Telehealth OT: Using Pediatric Case Studies to Inform Practice

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[Fawn Carson]: Our course today is Telehealth OT: Using Pediatric Case Studies to Inform Practice. Our presenter today is Dr. Aditi Mehra. She graduated with a Bachelor's in Occupational Therapy from Western Michigan University in 1998 and has a Doctorate in Health Sciences from Midwestern University in Illinois. She has practiced as a Pediatric OT for the past 22 years in various settings.

Early intervention, hand therapy, inpatient and outpatient rehabilitation in school settings. During her doctoral studies, Dr. Mehra also pursued a certification in Applied Behavior Analysis to improve and enhance collaboration within multidisciplinary teams. Once she delve deeper into this field of ABA, Dr. Mehra uncovered Fit Learning, an academic program based on the principles of ABA designed to... Sorry, ABA designed to build fluency and address all differences in learning executive functioning, ADHD, et cetera.

Dr. Mehra is currently the Director of Fit Learning Labs in the Chicago land area and continues to practice OT in the school setting. Her passion is rooted in IPE and aims to foster multidisciplinary collaboration within the field of OT and other allied health professions. She provides continuing education presentations to various allied health groups in the community and is an avid blogger for Psychology Today.
Welcome Dr. Mehra. So glad to have you back.

[Dr. Aditi Mehra]: Thank you so much, Fawn. Thank you everyone for inviting me here. I'm so thrilled to be here to be discussing this topic, which is really rooted in firsthand experience for me and quite an anxiety produced, I must say. About two years ago is when I was first introduced to telehealth and it was this jump in and figure it out approach because there weren't a lot of resources, I didn't know a lot of therapists

who were doing telehealth and so I was so intimidated, I do remember that. And that's one of the reasons I decided to delve into this presentation.
I remember the first thing I did was look up the research and go, "Okay, so there must be something out there on it." And there was, but I found a lot on adult rehab and I really didn't find a lot to help me with the pediatric population, and I'm sure all of you here probably know pediatrics is a whole different animal. There is a lot more research now than there was before, but still I think it's left clinicians feeling quite trapped about delving into pediatric telehealth.

That's why we're here today. Hopefully this presentation will help easen that anxiety and give you some solutions and strategies to implement.

I think learning outcomes, that's what it's looking for. Our learning outcomes today is really about identifying some decision making guidelines that you would need to consider prior to servicing pediatric clients in telehealth, highlighting some synchronous and asynchronous modes of delivery, describe the benefits of coaching delivery model and any challenges and solutions to addressing pediatric telehealth. I think that number four is probably the one that a lot of you are probably seeking.

The first thing I always do whenever I enter a new arena is look into AOTA and the research, and this position paper was really helpful when I first restarted researching telehealth and pediatrics because it provides you a lot of just general guideline. Just the use of telehealth, existing research, what sort of qualifications, ethics, and regulation. So I would really suggest reviewing this before you delve into telehealth.

Then the basics. I think you all know this, I just feel like I have to say it. The licensing requirements are very stringent, depends on your location, depends on the client's location, so you do want to look into that. Then determining the feasibility of telehealth for your specific client, whether it comes to technology or just their surroundings, if

they live in an environment where it's feasible. Then what sort of software, making sure it's HIPAA compliant, all that. I just wanted to mention that.

As far as delivery models, again, there are several, but asynchronous is really where you're storing and forwarding the information. So videos, things like that would be something that's asynchronous. Synchronous is what most of us are doing now, which is that live video conferencing environment. Then store-and-forward means basically... That's another asynchronous form of information.

It's a lot of your patient's medical information that you might be using or forwarding to say, another team member that you are consulting with. So just to review that a little bit.

When I first have a client who has the possibility of telehealth, there are several considerations, and AOTA, if you are a member, they have this beautiful guideline. It's like a nice flowchart and it really highlights what you need to think about, and it gives you a very clear distinction of, okay, have you met the State regulation agency requirements? And if it's yes, then you'd go down to pass, and if it's no, then it tells you where to go next. So really if you have that resource, please do use it. It is phenomenal in really helping you gain clarity on the next steps.

Also discusses consent, technical considerations, ethical and it gets really deep. These are just some key points from there, but it gets really deep into analyzing those aspects.

Many of you I'm sure have just started telehealth, there's been such a recent boom with it, and telehealth itself has several challenges, as you all know. There's a recent article by Cole et al., 2019, actually very recent. It is called Use of Telehealth in Early Intervention in Colorado: Strengths and Challenges with Telehealth as a Service

Delivery Model, and what really is highlighted that most practitioners claimed that technology management was the primary structural barrier which interfered with telehealth services.

It didn't talk a lot about pediatrics per se, but it was interesting to me that this pediatric field highlighted that as the major barrier. Now, in generally speaking, technology is a major issue and managing that is a major issue, but when you've got pediatrics, you're dealing with these secondary layers. Normally if you have an adult client, most of the time you're probably instructing that client to do X, Y, and Z.

