to prepare Steve for discharge to inpatient rehabilitation by primarily improving his ADL performance. Improving ADL performance will give Steve the foundational skills to apply to IADL/work/leisure/social participation rehabilitation further down the line. If he is not able to attend to his ADLs effectively, he will not be able to move forward through the rehabilitation settings, and get back a semblance of his previous daily life/routines/roles. Functional independence within ADLs will lead to a more hopeful and motivating prognosis moving forward. Additionally, ensuring that Steve is able to relax and sustain quality periods of sleep is essential for his overall healing and recovery process in the immediate period following his stroke.

Category: ADLs
- swallowing/eating
- toileting and toilet hygiene
- dressing
- bathing/showering
- personal hygiene and grooming
- functional mobility (includes transfers, postural control, and static/dynamic balance)
    - postural control is a starting point for functional activity

Category: Rest and Sleep
- rest
- sleep participation

Describe a 30 minute session in the ICU, including two interventions.
The OT will greet Steve and inquire about pain levels and general concerns with the assistance of pictograms. The OT will assist Steve to edge of bed and will monitor his sitting balance while summarizing the last therapy session that they had together. Based on Steve's last session, plans were made to work on bed mobility, sitting balance, transfers, and the process of going to the bathroom.
- Intervention 1: From edge of bed position, Steve will transfer with OT assistance to wheelchair, practicing safe transfers (lack of impulsive movements, locked brakes, communication/coordination with caregiver, good body mechanics), postural control, and dynamic balance. Any efforts possible from right side of his body, especially UE, will be encouraged. Getting Steve out of bed and in a position where he can be more mobile is essential for most ADLs and eventual IADLs.
- Once Steve is seated in his wheelchair, the OT will make sure that his wheelchair posture and positioning is comfortable and accurate. Adjustments will be made if necessary.
- Intervention 2: Steve will demonstrate/solidify his transfer skills by transferring from his wheelchair to a bedside commode. Physical and verbal cues will be given to

encourage Steve to utilize R side of body, especially UE. Steve will practice donning and doffing his LE garments or getting his gown out of the way for commode use. OT will assist Steve and cue Steve in sitting balance/postural control while sitting on the commode, as well as cueing/assisting in the cleaning of private areas post-commode use. Gaining independence in toileting will greatly improve overall ADL performance.

- Steve will transfer back from commode to wheelchair, and if necessary and no other therapy requires his time, back to bed if fatigued. OT will summarize session, collaborate on goals for next time with Steve/family, and confirm next appointment.

Write a long term goal and a short term goal for Steve in intensive care.

- **LTG:** Steve will transfer from his wheelchair to a commode over the toilet with minimum assistance by discharge (~8 days).
- **STG:** Steve will transfer from his wheelchair to a bedside commode with moderate assistance within the next 4 days.

What model is guiding your decisions about Steve's therapy? Provide rationale.

The Model of Human Occupation (MoHO) is guiding Steve's course of occupational therapy. MoHO is a client-centered model that describes how individuals perform their occupations. Within MoHO, an individual's characteristics and external environment are linked together into a dynamic system. This system provides feedback to the individual from the environment about their occupational performance. The system includes personal intrinsic factors: habituation, performance, and volition. These factors serve as the driving force in Steve's recovery. Volition incorporates Steve's motivations. Habituation describes Steve's roles and routines. Finally, performance generates skilled actions. Thus, as an occupational therapy practitioner, we can modify the occupational performance of a client with an intentional therapeutic process utilizing the interaction between environment and individual characteristics. In Steve's case, we can use motivation to return to his to interests (working in the yard and refinishing furniture), and desired roles/routines of being an employee (consultant for a national software firm), pet owner, husband, and father as the driving force in his therapy. Occupational therapy will use modification of his environment and feedback of performed actions as the foundation for interventions.

Case Steve Part II:

Identify new priorities for intervention; specific Areas of Occupation (Table 1) with rationale. These can be several specific areas under one category.

