continued Conversations:
Functional Goal Setting in Pediatrics
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Fawn Carson: Welcome everyone to Continued Conversations of OccupationalTherapy.com Podcast. The podcast today is Functional Goal Setting in Pediatrics. My name is Fawn Carson and I'm the managing editor of occupationaltherapy.com and I am with Dr. Patty Sharp. Patty is an occupational therapist with 17 years of pediatric experience and works in outpatient at Cincinnati Children's Hospital Medical Center. She received her master's in occupational therapy from Washington University in St. Louis in 2001 and her doctorate from Rocky Mountain University of Health Professions in 2012.

Fawn Carson: Patty previously worked in burns and neurorehabilitation, but she now focuses on enhancing care in the developmental world. She's also an adjunct instructor at the University of Cincinnati and has a contagious passion for evidence-based practice that she aims to share with students and peers. She leads the Developmental Coordination Disorder Translating Research and Clinical Knowledge Team otherwise known as the DCD-TRACK Team at Cincinnati Children's. She's a certified Cognitive Orientation to daily Occupational Performance or CO-OP therapist and is one of the few certified CO-OP instructors in the United States.

Fawn Carson: We are your hosts today. Before we begin, I would like to go over the learning objectives. After today's course, you should be able to describe the evolution of OT goal setting over time in relation to changes in the profession and healthcare as a whole. You should be able to analyze goal-setting practices in relation to the International Classification of Functioning Disability and Health or the ICF framework and current evidence. Lastly, you should be able to reflect on personal goal-setting practices and identify areas for improvement. Welcome Patty. I am so excited to hear more about your work on this topic.

Patty Sharp: Hi Fawn.

Fawn Carson: Hi Patty.

Patty Sharp: That makes me sound more important than I generally feel. Thank you for the intro.

Fawn Carson: No problem. That was a lot of words.

Patty Sharp: It was a lot of words. In general, I have the best job. I get to play with kids all day and I love what I do. I'm excited to have some conversations with you about pediatric occupational therapy.

Fawn Carson: I'm excited to learn more.

Patty Sharp: When you brought up me doing this podcast, I was trying to think of our big topics in pediatric OT. There's a lot of diagnoses we could talk about. There's a lot of specific interventions that we can talk about, but I wanted to start with something, just really basic. At Cincinnati Children's, we're lucky enough to have a lot of speakers come in. Recently, we've had two big ones in the pediatric world. Helene Polatajko. She is a Pediatric OT out of Canada. She has done a lot of work with developmental coordination disorder and she is one of the authors of the CO-OP or Coordination Oriental to daily Occupational Performance Approach.

Patty Sharp: The other one who came to us the past couple of years is Iona Novack. She's a world-renowned OT out of Australia. She does a ton of work with cerebral palsy. She's written a ton of articles that are really important and groundbreaking for pediatric OT, one of which we'll talk about the next time we chat. Anyway, when they came in, they first talked about goal setting. I think goal setting for peds is, in school, well, it should be client centered no matter if you're in peds or adults. We have to do what the client wants, what's important to them. We work on writing fake goals for them in school and then you get out into practice.

Patty Sharp: It's something that we all ... Of course, we do it, right? Of course, we're all client centered. All of our goals are client centered. They're functional. They're meaningful, right? That's what we've all been taught to do and we all assume it. Both Helene and Iona were like, "Well, make sure your goals are functional and they're client centered." I think we sit in the audience, we're like, "Of course, they are, right?" In general, in you, in your experience in your practice, your first thought is, "Of course, they're client centered. That's what we do, right?"

Fawn Carson: Exactly.

Patty Sharp: I don't know, if I take a step back, I really have to look at, "Are my goal functional? Are they meaningful? Are they occupation based?" When I really look at it, when I look at the goals that are

documented in the chart, I'm like, "Oh my gosh. I don't know if they are." I really want to about today what I'm doing, what we all are doing and what's recommended and reconcile maybe the difference between some of those. Aat least in your experience on, I don't know, what is your perspective on goal setting and what we should be doing and we are doing?

Fawn Carson: I think like you said you come out of school and you are determined that you're going to change the world and change your patients' lives and you get in there and you dig in and make these great goals. You always take a step back and think, "Okay, were those something that was very important to them or is that something that I was thinking was important to them for sure?" One thing that always sticks in my mind, I work in spinal cord for a long time and I remember one time where one of my clients I kept trying to work on lower body dressing. He was a pretty high para.

Fawn Carson: He said, "You know, I think I'd rather save my energy for things I want to do. My caregiver can put my pants on. Why are you so focused on it?" I had to take a step back and saying, "Hmmm, you're right about that." I do think that we come with some kind of agenda to every meeting with clients. We do have a little bit of agenda that I don't know that it's so blatant it's in our head that we think that we have an agenda, but we come across a client this type of diagnosis we've worked before with and so we bring this agenda to that interaction.

