Optimizing Rehabilitation Outcomes Through Contextualized Treatment

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Overview and Research

Read more about the research:

Archives of Physical Medicine and Rehabilitation
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ORIGINAL RESEARCH

Contextualized Treatment in Traumatic Brain Injury Inpatient Rehabilitation: Effects on Outcomes During the First Year After Discharge

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The TBI Comparative Effectiveness of Rehabilitation Study

- Used data from the TBI Practice-Based Evidence study (2008-2013) conducted by Drs. Susan Horn and John Corrigan*
  - Prospective, multi-site observational study (**real world**)
  - **Naturally occurring** practice variations
  - **Large data set** designed by providers and consumers

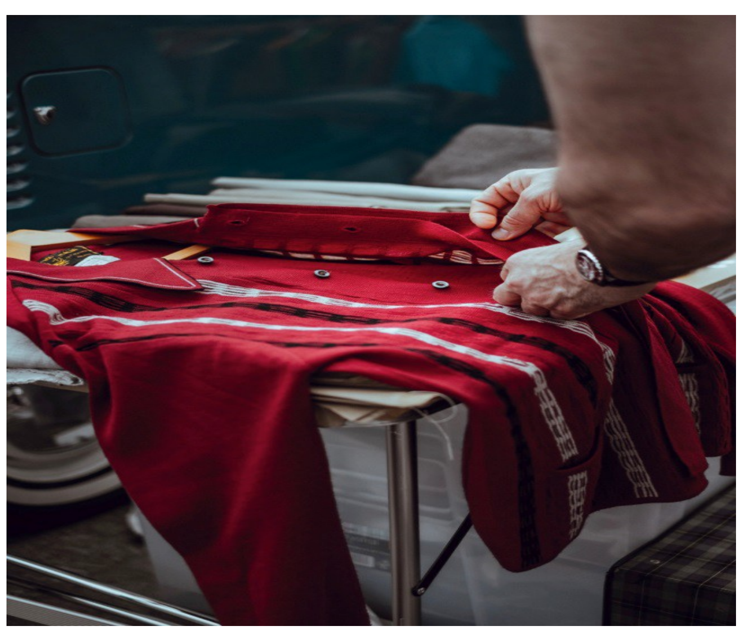
* Horn, S. D., Corrigan, J. D., Bogner, J., Hammond, F. M., Seel, R. T., Smout, R. J., Barrett, R., Dijkers, M.P., Whiteneck, G. G. (2015). Traumatic brain injury-practice based evidence study: Design and patients, centers, treatments, and outcomes. *Archives of Physical Medicine and Rehabilitation, 96*(8 Suppl), S178-S196.e15

The TBI Comparative Effectiveness of Rehabilitation Study

- Clinicians and persons with TBI wanted to know: **Does the use of real life activities (contextualized treatment) improve outcomes?**
- Used statistical methods to evaluate the effects of contextualized treatment
- Examined effects on all patients (n=1843) and also effects on patients categorized by severity of initial disability

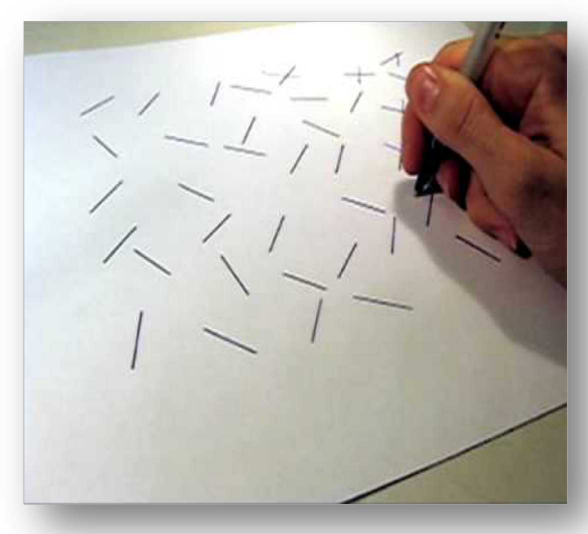
Contextualized Treatment Uses Real-Life Activities

Real-life activities are those that are identified by the patient and/or family that will be done in the home or community after discharge, such as dressing, bathing, cooking.



Decontextualized Treatment

Some treatment aims to strengthen component skills and abilities that underlie real life tasks. The therapy activities themselves are not typically done in real life environments, only in the clinic.