Priorities for Steve's inpatient rehabilitation occupational therapy interventions are to promote functional independence in ADLs and to begin promotion of IADLs. Additionally, interventions will focus on promoting Steve's directives in his care and use of a caregiver. Thus, intervention in inpatient rehabilitation will focus on patient/caregiver education to support the transition out of a full-time medical setting.

Category: ADL (Foundation for all LTGs. Improving ADL performance is used as a motivator to achieve other areas of occupation. Steve needs to continue to recover and modify ADLs that work towards functional independence.)

- swallowing/eating
- toileting and toilet hygiene
- dressing
- bathing/showering
- personal hygiene and grooming
- functional mobility (includes transfers, postural control, and static/dynamic balance)
    - postural control is a starting point for functional activity

Category: IADL

- Care of pets
    - Steve may be concerned with caring for McGee, his dog. He most likely would not be able to independently and safely achieve this goal at this time. Instead, use his dog as a motivator: incorporate aspects of pet care into therapeutic process and relate it to interventions.
- Health management and maintenance
    - Steve will need to make some lifestyle changes following his stroke. Without medical care team support in the hospital setting, Steve will need to maximize healthy habits to support the recovery process. Interventions may have secondary focus on nutrition, decreased health risk behaviors, and medication routines.
- Care of others (including selecting and supervising caregivers)
    - Learning how to direct his care will be important for Steve in his recovery process, especially learning how to communicate efficiently with his expressive aphasia deficits. Learning how to direct and select aspects of his care with his caregiver(s) will be an important skill following discharge.

Category: Education

- Informal personal education participation
    - Educating Steve on the reasoning behind occupational therapy recommendations, techniques, and interventions will allow Steve to better engage in his recovery process. Understanding the ‘why’ behind therapy may motivate Steve.
    - Steve will receive education within interventions on motor and cognitive processes, embedded in functional activities that contribute to regained foundational skills.
    - Steve will need education on how to use equipment, modify tasks, or use his environment as both part of the process of working towards independence and as way to gain independence in the process. Thus, his own occupational therapy services will serve as a model for Steve and caregivers.

Category: Leisure

- Leisure participation
    - Steve has indicated that he would like to return to participating in leisure activities (railroad modeling). At this time, Steve may not have the ability to participate independently in leisure activities. However, OT may incorporate aspects of his interests into therapeutic process and relate it to interventions.

Category: Social Participation

- Family
    - Social participation with Steve's family will provide motivation for his intervention process; essential for his rehabilitation setting. Due to Steve's expressive aphasia, finding methods of communication that allow him to continue having fulfilling relationships with his wife/family is important.

Write 1 long term goal.

- **LTG:** Steve will perform seated UE and LE dressing with minimum assistance in the next 4 weeks.

Write 2 related short term goals for Steve in inpatient rehab within the first two weeks.

- **STG:** Steve will complete self-care and grooming tasks standing at the sink with moderate assistance within the next 2 weeks.
- **STG:** Steve will complete UE dressing with minimum assistance while seated within the next 2 weeks.

For each STG, identify a type of intervention (Table 6).

- **STG:** Steve will complete self-care and grooming tasks with moderate assistance within the next 2 weeks.

Intervention: The occupational therapy intervention relating to this STG includes the use of *occupations and activities* to facilitate engagement in occupations that promote health and participation. Steve will transfer to his wheelchair from his bed with minimum assistance. The occupational therapy practitioner will provide verbal/physical cues as necessary as Steve completes his morning grooming/hygiene tasks (brushing teeth, combing hair, shaving face, etc.) in front of a sink and mirror. Steve will stand at the sink as tolerated with moderate assistance if necessary. This intervention supports and provides a track for growth in Steve's occupational performance capacities.

- **STG:** Steve will complete UE dressing with minimum assistance while seated within the next 2 weeks.

Intervention: The occupational therapy intervention relating to this STG includes the use of *occupations and activities* to facilitate engagement in occupations that promote health and participation. Steve will transfer to his wheelchair from his bed with minimum assistance. Steve will select a shirt from his closet and use RUE as tolerated and button hook to undo the buttons of his shirt. Steve will don and doff his shirt, buttoning his shirt once donned while the occupational therapy practitioner provides feedback and minimal assistance as required. This intervention supports and provides a track for growth in Steve's occupational performance capacities.