When you have a two-year old, for example, you might be doing parent coaching, so you've got two layers of instruction. You've got to instruct the parent, to instruct the child, or you're trying to instruct a child who may be a little older, say they're eight years old. You're instructing them, but you're instructing them on so many facets, not only what you require them to do for skill development, but also managing technology. So just thought is interesting that this article only identified technology as the major barrier. It did highlight a few other things, but this was the prominent one. Some of the major challenges, which at least I encountered and what I've heard from other practitioners, comfort with technology, if you are using a parent as a facilitator, sometimes that's hard. Obviously if it's a child, they have to know what to do.

Needing a facilitator, that's another variable. That's a confounding variable that we do often require with direct adult telehealth in situations. Then the receptiveness for a parent to do parent training, to be involved. Some parents are just not up for it, they don't want to do it and that's okay, but that's another barrier hurdle we have to get through.

Then of course, keeping children engaged. I hear this all the time and we will go through some scenarios to help you with that strategy. I think here is where my ABA really helped me try to figure out how to keep kids engaged.
Sensory strategies. That's another one that a lot of clinicians would ask me, "How do you do that when it's on telehealth?" And yeah, there are definitely some different elements there that we'll be discussing. Then obviously accessibility, not all families have accessibility.

There are several choices when you have a pediatric telehealth client. The first one is, are you going to do direct therapy via telehealth? Or are you going to do some coaching parent training? Occupation-Based Coaching is what I refer to based on an article that I read and it's really the same thing as parent training. That's your first decision. That can be a cumbersome decision in itself because you've got to make sure the parent is willing to participate in parent training.

Then direct therapy. Now, this is more... My gauge is if a child can follow directions, this is probably where I start, but if they don't follow directions, well, then definitely I go with parent training and coaching. And also some parents prefer that. Some parents will say to me, "Well, I know Johnny works really well with you, but I want to learn what he's doing." So then I may say, "Okay, well, then parent training may be something you'd want to consider."

Whenever I have a client, I really think about what sort of mode am I going to use; asynchronous, synchronous, or perhaps an hybrid, really considering the clients. So in this chart that you see, I've highlighted some aspects of the modes of delivery, but also limitations. If the client has major behavioral issues, that's something you need to consider is recorded videos, better mode or video conferencing. Are you wasting a lot of time in video conferencing sessions?

Again, do they want parent coaching? Hands-on sensory strategies, if you want to do that, maybe synchronous would be better because you want to show them hands-on techniques, or the parent may be more receptive to asynchronous. The only thing I'd be careful of with asynchronous modes there is having a disclaimer, because if you're referring them to some resources outside of what you're showing, then you do need to make sure that you have a disclaimer that these are just resources and you need to consult with the OT who's treating to make sure that it is a valid form of intervention for the child.

Parent training, this is the one that I typically use with students who, as I say, don't have an easy time following directions, my younger students, early intervention. An Occupation-Based Coaching is what is going to be referred to in this presentation, but it's really, as I said, the same thing as parent training. It is rooted in the principles consistent with Occupational Performance Coaching, if you've heard of that before, and it's really coaching families of young children, as I said, used a lot with autism spectrum disorder.

It's highlighted as best practice in the literature. There's an article by Little et al., 2018 that really highlighted this as best practice. And it targets caregiver and child function by building like a family unit and coaching the family to provide strategies for intervention.

As I said, it involves parents in creating goals and strategies to increase participation, so they're actually a very integral part of intervention. It involves a reflective questioning and problem-solving to really get through strategies, and really allows the parent to gain a better understanding of what their child's limitations are and what solutions can be offered. Again, a parent has to be receptive to this, otherwise, it really does not work because it is a very team approach.

The one thing that is quite a shift in Occupation-Based Coaching or parent training, it's not so much a skill focus, it's more of a participation focus, and this is very prominent in telehealth because you're in the thick of it. You're watching them in their daily activities of daily living. So when we, as therapists, just focus on a skill, and this typically happens maybe in a clinic setting, you might focus on a skill set, we may be limiting the extent to the child's ability to participate. So it's really important when you do telehealth to really look at, okay, what are we doing? What are we working on? And how will it improve participation?

Then the other aspect is when OTs work with parents to practice these strategies, it's actually more likely that they're going to practice it more because it's part of participation rather than just one skill. If I say, "I want you to work on 10 reps of this with Johnny," it probably won't happen. Whereas if I say, "Well, every day when you're doing the dishes, make sure Johnny stacks the cups like this." That's more likely to happen. So it's really changing your paradigm to participation focus versus a skill focus.

There are several key principles of Occupation-Based Coaching. However, one thing I wanted to point out before we go into the, it's really about encouraging the parent to create their own strategies so that they can match their own unique environment setting, whatever you want to call it. It's really important for them to look in to their home life and say, "Okay, these are the struggles I'm having within the context of the family." And you'll see these key principles highlight that.

The first is authentic context. That is really just like I said, we are in the setting of the home, the place where the child and family situate themselves. That's where you want to consider intervention. So making sure that it is a very authentic context. It's easier to do on telehealth because you're in the setting, right?

Second would be the family's interests in routines. We need to create strategies that occur within natural routines and interests. Just like I mentioned before, rather than saying to mom, "Let's do this X times," if I incorporate it into the daily routine, it's more likely to occur and progresses more likely to happen.

Caregiver interaction and responsiveness. Our role would be to support the transactional relationship between the parent and the child or the caregiver and the child. Behavior is a component of that, so really helping parents understand the behavior, what that really means and creating that sort of transaction between the child and the parent. Using the family's patterns, what they do every day to create and foster family strengths in relationships. That's more of a psychological bonding aspect, which I really love as part of OT because we are mental health and emotional health related to.