Patty Sharp: Right. I think we just need to be really aware of what we're doing. I don't think we're negligent or I don't think we're trying to step on their toes or their ideas, but it just can happen because we're busy. Just going back to occupational therapy at its roots, what is the point of it? The theory is that in doing, we feel better. One of my favorites quotes that's hanging over my desk from one of the fathers of OT, William Rush Dunton, I know this is making me look like a nerd, but I love it, it is that, "Sick minds, sick bodies, sick souls may be healed through occupations."

Patty Sharp: In doing things, we feel better in our mind, our body and in our spirits. Another great quote I think it's one from the Slagle lectures, I think it's Ginny Stoffel who did it. She says that, "Occupational therapy practitioners ask, 'What matters to you?' not, 'What's the matter with you?'" I love that. I just want to keep that at the forefront of our thoughts. Back when OT started, we were the ones that moved improvement from the rest cure to the

work cure. For a long time, it was thought like if you're sick, if your body is sick or you're psychologically or spiritually unwell that you should rest, that you should go to like a sanitorium and take some rest.

Patty Sharp: OT was the profession that moved that from, "No, actually you feel better when you're doing," that's when we started doing crafting and leather tooling and all that fun stuff. We were the ones that moved it from resting to actually working to feel better. That right there is telling me what we are doing, the intervention that we are doing is function. Then we started moving more into that medical model when I think science was expanding and we're able to really break people done into their components and their systems as an organ to the components, more into that medical model where we're thinking, "Well, you're well when your body is absence of disease. Your body and your mind of absence of disease."

Patty Sharp: I think that fosters a lot of goal setting and intervention from the bottom up, right? You look at, "Well, if this is wrong with your body, if your leg doesn't work, then we fix your leg and then you're better." That's when you're getting more into goals that are focused on body structures and functions. Where are we now? I don't know where everybody else is, but I feel like we're still, like if you had to look it on a spectrum of occupational function-based goals to medical model body structure and function goals, I think we're towards the middle, but I still think we're on that side of the medical model.

Patty Sharp: I think that we have so many tools available to us to analyze a person and measure that I think it's easy to fall into that like, "Let's fix every component before we move onto the top, the frosting of all of this which would be function." I think we might be just wasting time a little bit. At least in my experience, I love science. I love black and white. I'm like an answer. I like to fix things. When I first got out of school, I worked in pediatric burns. It was a really good fit because for that, like if you're in a hospital with a patient who is immobile and for the most part unconscious, there's not a lot of functional goals you can do. There's not a lot of even functional intervention.

Patty Sharp: The goal you are working on is lifesaving and comfort and preservation of the human body. It felt good to me to ... My goals were improve range of motion, maximize skin pliability, that kind of stuff. When I moved from burns into neurorehabilitation in the

developmental world, every area you go into is like starting over. I'm like, "Well, if I don't know what to do, I can just break the patient down further and work my way back up." I was really good at assessing. If a kid came in with a vague diagnosis like, "Fine motor skills are poor or uncoordinated or sensory problems," something like that, no specific diagnosis, I can run a ton of assessments and really figure out where they're scoring poorly.

Patty Sharp: I can assess their motor performance with the Peabody or Bruininks-Oseretsky. I can look at visual motor skills with a TVMS. I can look at visual perceptual with a TBPS. I can look at sensory with gazillion different things. I can measure range of motion and strength. I can take grip strength, pinch strength. You can really break it down. With a kid who's coming in with some kind of deficit or disability, at least in my mind as a young OT, I'm like, "Well, there's got to be problems, right? They have to have impairments." You can find them for sure.

Patty Sharp: What I'm wondering now is like you probably could find impairments in anybody, so I'm able to use those assessments to support impairment. Then I can put my brain on improvement those impairments. I don't know if it's similar in the adult world. I don't know if you have any experiences like that where if you don't know what to do, you're like, "Okay, well, looks at all these. Let's break them down and then build back up. That's going to get me to where I want to go."

Fawn Carson: I think that's when I was in rehab a lot of my thinking, but I think with the big push with evidence-based practice and just the top-down approach, it has changed things a bit. One thing that came to mind when you were just talking about that is Susan Bazyk's work on mental promotion. She said, "Let's stop looking at mental illness. Let's look at mental health," mental health as being, "Let's look at the whole person and let's promote mental health," versus looking for the deficits. That's just reminded a lot of her work when you're talking.