For each STG identify an intervention approach (Table 8).

Establish, restore (remediation, restoration) - STG: Steve will complete self-care and grooming tasks with moderate assistance within the next 2 weeks.

- The restoration intervention approach is used to increase functional occupational performance by remediating the use of Steve's RUE. Steve will improve his abilities and skills; restoring his actions to a functional level through the use of occupation as a means and an end.

Modify (compensation, adaptation) - STG: Steve will complete UE dressing with minimum assistance while seated within the next 2 weeks.

- The modification intervention approach is used as a way to compensate for activity demands at this stage in Steve's recovery. In this case, Steve will be seated during UE dressing to focus on RUE skills and motor learning. Modifying the dressing task with a seat grades down the activity of UE dressing; removing standing balance demands and providing built-in energy conservation techniques into the task.

Identify an intervention to manage aphasia with rationale.

Steve has aphasia as a result of his stroke - the damage to the brain is likely affecting Broca's area, which is found in the frontal lobe of the dominant hemisphere. In Steve's case, this was the left hemisphere. Specifically, Steve has expressive aphasia, which is characterized by partial to full loss of the ability to produce spoken, manual, or written language. Steve has the majority of his receptive language intact, which means he can mostly comprehend what is being said to him. It is important for Steve's family and healthcare team to note that he may produce effortful speech that may not make sense due to lack of grammatical and functional words. Additionally, Steve will likely be aware of his deficits and become frustrated and depressed due to others not understanding him. For these reasons, we propose interventions for Steve and his family to enhance communication using the following techniques:

- Encourage all forms of Steve's communication, including: verbal, written, gestures, pointing, and signals.
- Provide options for Steve to enhance communication
    - Pictograms for urgent messages to care staff: restroom, thirst/hunger, pain, etc.
    - Provide diagrams and schedules so that Steve can communicate about where he wants to go and when
- Communicate in a quiet and distraction free environment
    - Steve may have difficulty with attention and concentration while trying to communicate as a result of his stroke. Minimize distractions and focus on just one topic/one person at a time.
- When a communication breakdown inevitably occurs, the interacting party will make it clear that they are the ones having trouble comprehending Steve. Steve is never to blame for any communication deficits, and should never be made to feel guilty.
- Educate the family and caregivers on communicating with Steve
    - Involve Steve in the process of selecting what works and what does not
    - Make it clear to family to speak clearly, and not to "dumb down" their language

Identify an intervention to manage synergy and tone of the R UE with rationale.
The best way to manage Steve's RUE synergy and tone is to utilize the Brunnstrom Approach. Flaccidity, spastic, and primitive muscle movements are a natural part of the recovery process after a stroke. Rather than trying to inhibit these involuntary symptoms, Brunnstrom proposes that patients use them to their advantage. The Brunnstrom Approach includes six phases. During each of these phases, an increased amount of synergies are available to the body. Accessing the available synergies and using abnormal synergy patterns to his advantage at each phase is essential to Steve's RUE and general stroke recovery process. Steve's RUE muscles need to be used in order to retain their tone and definition, as his hypotonia is preventing his muscles from doing their job.

- Steve should engage in functional tasks where his RUE is required to bear his weight, for instance standing at a counter or sink and bearing weight on his RUE as he brushes his teeth or picks out his clothes for the day with his LUE. Additionally, Steve should be doing quick stretching to increase tone and spasticity within his RUE (could be done while watching TV before bed, reading the paper in the morning, etc.).

Identify an intervention to manage unilateral neglect with rationale.
Steve has R side neglect, which can make performing all areas of occupation difficult and poses safety risks. Relating an intervention to Steve's STG of completing self-care and grooming tasks, the therapist will place all nonharmful grooming and self-care items on the R side of the sink. If necessary, the therapist will support Steve with verbal/physical cueing to attend to his right side. He will practice scanning to his R side as well as safely reaching for items and using them (with RUE – if possible). If Steve repeatedly struggles to attend to items on his right side, the therapist may place a brightly colored note on the mirror above the sink reminding him to look right – the therapist may also involve anchoring techniques with brightly colored tape.