Then reflection and feedback. This is so crucial and this is the part I think a lot of people miss in telehealth, especially with pediatrics. I know I did when I first started because you are asking the parent to be something they're not. They are not qualified to be a therapist, they are not qualified to provide these interventions, so you are asking a lot of them.

It's so important that you take the time to guide the reflection and feedback, so the provider and the caregiver need to talk and really reflect on what happened today. How can we change that? Oh, you did a brilliant job with this. Oh, this was not as effective. Really opening up that communication base.

Then having joint plans. And this is basically where the provider and caregiver identify what each will accomplish between sessions to address the family goals. So you might send the parent an email and say, "You know what? I'm planning to work on cooking

with you on Tuesday, so wondering if you have these items and if you're okay with it. Are there any allergies," things like that.
Those are some strategies that you'd want to do, but again, we are a team. We are not just going in there and treating and saying goodbye, right? It's a really collaborative approach.

Does anyone have any questions thus far? I feel like I've been going awfully fast. So I might pause and just see if anyone has any questions.
Okay. Brilliant. I guess not. Okay.

What is this process of Occupation-Based Coaching? The first thing, the model really gives caregivers power. It empowers them to create strategies to increase their child's participation across natural contexts. That's what it's really about. OBC or Occupation-Based Coaching is a intervention that combined several principles. It's coaching with occupation-centered reasoning, that's the main one. And the process of this module includes one; setting goals, exploring options.

Then you plan an action with the parent. Then you carry out the plan, and then you've got to check performance, because if you don't check performance, then you don't know what's working and what is. Then you want to see, is it generalizing? Those are the components that can make parent training really effective. Although many studies have indicated like hybrid approaches of teletherapy are very effective with Occupation-Based Coaching, there's not as much on pure telehealth services and Occupational-Based Coaching.

We definitely need more research, but the direction is showing that there is some efficacy with students with autism, and I like to it and say, students who have a hard time with following directions and maybe some significant sensory issues.

So what happens is parents identify goals that aligned with their family's current needs and they identify how they could achieve such goals in their daily routine. So the studies have shown that through OBC, many parents identify adaptive behaviors as part of their intervention; toileting, eating, sleeping. So these strategies which are right up our alley in OT seem to be the core of parent training.

So the combination of four elements; one, parent identified strategies, two, parent identified goals, parent implementation, sorry, and full evaluation of effectiveness of strategies are the hallmark of Occupation-Based Coaching and it makes it unique from any other intervention process. So really parent is such an integral part of this type of training.

So it's a very effective method in increasing parent efficacy and child participation as per the literature. It also increases positive child caregiver interactions and capitalizes on the family strength while supporting caregivers because they are now using their own resources and they're learning how to problem solve their child's behavior and challenges.

Caregivers identify goals and therapists, we ask reflective questions. Reflective questions... Sorry. I don't know what happened there, I think we missed something. Anyway. The part of Occupational-Based Coaching is guiding a parent to create achievable goals. And like I mentioned before, it's very much about the parent being an integral part of this and identifying adaptive behaviors they want to dress. So there we are, sorry. There is a reflective coaching. This is really important when you're doing parent training, and so I took it upon myself to go, "Okay, I don't think all of us know how to do reflective questioning." I certainly didn't know when I started.

So I found this resource that helps you identify how to do that, asking one question at a time and creating this pause. I think for some of us, it might be difficult to create a

pause sometimes because we feel like we have to constantly instruct, that's really important. Then self questions, what do you think? That sort of thing. So these are just some suggestions and ideas that I found in the literature, which I thought was really helpful.

I have used some of these especially when I've had a parent who's a bit contentious who's not quite happy with the format. Sometimes I've noticed if I use this reflective questioning, it does dissipate some of that anxiety with parent training. Because it's a lot of work for a parent, for them to have to perform all this instruction and work with their child. They may not just be used to that.

If you're going to give reflective questioning, you also need to provide feedback. Now, feedback is really, really important and it occurs when the parent or the caregiver has been instructed on a scale, and then they perform it, and you have to give them feedback.

There are different types of feedback; affirmative, you can just say, "I understand what you mean. I see what happened." It can be evaluative, which basically means that you're giving them a critique, albeit softly. Then it can be informative where you can say, "You know what? I know this happens a lot."

For example, I've ever had a student who the mum was like, "She just doesn't listen. She's always arguing," or blah, blah, blah. I might say something like, "Well, for her age, that's fairly typical." If it's a sensory kid, I might say, "Well, for child who has this type of sensory issue, that's fairly typical." So what I'm being is very informative in my feedback. Those are things you want to consider when you are participating in parent coaching.

Overall, what you really want to do is create a mindful space for parents when they are parenting. This is really hard for them. I can't emphasize this enough because I get feedback from parents all the time. One of the things that I do often and sometimes therapists might be trepid in doing this is sending a feedback form. Maybe after six sessions, eight sessions, I email a feedback form and I just say, "Can you just be as real and honest as you can because this will help me provide better service to you." So they can tell me, "Well, I like this, I didn't like that." I know though it can be a bit harrowing to face those, that sort of feedback is really important for growth. But as therapists, we need to shift our thinking. We are not trying to increase the skill, we are not trying to control the session. What we are trying to do is help the parent shift their perception of the child and help their child.