Patty Sharp: Yeah. I think in OT in general, we're supposed to be, well we're not to supposed, but I think looking at, "What can the kid do? What parts are blocking them from doing it?" Anyway, when I'm uncomfortable, I don't know where I'm going and I don't want to look like I don't know anything. It's easy to step into really detailed assessment and then make goals to improve those little things. I would make goals knowing that they're important to the

patient because I know as the smart one here that they will get to the things they ultimately want to do which we're going to about later, right? I'm not even going to talk about it right now. I'm just going to say, "Oh my gosh, your visual perception is so you're like in the first percentile."

Patty Sharp: My goal is going to be, "We'll demonstrate improved visual perception from visual sequential memory by blah, blah, blah, blah," something like memorizing a series of pictures or for visual motor like, "We'll imitate a black design." I never ever questioned like, "Does it matter to do a black design? Do they really need to get good at doing Where's Waldo?" because I don't know, like I felt smart knowing that, "This is bad. They have a bad score. Then if I do this stuff, it will improve their score," which I do think is true. Then I never got to the part of like, number one, "Does working on that improve a functional and do they have a functional deficit that relates to this visual impairment or visual motor score?

Fawn Carson: We're even asking the question, "So what?"

Patty Sharp: Right, I know, but that's scary. I think that's why we struggle because then what? My personality, I want to be the expert. "You're coming to me and someone's paying a lot of money to see me, the insurance, whatever, but I need to give you something that's expert sounding. I can't just be like, 'Do you care if you can't do a jumping jack?'" because if they say no, then what? I've come around to that. We'll talk about that in a bit, but that I think is at least for me a big reason why my goals ended up really focused on some of these little components.

Patty Sharp: I remember even telling students like I'm like, "Well," I know that they don't really want to do black designs, but they really want to have a good score on their Peabody so that they can do a job in school, so our goal can be working on black designs. I'm like, "Oh, my gosh. I can't believe I would say that." I think that's where we get stuck. I know I'm not the only one because whatever we're doing, whatever our intervention is is guided by the goals we write. If I'm going to write a goal that do a black design, even though I know in my head they don't really care about a black design, I'm going to work on black design.

Fawn Carson: You're going to have at least assess it a few times, because that's the goal.

Patty Sharp: Right.

Fawn Carson: Something you just said just struck me is, well, I think that sometimes and I know I felt this way that what we do is so obvious to us why we're doing it, but it sounds so simple that we get in our mind that we have to have more serious sounding interventions and documentation because what we do is so simple. The art of occupation helps people heal. It sounds so simple like we feel like we have to put all this scientific lingo into it.

Patty Sharp: Right. It is scientific, but the lingo is not. It's just, "In doing, we feel better, period." It doesn't have to be, "In having adequate visual sequential memory, we feel better." It's just that we don't have to go there, but I get it. I don't know. Personally, I felt before the need to be really important and to know something different. Now, I feel like this is really important. Obviously, people can't get there themselves. Otherwise, they wouldn't be coming to see me. I just have to explain why, "If you want to get better at handwriting, you have to work on handwriting," is true, "And how I'm going to help you," but it doesn't sound as sexy. It's not expert sounding.

Fawn Carson: Can we come and meet at the middle?

Patty Sharp: For sure, yeah. I think when I moved to the developmental world, I was assessing and making these little, I mean they're nonfunctional goals. That's where I started. Then I found that I really wasn't getting anywhere. That's when I say ... Really, I don't know when it was, but the patients kept coming back to me with the same goals. I would work on visual motor and grasp formation and pinch strength and putting things in order, remembering two steps in a row, that kind of stuff, to get to shoe tying.

Patty Sharp: We would always work on shoe tying, but it was at the end. Like I felt like I need to lay out this groundwork to them shoe tie. That was the goal that the family had. We would get there. That episode of therapy would end after 12-16 weeks. They met their goal and then they're going to work on it at home. Well, six months later, they came back and they're like, "Okay, I want to work on shoe tying." I'm like, "Wait. We worked on that before." If I was working on their functional goal of shoe tying, doing all these little component goals, but they weren't getting to shoe tying, I'm like, "Oh, gosh. What's wrong here?"

Patty Sharp: I wasn't able to link deficit or impairment reduction to increase function participation. I knew that was the goal. I knew that as an OT, my job is to get to you have more function and to participate in things that you want to do and need to do, but I was stuck in impairment reduction and deficit reduction. That's where all my work was. That's where my goals were and then I wasn't able to link the two. Does that make sense?

Fawn Carson: Absolutely. I'm reflecting on my practice as you speak.

Patty Sharp: I was stuck and I felt a little phony because a lot of my family conversations were like, "Well, we have to get the tripod grasp if we really want to lay the foundation for blah, blah, blah," whatever. I felt a little phony because I'm like I'm promising them that, "Trust me. Their scores are really bad here which means that they've got really bad impairments and that's why they can't do what they want to do." I wasn't feeling honest because I didn't know that to be true. It might be true, but I wasn't seeing that relationship.