Describe how an occupational therapy assistant would participate in Steve's care.
An occupational therapy assistant would participate in every stage of the therapeutic process in Steve's care: screening, evaluation, intervention, re-evaluation, documentation, and discharge. The degree to which an OTA is involved in each stage of Steve's process depends on the stage of recovery, the experience level of the OTA, and the complexity of Steve's condition. Every aspect of the OTA's participation would be in collaboration with the OT and degrees of supervision by the OT. The OT and OTA collaborate on Steve's care with the common aim to facilitate Steve's rehabilitation.

- The OTA can begin the therapeutic process by assisting the OT in screening his referral with supervision. The OTA may educate Steve's referral sources about the scope of services and process of initiating referrals. The OTA will communicate their screening results and recommendations to the OT. The OTA will perform evaluations through interviews and observations. The OTA may assist with standardized assessments, if experienced in the specific assessments delegated to them by the OT. The OTA provides input for treatment plans in collaboration with OT, including goals and methods to achieve those goals, and reviewing the intervention plan with care team and caregiver. The OTA may provide valuable insight in modifying activities through their training and experience with activity analysis. The OTA may implement

interventions with supervision (in areas with proven competency). During intervention, the OTA may inform Steve and others of the benefits and risks of intervention, informally assess and observe, and document changes in Steve's performance. The OTA may need to modify the intervention to reflect changes in Steve's status. Documentation by the OTA is important input in tracking the progress of Steve's goals. Finally, the OTA may assist the OT in the preparation of a transition plan and implementation of a discharge plan with follow-up services.

List other health care professionals who would be involved with Steve in rehab.

- Physician (Physical Medicine and Rehabilitation physician)
- Psychologist
- Social worker
- PT/PTA
- SLP/SLPA
- OT/OTA
- RN
- Recreational therapist

Please write a therapy note describing a 45-minute session with Steve during week 2. Choose a style from the Same's text book and provide rationale for choice. Your note should be consistent with your chosen priorities and the inpatient rehab setting.
We have selected the SOAP note format because it is an interdisciplinary note style, self-explanatory, and it is commonly used for inpatient rehabilitation. It is efficient and convenient; allowing for objective observations, clinical perspective/reasoning, a clear breakdown of therapeutic services being provided, and a plan for moving forward.

S: Upon being asked if Pt was ready for therapy, Pt pointed at the 'excited' and 'tired' blocks on the pictogram. Pt reported 5/10 on the visual pain chart. Pt non-verbally reported readiness to work on teeth brushing.

O: Pt was supine in bed at beginning of session. Vitals were assessed and were within normal limits. Pt spontaneously reported pain level to OT. Pt required Min A to reach EOB using LUE. Pt attempted to use RUE to assist him in bed mobility. At EOB, Pt demonstrated adequate static/dynamic sitting balance. Pt transferred in stand-pivot fashion from EOB to w/c with Min A. Pt demonstrated safe w/c utilization by locking brakes, reaching for armrests with LUE, and making sure seat pan was at the back of his legs before sitting down slowly. OT wheeled Pt to sink. Reviewed energy conservation techniques for brushing teeth with thumbs up gesture from Pt to confirm comprehension. Pt demonstrated scanning techniques at sink, and was able to attend to necessary equipment (toothbrush, toothpaste) located on his R side/visual field. Pt demonstrated teeth brushing with Mod A standing at sink for 2 minutes, WB on RUE. Pt did not require seated breaks. After brushing teeth, Pt demonstrated safe w/c use when sitting down and remained in w/c to transition to his next therapy session. Call light easily accessible to Pt's LUE while he waited for SLP session.

A: Problem list: pain in RUE, impaired ROM in RUE, impaired static/dynamic standing balance, quick to fatigue, limited independence in grooming and hygiene skills. Summary: Pt's RUE pain is limiting full independence in bed mobility, however, RUE utilization has improved since last visit - Pt attempted to use RUE to get to sitting EOB position. W/c awareness and safety adequate, verbal/physical cueing from OT was not required this session. Though fatigued, Pt demonstrates increased RUE WB while standing ability, activity tolerance, and endurance. Brushing teeth while standing required Mod A, and Pt would benefit from continued occupational therapy.