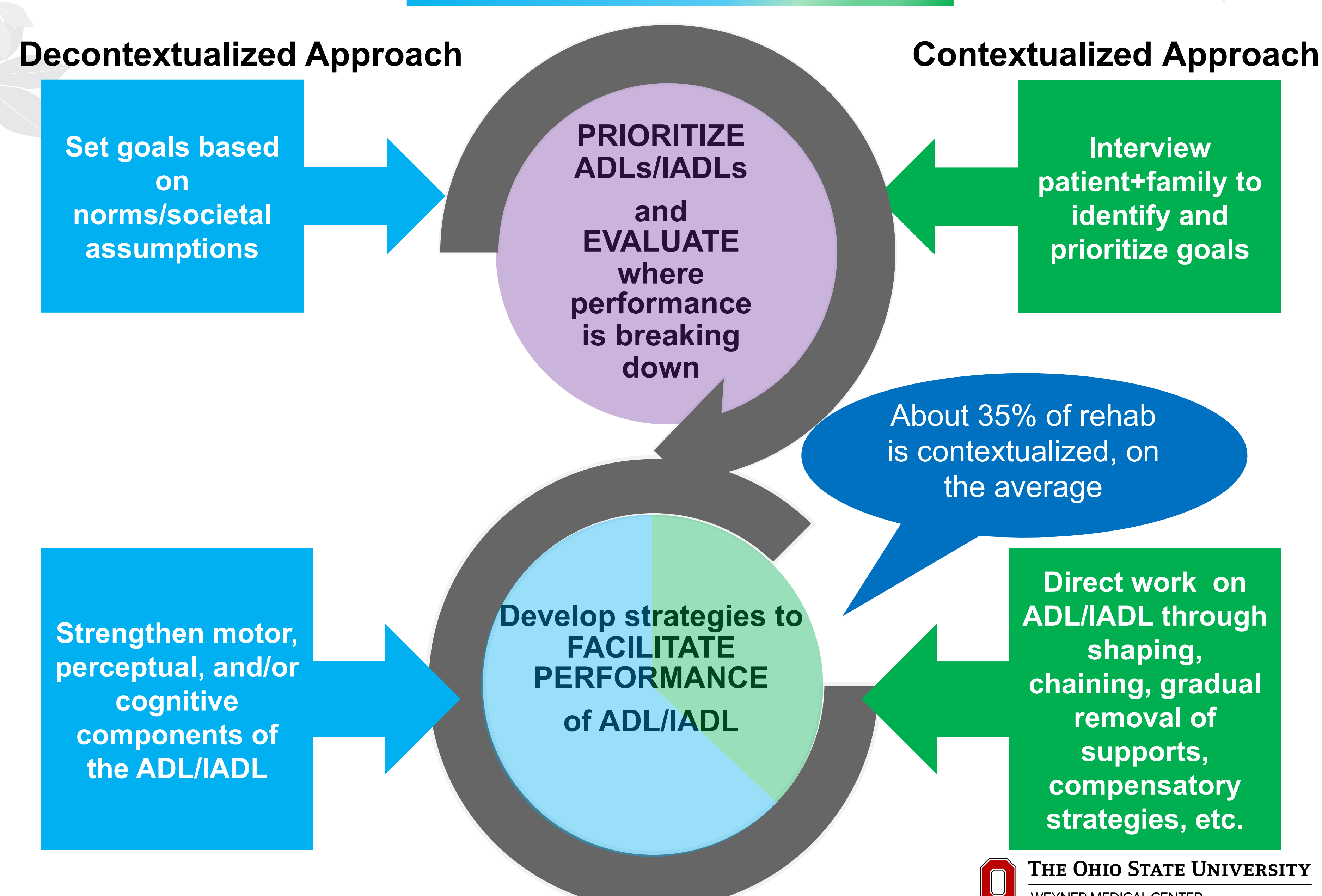
Quasi-Contextualized

- Treatment focuses on compensatory or metacognitive strategies that can be used in the future real-life activity.
- Includes virtual reality and simulation activities
- Quasi-contextualized may result in better outcomes than decontextualized, but is not equivalent to contextualized in regard to effectiveness

*

What are some things to remember when you cross the street?