Patty Sharp: I was starting to lose a little bit of patient and family engagement. They weren't mistrustful of me. They didn't dislike me. They weren't bothered by the interventions, but when you're doing nonfunctional stuff, we all know this. Remembers cones and that like rainbow arc thing that move little plastic pieces over to the side or even, what was that big machine? Basically, you could simulate the movement of pouring-

Fawn Carson: BTE.

Patty Sharp: Yes. It could simulate the movement of pouring coffee but this giant, like I'm sure it was like, I don't know, $100,000 machine. I'm in grad school on a field work and I remember thinking like, "Why don't we just pour coffee?" but they got this giant machine. [crosstalk]

Fawn Carson: Remember, I would just interrupt and say I remember in our OT gym, we had the BTE, but we also had a kitchen right next door. It was just like side by side, right?

Patty Sharp: Right. That's the effect of the medical model. Maybe it was impacted a little bit by measurement because the BTE could like spit out numbers that look like good stuff. Anyway, when you're doing that junk, whether you accept it or not, people are not

super engaged. They're engaged maybe with me, like my therapeutic [inaudible] talking about everything else that's going on, but they're not engaged in the activity. No one goes home and sorts beads. They just don't. As much as I thought that was a great activity to work on pinch, no kid needs to sort beads. They just don't.

Patty Sharp: I was losing some of that engagement and I wasn't really getting anywhere. I had to reflect and go back to looking at, "What is client-centered practice? Am I doing it?" What really forced me to do it is when I started teaching at UC the Intro to OT and, what is it, Professional Practice, that kind of stuff. It really forced me to when I'm defining these things for the students and I remember learning about them looking like, "Do we really do this because we can't just teach and then not do it?" I'm looking here. CanChild is this great website. We can put it in the resources, but it's just canchild.ca. They just got a lot of information on therapy support for kids with all sorts of disabilities.

Patty Sharp: The basic assumptions of client-centered care is that, 1) clients or families know themselves best, 2) clients and families are different unique, 3) optimal client function occurs within supportive family and community context, 4) this is the most important one, rehabilitation success is more likely when clients are involved in setting their own goals which we look at that. We're like, "Duh, yeah, but okay, are they really involved in it if I'm assessing them with the Peabody and then making the Peabody-based school?" No.

Patty Sharp: It's really important that we have to have the clients, the kids or the families involved in setting their goals and therefore determining the intervention. We have to be more partners with the clients and the families. We have to listen. We have to be okay with them failing. We have to be okay with them setting a goal that may not reach. We have to be okay with them choosing to decline maybe a goal that we want them to do. If I have a kid who's eight and they're not tying their shoes, "You should learn to tie your shoes, buddy." I don't do that anymore because if they don't want to tie their shoes, they're not going to tie their shoes. If they don't have to tie shoes, they're not going to tie their shoes."

Patty Sharp: If the family doesn't have the time to sit down and fight with the kid in the morning to really say, "No, you have to work on Ms. Patty's shoe tying," they're not going to do it. Why would I waste my time on that? They're coming to me. Why would I push that

on them? I really had to look at that. Two things that I wanted to talk about, one, what are people actually doing in practice? It's a sticky wicket. Number one, I don't really know what people are doing in practice. I know what I see around me which is a small snippet of the world. I see people doing what I did, well-intended, very clear measurable goals that are theoretically linked to a functional goal of client-chosen functional goal, but the mismatch is happening that I don't know that those things relate.

Patty Sharp: We can talk about that next time when we talk about intervention, but there's not so much clear evidence that working on reducing an impairment actually improves function. There is some, but there is not a ton. We have to look at that. I don't know, what do you see in the adult world, in other people? I know you work on a ton of con ed, but what are you seeing?

Fawn Carson: Everything that you're saying is resonating for me for sure. I think that a lot of therapists are thinking about this. How can we tie these two together? A lot of the research especially out of the stroke rehab where repeated practice and functional activities that they are doing at home is the best way. Again, when you're talking about the beads and working on beads with little kids picking up pinch and how that probably would not happen at home, I was just thinking, you could just see what kind of ... This goes back to crafts a little bit too. Do you know those little beads that you put on different like a heart or a star and then you-

Patty Sharp: Yeah.

Fawn Carson: My kids did that when they're little. Thinking things like that like, "What kind of activities do you like to do?" and then figuring out from there, "What activities promote pinch?" and talking to the parent to see if they have the environmental setup and resources to actually provide that. I think that's the best-case scenario. You want whatever they're going to be doing to be fun for them at home so parents can support. In the adult world, this takes even a step further because they're able a lot of times to tell you exactly what they want and be able to get the resources as well.