P: Continue OT sessions 5-6x/wk for 1 hour sessions to improve grooming/hygiene tasks while standing and WB on RUE.

Case Steve Part III:

Identify the model you will use to guide your outpatient therapy for Steve. Identify two complementary frames of reference that will additionally guide your assessment and treatment of Steve. Provide rationale.

The Model of Human Occupation (MoHO) will continue to guide Steve's course of occupational therapy in the outpatient setting. The internal system that encompasses personal capacity and motivation will continue to be central to the driving force in Steve's recovery. Steve wants to return to habitualization (roles, routines, habits). Steve is focused on driving and money management. In this setting, Steve will need motivation to engage in his therapy process and collaborate with the OT in maximizing his functional independence. Additionally, the cognitive and rehabilitation frames of references (FoR) will be used in conjunction with MoHO to guide the occupational therapist in each stage of the therapeutic process. The rehabilitative FoR includes concepts of adaptation, compensation, and environmental modifications; with clients focusing on their specific strengths during rehabilitation. At this point in Steve's recovery, he may have permanent impairments on RUE tone and nerve damage (stereognosis, sensation) that are further complicated with R side neglect. Steve has a permanent R upper quadrant field cut that cannot be restored, so compensatory strategies will be crucial in continued engagement in desired occupations. The rehabilitation FoR uses education of compensatory methods as well as the use of assistive equipment and environmental modifications to restore function. The cognitive FoR will guide the OT in addressing Steve's cognitive issues, including: attention and social cognition (in relation to his liability), as well as improving his functional cognition skills to support maximized occupational performance.

Identify an assessment you would use for each model/FOR.
MoHO: Assessment of Occupational Functioning (AOF)

- AOF will provide information on Steve's view of his own strengths and limitations in personal causation, values, roles, habits, and skills through interview or self-report. The OT will also complete questions about the client's functioning on a five-point scale. The assessment will allow a profile of strengths and weaknesses to be obtained, and it will yield qualitative and quantitative information about factors that are

impacting Steve's occupational participation as he continues his therapy process in the outpatient setting.

Cognitive FOR: Independent Living Scale (ILS)

- ILS is a standardized assessment of competence in IADLs. It will require Steve to demonstrate problem-solving skills, and is composed of five subscales including: memory/orientation, managing money, managing home and transportation, health and safety, and social adjustment. The ILS will evaluate the degree to which Steve is capable of caring for himself, his property, and others.

Rehabilitative FOR: Functional Independence Measure (FIM)

- The FIM is an assessment/basic indicator of the severity of patient disability. The FIM will track changes in Steve's functional abilities throughout his outpatient rehabilitation, and even in comparison to his ICU/acute care and inpatient rehabilitation settings.

<u>You are pre-authorized for 20 outpatient visits. Prioritize your treatment by setting 2 LTG.</u>

- **LTG:** Steve will demonstrate modified independence in financial management within the next three months.
- **LTG:** Steve will demonstrate supervised home establishment and management within the next three months.

<u>For each LTG, provide 2 STG</u>

- **LTG:** Steve will demonstrate modified independence in financial management within the next three months.
    - **STG:** Steve will pay mailed bills with minimal assistance within 2 weeks.
    - **STG:** Steve will create a monthly budget with his finances with minimal assistance within two months.
- **LTG:** Steve will demonstrate supervised home establishment and management within the next three months.
    - **STG:** Steve will perform standing, non-power tool yard work with minimal assistance within 1 month.
    - **STG:** Steve will demonstrate independence in feeding pet with fair standing balance for 4 consecutive days within the next 2 weeks.