It really does require a lot of non judgemental intervention. You think to yourself, gosh, if I was sitting with Johnny, I would have gotten this done in no time, right? And this mum might be humming or lying about it, or she may just not have the type of relationship that you have with Johnny, and so she may not be getting the results as fast.

So it can be awfully frustrating as a therapist, but keep in mind that our job is to be nonjudgmental and it does require a lot of patients and team. It's a really strong team approach that you were implementing.

During the interviews with parents who have received parent training or Occupational-Based Coaching, it really shows that their perspective of focusing on what their child can do, rather what they can not do. That was a theme that I saw in the literature, a lot of parents was like, "Wow, I really didn't think about that. I'm constantly thinking, well, Johnny can't do X, Y, and Z, and that's why he needs therapy and dah, dah, dah.

But now it was like changing that paradigm and going, 'Okay, Johnny can't do this, but he can do this and how can we build on what he can do?'" So that was quite consistent. It was also consistent with study suggesting that a focus on strength actually released results in parents increasing their own positive statements and changes the perception of their child's disability, and I thought this was really, really profound.

It also increases their physical affection with their child. How lovely is that? That was in Call Center Tool, 2010 article. If you read that, it really is very heartwarming because when parents are engaged in this, they're really able to see the little bits of progress that you and I, as clinicians see, and we get so excited about, but the parents like, "[inaudible 00:29:02], whatever."

They don't get, how profound that little bit of progress really is. So that's why I think Occupation-Based Coaching is a brilliant intervention for certain parents and clients. You see this model really requires therapist to shift our perspective and teach parents to be very mindful in their presence with their children on a daily basis. And now we're going to go into talking about how do you grade activities. That's something you have to be very careful of when you're doing Occupation-Based Training or parent training. When you are in a clinic setting with the student, you might be like, "Oh, brilliant.

Johnny is doing this now. Now we can step it up to this, but the research really shows that we need to take a slower pace when it comes to parents. Because families, the quote right here, "Families generate their own solutions and are ultimately responsible for carrying out the intervention and evaluating its effectiveness." So we cannot expect them to be as fast as we are in this., we just have to take it as a step slower.

So what we're really doing is partnering with parents, and this is so important for us as a profession and as individual therapists because if you don't telehealth, let's just say

for a short period and the anticipation is you're going to go back into the clinic setting, think about the reinforcement that parent feels when they are an integral part of the intervention that you are providing for their child.
And then when they're ready to go back into the clinic setting, they're going to value you so much more because they know what you can do via telehealth that they can only imagine the outcomes and the progress you're doing in person. So it's really important for us to partner and use this coaching model to really focus on the parents' goals and priorities and be very family-centered and really goal oriented, focusing on the strengths of the child. There's a lot of literature out there that really supports this.

Let's move on to a case study. This is the meat of everything. We're going to start with George. George is three years old. He has a diagnosis of autism. He was referred for OT for sensory processing difficulty. He lives in a rural area and has not been able to receive OT services.

He does receive speech therapy in a home setting. He is currently in a wait list for ABA services. George's parents are very eager to get started with telehealth OT services to address his sensory needs. OT goals have been established by the team to help George get ready for preschool, stay seated for activities like mealtime and other fine motor tasks.

Now, this is similar to a case that I did have, but I've added a little bit of information for teaching purposes. Let's look at the family structure. Based on the medical records, you might know that George has a teenage sister, he's cared for by his mother. His father works at nights and so it's only available on the weekends to work with him. George has a recent diagnosis of autism and was assessed for early intervention by OT.

Parents have identified their main concerns are about managing Georgia's sensory needs. They report that George's sensory needs continue to impact everyday activities like eating together family meals and just even following simple directions, going places is going to be an issue.
Based on that, just on what you've read, you can see that your mind's already going, oh my goodness, is this going to be a direct therapy child? Or is this going to be a parent coaching? There are some three-year-olds who can do direct therapy and telehealth, but given his age and given his sensory issues, and we know that following directions is a bit of a task, I would venture to say he is a parent training candidate.

The step one, what would I do first? After I've read the medical history and I've made sure that they do qualify for telehealth services based on my IOT decision making guide, I would step into looking at the evidence. I know he has autism, so I'd look at all the autism research that I could locate, and that's fairly easily easy to do on Google Scholar, just look on there. And if you were part of AOTA, of course, you've got access to those articles.

I've just highlighted a few here for you to take a peek at, some of them are fairly recent. I did like this one from 2011 because it really gave you a family-centered approach, which might be beneficial. So that's the first thing you want to see is, is there efficacy to support what I'm about to do?

Then I would share a pre-session screening. What that is, is basically I talked to mom and I say, "I really would like to observe and just be a silent observer." And I would not put my video on because I don't want to influence Georgia's behavior. There's actually a term for that called reactivity by my mere presence, his behavior might change and therefore I may not be able to manage or really learn the situation as I need to.