Fawn Carson: It's that repetition. We had someone come on, I really like this idea too, every time the client came in ... This was outpatient. Every time the client came in for outpatient therapy for stroke, they said, "Name three things that you had trouble with this week. Tell me what those were."

Patty Sharp: That's a really good trick.

Fawn Carson: "Tell me three things." That ended up being the three short-term goals for the week. One was, "I want to be able to open the refrigerator door with my affected arm," say it's the right hand. That goal that week was, "Okay, you can only open the refrigerator with your right hand. Put a sticky note on the refrigerator door that says, 'Only right arm,' and that was the goal for the week. Everything you do is with that right arm for opening that refrigerator." I think that is tying not only function right at home, but then they have to go to the refrigerator. You're obviously building in that repetition as well. Which is better, "You go home. I want you to do 20 reps of this exercise three times a day"? Now, what are they more likely to do? Use their right arm to open a refrigerator.

Patty Sharp: Something that fits into their life already. Really looking at when you're talking about the beads, number one question, "Can they not do the beads? What can they not do that they want that pinch better for?" A lot of times, our families can be, especially kids who were born with disabilities like cerebral palsy or something genetic, they're overtherapized. They know the lingo and they know they're supposed to have a pincer grasp or a tripod pinch or something. We taught them up. I taught them that. That was my fault. That's what we're working for.

Patty Sharp: If we look at instead say, "Are they having trouble picking?" If they say, "I want my child to have a tripod grasp." Years ago, I think I would have said, "Oh, great. I know exactly what to do." The goal would be to improve tripod grasp and I will do all sorts of picking up little things and thongs and stuff like that. Now, I think I'd say, "Okay, well, what can they not do because they don't have a tripod grasp?" That takes time for ... These families, they're shifting too because we taught them to talk about tripod grasp for goodness sakes and we taught them to talk about body awareness and sensory processing, the component type things. That was our doing.

Patty Sharp: Now, we have to undo that a little bit and teach them, "Well, if they can pick up their Cheerios and their beads, is there anything they can't do because they don't have that grasp pattern? Are they using maybe a lateral pinch? It's just fine." Really looking at, "What is your barrier to the thing you want to do or need to do?" That takes time for the families to get there too because we've pushed them in the other way. I really like the ICF model, the

International Classification of Functioning Disability and Health. I think we've all seen it, but there's three ... It's how we look at how people do things and what might be barriers to performances. We'll put it in our resources, but it was written the World Health Organization.

Patty Sharp: It's a framework for measuring health and disability at both individual and population levels. In the middle here, on the left, you've got your body structures and functions which is where the medical model hangs out. That would be your muscle strength, your range of motion, anything you can kind of measure, your visual perception, your sensory processing. Then in the middle is your activities, your ability to do activities, your ability to ride a bike, handwrite, tie your shoes, that kind of stuff, where our goals should be focused. Then on the right is participation.

Patty Sharp: Our goal should be ultimately focused here where the goal should be that the child can be a student in school, a brother to his sister, ride the bus, participate in daily life. Medical model goals are focused at reducing impartments, looking at changing those body structures and function which sometimes is possible. In a rehab setting, when you're building back up, from a burn or a brain injury or an amputation or something like that, those things can change. If we're looking at more chronic conditions like CP, Down syndrome, that kind of stuff, we can't really change hypertonia. We can adapt around it, but we can't change spasticity. We can't put a brain back together.

Patty Sharp: Working on trying to improve some of those things, we used to stretch kids with CP all the time, like tons of painful stretches. Now, we look at the literature and it doesn't do anything, so why are we doing that? We can't change some of that. Focusing our goals or just focusing our attention on the middle part, the activities and using that as a focus for our conversation with families is where we should be. That's what the literature is saying. That's what the European Academy on Childhood Disability, they have all sorts of guidelines based on different conditions. Most of their guidelines say that best intervention starts with functional goal setting. It's written.

Patty Sharp: What is interesting though is in prepping for this conversation I pulled out some textbooks and I've got the latest edition here of OT for Children and Adolescents and there's no section on goal setting. I know the whole book is about doing functional interventions and ultimate goal of improving function, but there is

no specific chapter on functional goal setting. I don't know if we need that or not. It's obviously the undertone of everything that we learn, but I'm not sure if it's super overt. It's in the literature that what we do should be focused on their function, their activities and their participation.

Patty Sharp: Iona Novack's new article which was just massive systemic review of all pediatric interventions concluded that the best interventions are those aimed at improving activities and participation, not at body structures and functions. Like I said, so even if it's not written, she didn't mention that the goal should be written in a functional or client-centered way, but our goals drive our intervention whether we want to or not. We can say that we have a different goal by doing this intervention, but your goal, that's where you're going to go to. When you have patients back to back to back to back, you're going to look at that goal and that's where you're going to start.