<u>For each STG list 3 intervention ideas and provide rationale</u>

- **STG:** Steve will pay mailed bills with minimal assistance within 2 weeks.
    - Complete a mail sorting activity where mail is prioritized: bills, junk, and other. Once bills are identified, sort into organization system to be used at home; identify bill due dates and file away once completed. This intervention will focus on attention, sorting, and organization - remediating and compensating cognitive skills that work toward functional cognition in financial management.
    - Steve will co-create and utilize a checklist for his bills, incorporating receiving it in the mail, paying the bill, and filing receipts. This step-by-step guide will serve as a compensatory strategy for attention to each step in the bill payment process.
    - Steve will complete writing checks and mailing checks. He will write 3 mock-checks correctly to his actual utility companies grading up with less cueing. He

will reference example bills. He will prepare envelopes with a provided example for reference, and mock-mail three checks. Example references will be compensatory with potential for remediation over time – can refer less to examples for each bill cycle.

- **STG:** Steve will create a monthly budget with his finances with minimal assistance within two months.
    - Steve will utilize a monthly/daily hybrid calendar to track his spending schedule and income schedule throughout the month. This compensatory technique will allow Steve to accurately assess his budget and expenditure output versus his incoming finances.
    - Steve will practice errorless learning budgeting math for a two-week cycle of his expenses/income with graded verbal cues. This remedial intervention will allow Steve to practice making a short-term budget without the fear of making mistakes and decreases the "learning" of errors within his thought and budgeting process. Graded verbal cues will remediate Steve's independence in creating his own budget.
    - Steve will learn to use a mobile banking application on his smartphone, and specifically, the spending and budgeting tool within the application. This compensatory technique will allow Steve another medium to track his finances, and it's a tool that he can use on the go. He will be able to check his own budgeting work against an accurate technological tool, also allowing for error correction.
- **STG:** Steve will perform standing, non-power tool yard work with minimal assistance within 1 month.
    - Steve will demonstrate modified independence in raking and bagging movements. This can be practiced with broom and dustpan. Steve will use pacing and seated breaks to safely complete activity without falls. Raking/sweeping items to a movable seat and then sitting to scoop and place in bag/receptacle is therapeutic. Modify environment with seat and lightweight items to compensate with Steve's low tone in RUE and to address fear of falling.
    - Steve and wife adapt gardening activity with raised beds and potted plants. Steve will stand, use bilateral integration to re-pot plants at table, and use lightweight watering containers. Modify items used in activity for potential to restore strength and improve RUE skills (fine motor, stereognosis, strength).
    - Steve will pick up dog feces in his yard with long handle 'pooper-scooper'. This eliminates bending over and decreased potential fall risk. Steve will attend to RUE with placing trash can on R side of body to cross midline when depositing feces. This intervention involves common equipment for compensation of balance and decrease fall risk, potential to remediate R side neglect by demanding attention to receptacle, and compensate function reach.
- **STG:** Steve will demonstrate independence in feeding pet with fair standing balance for 4 consecutive days within the next 2 weeks.
    - Steve will use raised, rolling food bins to decrease heavy lifting due to RUE low tone and RUE subluxation. Steve will roll food bins out from storage area and scoop food from bins without loss of balance, and to avoid fall risk. This is a compensatory intervention with adapted equipment.

- Steve will use an environmental modification by permanently moving dog bowls to seat/stable surface, or vice versa. Steve will demonstrate balancing hand on stable, weightbearing tables/seats to bend over and retrieve dog bowls. Steve will retrieve items from floor using safe bending techniques and place items on stable/flat surface. He will gather one bowl at a time and pace himself between bending over and standing up to avoid loss of balance or dizziness. This is a compensatory technique that will allow him to use his environment as an advantage when feeding his pet.
- Steve will wash with soap/rinse dog food dishes while standing at sink, with preferred scrubbing item (scrub brush, sponge, universal cuff brush). Will work on standing at sink for 5 consecutive minutes using UEs to stabilize and rest on counter for breaks. This is a remedial approach as the hope is to increase his endurance, improve weightbearing through his UEs, and decrease the need for breaks.