So observe the setting, I want to observe how the parent interacts with the child. This is where you want to put that hat on of parenting styles or types like are they fairly passive? Are they very authoritarian, authoritative? You want to go through that in your head and make some notes on that. You also build rapport with parent-child. Now, I do that at the end.
Let's just say it's a 30-minute observation session, I will observe for about 15, 20, and then last 10, I might try to talk to mom and possibly engage with the child, and I'll talk more about that. Then of course I will explain the process involved in telehealth, make sure I go through all the technology issues, logistics, making sure she understands privacy of that, any informed consent. All that's happened by now.

Then I'm also taking lots of mental notes on the student... The child, sorry. Then the last thing is I look at preferred and non preferred activities. I talk to mom about that before and review all the evaluation data that I've already received.

So then we go, "Well, how did the session go? How did George do?" So I'll give you a little synopsis of what went on. When I observed George for the first 15, 20 minutes, this is what I saw. We were situated in the living room, so it's very big open space and I thought, okay, that's a good space because George was very active, running a lot, jumping around. It was open floor plan with plenty of room.

The family had positioned the laptop in one corner of the room, so I could see a nice area, which was great, but George has ran from one end to the other. And sometimes I couldn't see him, he would go behind the furniture. He did escape a lot, like every time mom asked him to do anything, he just ran off. He was happy little guy, but he just ran off a lot.

So I did text mom and say, "Can you reposition them laptop so I can see the things." And then I asked her, "What do you typically do when he runs off?" She said, "Well, I

try to block him." I saw her trying to do that, but it was very difficult to manage the whole situation.

Mum did say that when dad's there, it's a little easier because the two of them can block him or whatever. But I also saw that George would hit a lot and throw things, especially when he was blocked, so I knew that was going to be a challenge too.

So what did I learn from the screening? So I took a few notes... Oh, the last thing I want to mention is in the first initial screening, after I observed George for about 15, 20 minutes, then the last 10 minutes, I tried to build rapport with George. It was very difficult. He was just running off, so I asked mom, I'm like, "Do you have bubbles?" So she went, she got bubbles and she tried to blow those.

And he would come for a little bit, but then he took off. Because at this point, I didn't know what George likes and doesn't like, I was just sort of randomly trying to figure out what do most three-year-olds like, I was going that angle. The iPad, he did like the iPad she brought him there, so we did a little bit of that, but it wasn't a very engaging session and I knew that was going to be one of the issues.

So took my notes, after the session I sit down and I go, "Okay, I'm going to look at each area, I'm going to start with behavior." Has awful time sitting still, can't do it. Obviously, that's one of the parent's goals. He elopes so leaves the room several times. I did not see any purposeful play, there was a lot of dumping of toys, jumping, walking on toys, just running around with things more.

Mum had asked him several times, one-step direction and they were fairly simple like a note, "Pick this up. Come sit down. Give me the remote," that sort of thing that were familiar to him. He was constantly moving. He covered his face often. He did like to

smell things, he was smelling mom's shirt, I noticed that. Dumping toys on the floor and walking on them or laying on them.

The setting, family room had a lot of toys. There was a cat there, I saw the TV was on in the background. His sister was on her phone. I did notice that. So as far as parent interaction, what did I see? Well, it's very passive parenting in what I could see. Mum was really chasing George a lot. There was a lot of bribing going on, but still to no avail. That was a bit difficult for George to attend.

And then George has preferences. After the session ended, I asked mum, "Can you just tell me a few things that George likes?" So she told me like "Curious George, water slides." But one of the things that stood out to me is that Georgia loves to eat bacon, and I was like, "Ooh, that's perfect. That's like his currency." Whenever I work with a pediatric client, I try to figure out their currency. What makes them want to do things? What is their currency? And I knew that bacon was his currency, so that was my first clue.

Then step four is exploring options, right? What I want to do is now that I've got some preliminary data on what life looks like for George and mum on a day-to-day basis, I have to go, "Okay, we need to think about what options do I have." Obviously the family room was a disaster, so talking to mum about modifying certain things, let's pick his bedroom or a playroom, where it's a little bit more confined where we can close the door, so chasing doesn't become the activity of the session.

Toys should not be all over the place. Maybe put some in a box, take one box at a time and control it, so George can't just randomly open it. That would be something we'd have to do, he'd have to request. Then creating a sensory bin based on his sensory needs would be another idea.

Again, we need to establish goals that are parent-oriented and not based on EI or an outside setting. George's mum says, "I really want him to sit and play with his toys. I don't want him to throw things. I want him to follow directions. Can't get him to sit still, I'm chasing him around." So what you could see, it was really important for George's mom and their family to get George to actually sit and do something purposeful and follow directions because it was impacting the family dynamic.

In the EI goal, it was the George will sit down for meals at the table with his family, which is a perfectly brilliant goal. The problem I saw with that goal was it's too big. When you are doing pediatric telehealth, we need to really shave down the goal to the basic. It's like a task analysis, what's the very minimum thing you need to do first? So this is the goal we came up with, mum and I. George will sit and complete one activity at the table with the parent independently. Now, it seems like a small thing, but it was very hard for George and that's where we started. Once you've done that, then you've got to go, "Okay. We know sensory is a big component here and mum's already filled out the sensory profile, I have all the data. I've observed him a little bit. I need to figure out what sensory and what's behavior."