Fawn Carson: Absolutely. I totally agree.

Patty Sharp: I wanted to bring up a couple of different tools that can be used in pediatrics. I know that every setting is different. School-based therapy is different and I know they have a different structure, but there are several things that I found really helpful. The number one thing, the basic thing is when you're doing an evaluation and you're using the OT practice framework, just running through that occupational profile is the easiest, simplest, most clear way to do it where you're running through their ADL performance. "Tell me what it looks to feed yourself. Tell me what it looks like. How does it look in the morning when getting dressed?" Just having a conversation.

Patty Sharp: That is driving you to look at function and what they're doing on a daily basis. Just running through that and asking. I think the problem is at least the way I've done evaluation is I started there and then I got solely more detailed in looking at grip and pinch and all the little components. I think we can get a lot just from the occupational therapy profile. I think that should be the meat of where we're driving our goals. That would be a way to start. There's a couple other things in peds. You can just to do a daily log because sometimes families have a hard time thinking through.

Patty Sharp: You could just say, "Well, what are you having trouble with? They'll have a hard time bringing it to something functional. Just

giving them like a sheet with times listed on it. Like, "A Day in the Life of Sally," just writing out, "8:00 a.m., wakes up. I helped her get dressed." That gives me ideas there. It helps the family run through some places where they might want to intervene or things that they might have trouble with.

Fawn Carson: That's interesting. I haven't heard of that before. That's nice.

Patty Sharp: I think families get caught up in ... Well, they want to please us too. There's all sorts of dynamics going on, but especially if they've been in therapy before. They have a really hard time of knowing why they're there which is unfortunate. I think again that's our fault, but it's our job to remind them they're there if they have something they want to get better at, not they're there because their child has CP.

Fawn Carson: Right exactly.

Patty Sharp: That's where we have to go. That's a really easy thing to do. Just give them a schedule of the day. Another tool that people seem to like, it's not my favorite, but people seem to really like it is something called the Pediatric Activity Card Sort. I know that there's an adult version too which is called the Activity Card Sort. You really have trouble ... I think this would be useful for a new grad because there's not a lot of experience and maybe you're not a parent so you don't really know what kids do even though you think you do.

Patty Sharp: The Pediatric Activity Sort is a series of picture cards and they've got kids doing all sorts of things in different areas in their life. They've got leisure activities and productivity, things like homework and social things. There's just pictures of kids doing a gazillion things. There's like a hundred, probably more at 75 cards. The categories are personal care, school or productivity, hobbies and social and sports. Then you separate them into piles of, "Can do easily," or, "Wants to do but can't," or, "Needs a lot of help." That can help foster a conversation of where a child might want to go.

Patty Sharp: You can use it with the parent and you can use it with the child themselves. People like it. I think it's a good way to start practicing having conversations about function. What I don't love about it is that it's already outdated. Every technology thing is outdated by the time it's published just because like it's a picture of a kid on a phone with a cord [inaudible] or like a calculator.

Things are already different by the time it comes out or it's missing things that aren't there. There's no iPhone. That's where a lot of things come in or webcams and stuff, like there's just things that are not there.

Patty Sharp: It's a good place to start like I said for people who maybe are having trouble just having that conversation. A lot of times families are like, "What are you think I should be doing?" This would give just a list of activities for them to be like, "Oh, I never thought about that." They can't pull their key out of their pocket or whatever. Did you see the adult version? Have you seen anybody use it?

Fawn Carson: I have definitely had people come on and talk about it on the site for sure. Yes, I think that's a really good activity. Again, I just laugh about that because you're right, it's so outdated. I wonder if they could do like an online or an app or something that you could pull up on a phone and somehow, it's like a Pinterest board where you tag that ones who are interested in because that seems it would make it so much easier.

Patty Sharp: So much easier, yeah. I feel ... it's just their ... They look like the pictures were taken in the '70s when they're probably taken in like 2005.

Fawn Carson: Right.

Patty Sharp: It's just so fast. We'll get somebody on that to update that into an app. If they can swipe them into different categories or whatever, that would be wonderful.

Fawn Carson: Not only that, oh my goodness, kids love getting any [crosstalk] electronics, so they would be totally engaged in that activity.

Patty Sharp: Yup totally. The thing I like best is the Canadian Occupational Performance Measure. That's my favorite. We use it at Cincinnati Children's. It's something we learned about in school. When I got to the burn hospital, of course, we didn't use that because we're just working on survival. Then I just thought, "Well, okay. It's like everything else. It's a great assessment, but nobody really uses it," but we do. It's really well supported in the literature because it is one of the things that you can show improvement in function that is important to the family and child. It's very well supported. It's super easy.