<u>What strategies will you use to maximize Steve's outcomes? How will you utilize and prioritize interventions for the 20 sessions.</u>

Throughout Steve's therapy sessions, the most important strategy will be to utilize and encourage his motivation. Each session will include a 'why' - why are we working on this activity, how does it tie into goals and interests? By communicating the foundation for each intervention, Steve may be better engaged in the intervention. For example, completing worksheets with foundational math may seem irrelevant to him at first, but these tasks are strategies to compensate for his cognitive impairments - allowing him to increase his financial independence. Below are strategies that we will use to maximize Steve's outcomes:

- Use Steve's motivation for functional independence in every session and relate each intervention to his goals.
- Involve his caregiver, family, and other supports in his rehabilitation
  - Lean into these supports emotionally
  - Provide communication strategies between Steve, OT, and caregiver/ family - keep them updated on progress and focus on strengths
  - Provide Steve with choices and options - give him autonomy over his life after a traumatic event.
    - Involve Steve in choosing what modification methods he prefers when options are available
    - If he can provide an alternative approach that demonstrates functional independence in an activity in a way that does not affect safety, allow him to do it, regardless of whether it was planned or not
- Modify his environment to maximize independence
  - Model within outpatient environment and translate to home environment
  - Maximize RUE use with non-safety concern activities by placing items on R side to target neglect (ex. utensils, at sink ADL items, writing instruments, TV remote control) - focus on attending to R side
  - Modify environment in safety areas to use strengths (grab bars in bathroom, handrail for stairs, etc.) for LUE use

What would you do if Steve's insurance will not cover the therapy you believe he needs?
If Steve's insurance will not cover the therapy that we believe he needs, we would schedule a care conference between Steve, the family/caregiver(s), and potentially a billing specialist with extensive knowledge of the billing and insurance policies (this may be a front office assistant or OTA who sought specific knowledge for this conference). The OT would explain why therapy is valuable and how it applies to achieving his goals of standing balance, RUE function, improving money management, as well as other areas of occupation Steve wants to improve functioning in. With an understanding of why/how the OT could maximize Steve's outcomes, Steve will need to decide if he would like to try and pursue further intervention. Hopefully, Steve will choose to continue with occupational therapy. At this point, a discussion of the billing, insurance, and reimbursement processes specific to Steve's situation will occur, but additional support from a billing specialist may make the process seem less overwhelming to Steve and his family. Steve and his family may have the financial means to pay privately and decide how much they are willing to pay - he may not want to pay out of pocket for 20 sessions. If private pay is not an option for Steve and his family, an appeal with a letter of medical necessity will be pursued by the OT. For further support, the referring physician may co-sign the appeal.

Please write a note. Choose a style from the Same's textbook and provide rationale for choice. Your note should be consistent with your chosen priorities and the outpatient setting
A narrative style note was selected because it allows for a chronological record of what occurred during the therapy session. Narrative format is often used for contact notes, which for an outpatient occupational therapy setting is ideal because therapy can be less intensive or often involves instructing or educating a caregiver in certain tasks/activities. Narrative notes are less restrictive than other note formats, are easy to read and follow, and avoid professional and healthcare specific jargon.

Steve continued to make progress during his fifth session of outpatient occupational therapy. Steve participated in a 30 minute session to download and learn how to use the mobile banking application on his smartphone. He wanted to input his personal financial information into the spending and budgeting tool located within the application. He primarily uses his smartphone for business, however, he nonverbally communicated motivation and excitement to expand his financial awareness and budgeting skills with the use of his mobile device. At the start of the session, Steve reported his pain to be a 3 out of 10. Steve was able to download the application from Google Play with only 1 verbal cue for sake of errorless learning. Using the list of his monthly expenses versus his monthly income from last session, Steve was able to stand at a counter for 5 full minutes independently with adequate static/dynamic standing balance, bearing weight on his RUE, and using his LUE to input his information into his phone budgeting tool. After 5 minutes, Steve sat down to complete the activity, and began to look around the room more frequently. Steve required 3 verbal cues to correct for input errors and to stay on task. Fatigue and sustained attention continue to be an issue, although Steve chose to forego any built-in breaks. Steve is improving with his

static/dynamic standing balance and endurance/engagement during completion of functional activities and tasks. At the end of his session, Steve reported his pain to be a 5 out of 10. OT reminded Steve of his next session in a week, and Steve confirmed his understanding with a thumbs up and a note in his smartphone.

References

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