So I typically make two columns and I write down what I've seen. And I do refer to the sensory profile, however, I like to be very objective in what I've seen in the session, which may be more poignant for the actual setting and time. I know that he needed to smell things, I know he's seeking movement. He's very distracted, difficulty with tolerating sounds.

Behaviorally, I know he's avoiding, he has a lot of sensory seeking behavior and I know his reinforces. So this is the information I know. I can use this to troubleshoot what I would do with George. And so this chart really helps me figure out. I go through each one, I go through each quadrant and go, "Behavior, I need to figure out which

behaviors are sensory, which ones are actual just behavior. I need to get instructional control. I need to talk to his speech therapist because she's already working with him." Fine motor goals and sensory goals, I need to figure out which ones are what and how would I create those? What would I do? So I would offer one sensory strategy at a time and create a very step-by-step sensory diet for mom, one table type tasks. Parent training, I want to make sure it's step-by-step train, observe, reinforce. Don't forget to reinforce, and then re repeat.

Then privacy considerations. Remember I told you he had a sister? A teenage sister? Well, she was on her phone when I was observing. So that's a privacy issue and I need to make sure mom is aware of that. Those sorts of things, I need to really consider. Pets in the room to how that is impacting, and you've got to be careful with liability issues too because that's your session and you could be liable if something happens. Considering recorded videos, if I say, "Mum, I want you to record your nighttime routine." I need to consider privacy when she's sending those videos to me, for example. And then the setting was an open room. Anyone could be coming in, even if it's the UPS person or whatever. I need to make sure mum understands the privacy rules and regulations that could be an issue.

So what sort of synchronous methods would I consider for George? Well, I might refer mom to certain resources online, visual schedules, videos, blogs, et cetera. But again, I would give her a disclaimer, "These are simply resources. I'm happy to talk to you and work through them to make sure they are applicable for George." That would be the only thing I would make sure you are saying.

Synchronous step, eight would be setting up a sensory diet and starting very small. So here is an example of just what I might say to them. "Let's say at 8:45, every day for 20 minutes, I want you to go to George's room, close the door and limit how many toys, make sure it has a box. And then let George do what he wants to do, but have him

carry heavy backpack while he's doing it. And then see if he will come and sit at the table with you."

And because I know bacon is his reinforcer, I would say to her, "Do not give him bacon any other time, only have it available at the table. And don't handle George to come to the table, just have the bacon right there and see if he'll come sit down." So that's my sort of slowly getting him to get in a seated position and then maybe see if he'll do one activity and present the reinforcer. That may be one strategy you could do.

It's really important to choose the right activity for George because it's a little tricky for him. So I would just do a very simple put in, coins in a piggy bank, that sort of thing. You want to make sure it's short, repetitive, easy, very easy and behavior. The way to change behavior is you have to change parent behavior to change the child's behavior, so some do's and don'ts.

Set small expectations, very short directions, boundary like that table chair-setting is very important. Very short sessions, if it's five minutes, oh, well, it's okay. Praise whenever possible. Be a light switch. What does that mean? Well, when they do what you really want them to do, just go crazy with reinforcement and accolades and, "Oh, you did brilliant." And then when they're not doing what you are asking them to do is really just shut off like a light switch and no reaction whatsoever.

Use a 1 to 1 ratio for reinforcement, so every one thing that you do, you get what you want, YouTube video, bacon, whatever he wanted. And then you don't want to give them attention for undesired behaviors, so anytime he's running off, as long as the door is closed, you just let him and ignore him. Save the preferred reinforcer for playtime, and then block and redirect desired behavior.

Then you want to see, is it working? You do want to make sure mom understands the signs of sensory overload because that may happen. You're not going to be there all the time and she needs to know. And then make it super easy from mom to collect data, little X marks, check marks, really easy. And then that will inform your decisions. Observe, and then obviously provide feedback. Then you might have her say, "Okay, Tuesday, we did this. I observed you, you did brilliant. I think I'd want you to do the same thing every day, but next time, maybe do it with a different activity, record it, send it to me." So you want to see if it's generalizing.

Grading activities, how would I make this easier or harder? Easier, probably would have to find something even simpler than just putting coins, but making a little harder, you may make it into a two-step activity. Coins and rice, and then placing into the container, increasing the time span, so get two things which are put in type of activities.

Using 1 to 3 ratio, that is for every difficult task, which you perceive as difficult for George, you want to do three easy things like blowing bubbles or something very simple. Then feeding up prompts to make it a little harder, and then decreasing the frequency of reinforcement. So right now you're doing every one task you do, I'm going to give you a reinforcement. You might do, after you do three tasks, I will give you reinforcement, that sort of thing.

What do parents say of this type of training? Well, I can tell you based on the research that lots of positive feedback. That's what the research is showing, so I really am very confident that parent-based coaching does work, but it does not always fit every family.

Feedback once again is the most important thing. This is an article in 2019 by Wallisch et al., and it gives you some questions that you can ask the parent if you want some

feedback, and I really think this is super important as a pediatric therapist. It really helps you grow and be a better clinician.

Parent perspectives, I think most parents felt parent empowerment, collaborative relationship, and improved compatibility with daily life, so that was a really telling article. Then as I said, some parents just really enjoyed this type of coaching, but it does not always fit every parent's needs.