Patty Sharp: It is basically just a way of you asking the family what ... It has prompts that can get you really guided into talking about the different areas of function like ADLs and leisure and productivity. Once you get used to it, I don't even use like the script of it anymore, I just know it in my head, it's just like, "Okay, what's important to you?" Then you have the family rate their performance on a scale of one to 10. "Currently, how do you feel your child performs at shoe tying?" That's not what they can do on their best day or their worse day but what do they generally do. On a scale one to 10, one they can't do it at all or won't do it at all, 10 they do it perfectly every time. They rate that.

Patty Sharp: Then they rate their satisfaction with that. "On a scale of one to 10, how do you feel about the way they're shoe tying right now? One, I really am so unhappy with how they are tying their shoes. I really want it to change right now. It's very important to me that it changes or 10, even if they don't do a good job, I don't care. I'm pretty happy with it. It doesn't matter to me." It gets not only how they're at it, but how much the family or the child actually cares about it. It's something that they can't tie their shoes at all, that's a one in performance, but it's eight in satisfaction because I don't have to tied shoes and I don't care if they ever tie their shoes. That really guides your goals.

Patty Sharp: You do it at the beginning of your episode of care and then you do it at the end. It's a great way to show improvement. Just an improvement of two in either performance or satisfaction is significant statistically. It's really handy and it's a good way to just really pare down at three to five goals. I really like that. Some conversations, I've just gotten better at supporting ... I've had to really clarify that, "It's not about me. I don't really care," because I think that the medical model is that, "I am the expert and I know what you should be doing and I have the scores. It's all about me." The opposite of that is, "It's about you. I don't care."

Patty Sharp: I have to come from a perspective of, "Yeah, I'm a mom too. My kid doesn't make his bed and I don't care." I have to say, "It's fine," because it'll bring up, "Well, let's work on shoe tying. Do you really want to work on shoe tying? Is it important to you that he ties his shoes or are you okay with him wearing Dockers shoes?" Just me saying, "I really don't have a feeling either way. I don't care. I am not judging. I want you guys to be happy and functional and I want to be useful to you. I want to spend your time well."

Patty Sharp: Just really laying that all out there I think has given my family's permission to drop some things that they think I want to work on when I don't and giving them freedom to ask for some things that they maybe feel are silly like, "I want to work on a cartwheel," or, "She really would like to be able to braid her sister's hair." Great, those things are awesome, but I never would have gotten there by assessing with a standardized measure. Really just laying it all out there, "What can't you do that you want to do? What would be great?" One way that I answer that conversation is, "If you had a magic OT wand, it's just you and the magic OT wand, what would that wand do?"

Patty Sharp: That gives them a little bit of permission to say, "Oh, well, it would be that he would wipe his own butt." "Great. That's awesome. I can do that." They might say, "Well, it would be that he doesn't have cerebral palsy." "That would be great. Unfortunately, my OT wand can't do that." You'd be surprised. When I first started giving the freedom to set goals, I was afraid I was going to get a lot of that or, "I wish that the car accident never happened." It rarely happens. It never goes there. That was my big fear that they would say something super sad or snarky or hopeless.

Patty Sharp: It rarely, if ever, happens. I can't say there was a time when I got something like that. They really say really amazing meaningful stuff. I always find more things to work on. It's really cool. "I really wish that he could hand up his mobile in his room. He loves his mobile. He knocks it down all the time. I wish he could hang it up." "That's awesome. That's great. You're engaged. The kid is engaged. We're going in a functional direction." Is it sexy? No. Is it experty? Yes, it is because you can't get there on your own. You don't see how valuable this is. That's my role. That's my job.

Fawn Carson: Right.

Patty Sharp: Another thing that I was afraid is what if they set unrealistic goals or "unrealistic goals." First of all, that's not really my place to judge if it's realistic or not. I have my experience as a therapist and I have science, but I don't really know what's realistic or not. Let's just not make this dramatic, but let's say it's spinal cord injury, like a C-level spinal cord injury and their goal if they say, "I really want to walk." "Okay, I think I need to know that that's in the back of your head and I need to know that's what you feel that maybe is the only thing that's worthwhile. I can give you the information on what needs to happen before we get there. We can work towards those things."

Patty Sharp: It's not my job, "That's not possible. We're not going to work on that." Again, it doesn't happen. It rarely happens that they set something unrealistic. What happens more often is they'll set something that maybe I feel is silly or the parent feels is silly. For example, there is this one, If a child with CP, pretty severe dystonia, so couldn't really stand unsupported because of the spasticity and his goal was to stand up and throw and catch a ball. I'm like, "Okay, but why?" In my head, I'm like, "Why don't you just do it sitting down? Why would you ..."

Patty Sharp: This is when I'm just really trying to go with the client-centered goals and the mom was like, "That's dumb. You can do it sitting in your chair." I'm like, "Oh well, hold on. Let's just see." We came up with this crazy way to ... He was like leaning back against the wall and then he had a little bench on one side of him. He was standing up and he was happy. He threw and catch a ball. He couldn't be happier. He was so excited. We figured out a way to get what exactly what he wanted to do. Now, is that something that he's going to do every day in gym class? I don't know but maybe.

Patty Sharp: Trying not to judge whether this is realistic or not, maybe that's not fair. It's not really fair for us to say. Those are some things that I want to keep in mind that letting it out there, giving freedom to set whatever goal they want. I don't know if you have any experience with that. These are fun with things that you feel were silly or unrealistic.

Fawn Carson: Well, I work in spinal cord injury for a long time. I definitely had to deal with ... Like I said, you don't ever want to break someone's spirit. All they're ever saying is they want to walk. That's a really hard thing out of the gate to work with. I think just being honest with them and saying, "Okay, well. That can be something that in your mind is the end goal, but in the meantime, what's important to you?"

Patty Sharp: Right. I always talk about, "I don't know what science is going to do. We need to make sure we keep everything healthy enough so we've got to keep you stretched out. We got to keep your bone-bearing weight, so let's figure out ways to get these in, so that's there. Also, in the meantime, what are we going to do?" I think that's key too. Time and time again, I'm just so shocked by how rare it is for a family to set an unrealistic goal or to throw that

out there even in trauma, like I worked in brain injury for so long. When I started opening it up a little bit more, they rarely ...

Patty Sharp: Maybe they had it in their heart and they didn't say it to me, but I was just impressed by the acceptance on some level that this is what we're working for now, so [crosstalk 00:53:19].

Fawn Carson: Right, I agree. I think I only had a couple of times where someone said, "Well, there's nothing you can do for me. Since I can't walk, then I don't want to do anything else." I did out of the gate would have people say, "Well, my end goal is to walk again." I would say, "Okay, well, again that can be a long-term goal. Again, I don't know what science will bring to us in that capacity, but let's work on what we can work on now. Your arm is strong, keeping you mobile, being able to do what you need to do every day."

Patty Sharp: I do want to wrap up here. Does that mean that we don't ever assess from the bottom up? No, of course, we have these great tools and they are important. We have to figure out where our client's strength and weaknesses are. If they have an impairment that is getting in the way of the thing they want to do, we need to know that. Of course, it's not like we're dropping all of our assessments and tools. We need to figure out what we're working with. Sometimes, that's a way we find what is the barrier to the things that's important to them.

Patty Sharp: It doesn't mean that we're just going to forget all of our tools or stop looking at the pieces that put this person together, but we should really look at our goals that are in the chart and really determine, "Are these things that the client wants to do? Are they functional things or is it just active wrist range of motion?" because that's not function. Active wrist range of motion for what? Active wrist range of motion for what thing that the client wants to do or needs to do? Just really taking the time to lead yourself there. That doesn't mean, of course, that we're not going to ever use any of those tools to get the strength and weaknesses.

Patty Sharp: In summary, I just want to really encourage people to get in a place where you can honestly look at the goals that you're writing and not to put them in a defensive place. To just honestly look and not be like, "Oh, my gosh, I'm doing this wrong," but just be like, "Oh, wow. I am writing some nonfunctional goals. Is there maybe one of these that I can move to something more functional?" or, "The way that I do my evaluations, it seems to be

leading to a lot of component-based goals or impairment-based goals. Is there a way that I can open up the conversation a little bit more?"

Patty Sharp: I want our listeners to feel comfortable looking and reflecting at their practice honestly and then maybe making some small changes to move towards allowing a little bit more functional and meaningful goal writing. That's what I'm encouraging people to do that. That's how I came to it. No one told me like, "Hey, all your goals are really bad." It was a process of me being like, "Okay, I'm not getting the results I want. Where can I start?" Like I say over and over, our goals are driving our intervention. Those are the things that are driving our reimbursement. We really need to be looking at ... Just take a look at them. Go to your charts. Look at one chart. Don't overwhelm yourself. Don't put yourself in a hole of like, "I have to fix everything." Just take an honest look and see, "What little things can I change?" I'd love to hear people's experiences with that.

Fawn Carson: Kudos to you, Patty, for recognizing that and trying to make a positive change.

Patty Sharp: It's been awesome. It's been great. It's just so fun to see people proud of themselves for the things that are important to them versus proud of themselves for improving strength or something. It's really different. It's really empowering. It's been just delightful. It's just such a nice part of my job and I love it.

Fawn Carson: Thank you so much for joining us on Continued Conversations and can't wait to talk to you next time.

Patty Sharp: Thank you.

Fawn Carson: Talk to you soon.

Patty Sharp: Bye.