Oh gosh, we don't have a lot of time, so I'm going to go through the second one, which is an older student and it was more of a school referral, so handwriting. Ryan is seven years old. He was doing letter reversal, sizing, placement, letter formation were the issues.

Again, step one, making sure that we get informed consent and make sure that they have parent expectations. Maybe review the plan with the parent via email or a video session, watch them writing, have parents send you samples of their work. Step two would be again, look at the research and I've just highlighted some really nice articles that can help you get an idea of the efficacy of this type of intervention with students. Assessing the goals based on the research, what type of goals are you going to set for the student? Again, do a pre-session screening observation. For Ryan, he was fairly compliant. He would walk away sometimes, had some verbal outbursts. Did get distracted somewhat easily, did very well with visual schedule as per parent report and teacher's notes, so I didn't feel like he needed a facilitator.

He likes sensory activities, and so what I did was send the parent a checklist of what they had available, and I think this is in your handouts. It's just a handy little thing to have. Again, consider environmental modification, does he need a pencil gripped, a slump board? What sort of seating? Where is he located? He actually worked in his

room because the siblings were in their shoes, so we just had him work in his room. So that was a very simple modification.
Here's a little visual that I used with him. This is actually one teacher and I created for a group class, but I used it with Ryan too, just giving him the expectations and some visuals, which can really help.

And for him, I used a PowerPoint. So what I did, I just set it up on PowerPoint and I figured out, "What are we working for today, Ryan?" And he'd say like candy, for example. And then I'd ask him, "Well, do we have everything we need?" If it was puzzles, he would click, this is him clicking when I share the screen that we have everything we need.

Then I'd ask him, "Are you ready?" And yep, he's got the puzzle, we're ready, so we do this activity. And he knew that we had to do these three activities before he got a break, so every time he completed one, he would check it off. This is a great way to engage a student and it keeps them really engaged in what they need to do and what you want to get done.

And when he's finished, I would just. And it has a little... You can add different elements in PowerPoint like sound effects and it's fun to play with that. And sometimes his a reward would be, he could change the sound effects or choose them. Simple things like that. And then he'd get a break, he did earn three minutes and he earned a three-minute break and then he could tell me what he wanted to do.

Then again, the goal was hand-writing, so I'd review the research on handwriting and figure out, well, what really works on handwriting, especially in telehealth? So some of the data I saw was using a multisensory approach, Stamp-and-Screen, wet-Dry method, spaghetti, Wikki Stix, just doing a little bit of research and looking at what modes have worked in the past.

You could use a hybrid approach here as far as synchronous and asynchronous. I would attach an iPad and use a stylist. He could attach that and use a stylist so I can see how he's writing using Doc-Cam. Is another thing I like to do a lot where I put the Doc-Cam on and it shows on the screen what you're writing. So I might tell mom, "Use your Doc-Cam so I can see what he's writing," or she could even use her phone via FaceTime, I can see what he's writing. That's where you would sign in with two devices.

Asynchronous format would be like sending them a work book, printables, and they might send me a photograph at the end of the session of the work he did.
Keeping students engaged. Some of our older students can be a little tricky to keep engaged. Again, the biggest thing you can do is pay yourself with reinforcement. What do I mean by that is when Johnny sees me, I want him to go, "Yay." Not, "Oh no." Because then nobody's going to win that, and that's just going to be bad all the way around.

So pairing yourself, let's go back to George, for example. George loved bacon. If every time I have my session with him on telehealth, mom has a plate of bacon. He's going to pair me with that reinforce of bacon. He knows that anytime I'm around, he's going to get a reinforcer. This is basic applied behavior analysis that really helps in telehealth sessions.

Initially I just pair myself with sitting with mom on the screen and bacon, and then I ask him to do something. So I say, "George put the coin in." And he puts the coin in and I go crazy giving him reinforcement and, yay and hoorays, and then mom gives him the bacon. And again, he knows that every time he sees me, it's going to be a positive experience. That's what we want to create.

Use a fixed ratio of reinforcement. Other ideas are, with Ryan, he was the funniest thing. One day I was putting a sticker on something. I put it on my face and he just thought it was the funniest thing, so he was working for putting stickers on my face. So being silly and really enjoying and having fun. I think pediatric telehealth is all about having fun, because the more fun you are having, the more you are pairing yourself with fun. And when you can do that, you have greater compliance and progress.
I Spy game, I use visual timers a lot. I share my screen and do that, and then again, reinforcing behaviors. Trading places, oh, that's one of my favorites. Ryan, I do that with him a lot where he is the therapist and I pretend to be Ryan, and he tells me what he wants me to do and what he wants me to write, what games we're playing, et cetera. Withhold reinforcer as necessary, and then grading exercises.

Parent perceptions. Most parents really like this type of intervention for school-aged kids, the telehealth intervention. The literature shows really positive information on that. This is Ryan's mom, it's not her, this is just a random picture, but this is what she said. That initially it was work, but she liked it and now Ryan's independent and she doesn't really have to do much about that.

The one thing I wanted to caution you, I just saw this on Facebook yesterday that telehealth is not always good for every family, so we need to be very cautious of who we use it with. This is a family who said, "I'm not having fun. It's too much work. I just see the OT or whoever sitting there and I'm doing all the work." That's a reality for a lot of parents because it's hard work.

Last thing is to really use your clinical judgment and ethics and go, "Is this appropriate for this client? And if it's not, what other alternative can I offer?" That's something you really have to consider as a telehealth pediatric therapist.

Lastly, make time for telehealth. Telehealth takes a lot of work. There's a lot of time you have to spend preparing items, scanning, reviewing, so make sure you're taking time to do that and planning that into a day. It can't just be sessions back to back because you will get burnt out too, it's a lot of mental work too.

And that's all I have. I can't believe I actually made that work in an hour. Any questions? Let's see. Fawn, are you're going to be guiding the questions? Thanks. Sorry about that. Yes. We have a lot of questions coming in and let's get to a few of these here. What is your recommendation when families just are not interested in being involved at all?

It depends on the age of the child, and this is where your clinical judgment really comes in. If it's a child who's running out to the room, you know it's not going to work without a facilitator, you just have to be honest. You just have to say, "We really need a facilitator and if you don't feel comfortable being that, is there a sibling, or a babysitter, or an aunt, or anyone else who'd be willing to assist?" That's what I would do is really ask and be candid.

Okay. This is another with the parents. When children progress typically slower, you had talked a little bit about this, how do you encourage parents to stick with the program when they are not seeing improvement?

This is where you have to be very intuitive and making sure the goal you assigned for the week is very, very small. Like in George's instance, the goal was for him to sit and do one activity with mom, but that's a grand goal. I would say for mom in a week, I might say, "Mom, I just want you to sit at the table, have your reinforcer or your bacon ready and all I want for this week is for him to come and sit, even for five seconds. Give him the bacon, give him the reinforcer for doing that." And it's okay.

So that's what you have to really tease down the goal and make sure it's so small and achievable because you're so right, the parent needs to feel that reinforcement, that this was a successful session. If they don't feel that, you're not going to be seeing them very long.

Here's another one. "I work for a school system, is parent training considered education when billing?" Excuse me.

I think it depends on your school system and how it's worded in the IP. I think consultation minutes are for teachers and during e-learning, it was also for parents. So you'd have to get clarification from your special ED director, but I know in the school when I was working, it was applied to parents too, so we could do either.
Okay. How frequently are you completing the observation sessions? Do you try to have parents record these sessions as well or just filling out feedback and observation form? I typically start with an observation session, and depending on how things go, so I'll go back to George. The first thing I did was observe him in the family room and it was quite a disaster. It was quite apparent that this setting was not going to work. Then I asked mom to move into the bedroom and I did an observation there because I didn't want to... It's like a science experiment, you don't want to change so many variables at one time.

So here was, "Okay, we've changed the setting now, so I'm going to observe here and see if there's a difference." So depending on what you're changing, I would suggest direct observation, but once I knew the setting was the same and all I was changing was the intervention, then I might say, "Okay, mom, this was great today. I want you to just record it next two times so I can see what's... If it's generalizing and if I need to tweak it further."

Okay. And another comment here, "I can definitely see the benefits of telehealth, especially in parent coaching. However, it seems to take more time than traditional therapy with the preparation, and the feedback, and reflection. How do you do that with the productivity demands that many therapists have? And how do you address that to a non therapist management? Our center is looking at combinations of face-to-face and telehealth."

That's a tricky one because it depends on where you work. I work for myself, so I just build it into my schedule. I know that working with George requires X amount of planning time, so I build it in. I do think that's a trade off when you're doing telehealth. If you were doing parent coaching, you're not the one running around with the student, so you almost have to take that on.

It just takes time to figure out what works for whom. I will tell you though, it gets easier because once you have the shell or this outline of how to manage certain situations, you're applying the same thing to a different scenario. So it does get easy. I don't know if that helps or answers your question.

We have a couple of people asking about what telehealth platform do you recommend and use?

I use GoToMeeting, the paid version and it's like $20 a month or something, and it's HIPAA compliant. That's the one I use.

Okay. And a lot of people are also asking about billing. I know you just said just a minute ago that you work for yourself, but like one question is, "Do you bill for the pre-session screening?"

I don't. You'd have to check with your agency and billing preferences. I typically don't do that just because I don't feel fair in doing that. I'm not really doing any work, I'm just observing. So I would say you'd have to base it on what your agency's requirements are and your insurance payer.

Okay. I am going to take one more question here and then I just want to also make mention, we have them coming in nonstop, but she did graciously share her email, so please reach out to her if we didn't get to your question. I want to grab one more question. Let me find it here.

This is back to billing, I just wanted to grab this last billing question. "How is your documentation and billing different when treatment provided by telehealth versus regular? And is there any reimbursement challenges with that?"

I have not experienced any reimbursement challenges and that's a brilliant question as far as documentation. I just make sure I write everything that's there. For example, if in the room the grandma comes in, I make sure I write that in there. And of course I document that it is an actual telehealth session. That's the main aspect that differs from a telehealth versus a traditional session.

Okay. I want to be mindful of everyone's time today, so we're going to wrap for now. So thank you so much, Aditi for a great talk today. Again, she has her email right there, please jot it down and reach out if we did not have a chance to grab your question. So thanks for all those great questions that came in at the end.

Thank you so much.

I hope everyone has a great rest of the day. You join us again on continuED and OccupationalTherapy.com. Thanks everyone.