Rehabilitation "On the Average"



THE OHIO STATE UNIVERSITY
WEXNER MEDICAL CENTER

Rehabilitation "On the Average"

Decontextualized Approach

Set goals based on norms/societal assumptions

Strengthen motor, perceptual, and/or cognitive components of the ADL/IADL

Contextualized Approach

Interview patient+family to identify and prioritize goals

Direct work on ADL/IADL through shaping, chaining, gradual removal of supports, compensatory strategies, etc.

PRIORITIZE ADLs/IADLs and EVALUATE where performance is breaking down

Develop strategies to FACILITATE PERFORMANCE of ADL/IADL

Patients with increased portions of time in contextualized therapy have better outcomes

Findings Regarding Contextualized Treatment

1. Increasing the proportion of treatment using a contextualized approach results in better community participation one year later.

   Patients with a 30% greater proportion of contextualized treatment were more likely to be out of the house 1-2 more days a week one year later.

2. Patients with greater disability experienced more benefit in regard to self-care and mobility than patients with less severe disability.
3. Effect sizes were small, but meaningful.
4. The findings do not indicate that decontextualized should not be used, but to use contextualized treatment whenever possible given the therapy goal.

If you can't do the contextualized activity, try quasi-contextualized:

- Simulates real life activity:
  - virtual reality, pantomime, play acting, role playing, show-me-how, simulation
- Demonstrates knowledge without action:
  - Hypotheticals, what-if's, to-do lists
- Instructs on ways to act:
  - Compensatory strategies, sequencing steps, prevention (safety) training

Strategies to Assist Learning During Contextualized Treatment

Strategies to Assist Learning During Contextualized Treatment

Rationale:

- Many patients with severe cognitive deficits will have difficulty learning from their mistakes. Instead they will learn and repeat their mistakes.
- For these individuals, **set up for success and prevent mistakes.**

Strategies to Assist Learning During Contextualized Treatment

- **Shaping:** Reinforcing successive approximations to target behavior

- **Fading of verbal and physical supports:** Initially provide whatever verbal and/or physical supports are necessary for the patient to successfully complete action. Gradually lessen supports, while ensuring continued success

Strategies to Assist Learning During Contextualized Treatment

- **Forward chaining:** Break down task into successive steps. Teach first step until reaching criterion (using fading, shaping). Next, patient performs first step and then proceeds to learn second step. When second step meets criterion, proceed to 3rd step.
- **Backward chaining:** Break task down into successive steps. The therapist first completes all steps for the patient except the last step. Provides prompts/support to complete last step and fades prompts until independent. Then the activity is repeated, but the patient is asked to do the last and second to last step, and so on.

Strategies to Assist Learning During Contextualized Treatment

- **Spaced retrieval:** Method that uses procedural learning to remember a new piece of information. Steps outlined here (includes swallowing example) https://tactustherapy.com/spaced-retrieval-training-memory/
- **External focus:** Prompt patient to focus on the effect of their movement rather than the movement per se, i.e. the swing of the golf club rather than the movement of the arms and torso. External focus engages automatic processes
- **Environmental supports:** Set up environment to provide sufficient cues, nudges, and support to prompt successful completion of behavior

Strategies to Assist Learning During Contextualized Treatment: Left Neglect

- **Anchoring:** Patient uses a target to assist with complete scanning to left
- **Guides:** Patient uses a finger to guide scanning to left
- **Turns:** Patient is taught to turn eyes and head to the left
- **Lighthouse:** Patient is taught to use anchoring, guides, and turns as part of habitual, planned strategy

Translation Menu

Upper Body Dressing
Calling on Physical Abilities

Evaluation: Where does performance break down?	Contextualized	De-Contextualized
Unable to perform the movements necessary to don and doff a shirt	Practice donning and doffing a shirt with buttons, have them practice buttoning and unbuttoning the shirt, discuss methods to compensate (e.g., start button by threading with one hand) and adapt (e.g., button hook) Practice donning and doffing different types of shirts (e.g., button-up, pullover, heavier clothing like a sweatshirt or coat) and increase repetitions Practice applying shirt using different approaches, grade activity to maximize movement by threading arms and then pulling overhead. Discuss and practice compensation techniques (e.g., hemi-dressing)	Fine motor / dexterity skills – pinching and gripping activities to grasp/ manipulate(pegs, putty); becomes quasi-contextualized if manipulating fasteners (e.g., button, zipper, belt buckle, tie) on a fastener board Strengthening skills /resistive exercises to develop UE strength to 4/5 as needed to perform UB dressing Range of Motion – bilateral overhead reach or unilateral overhead reach In preparation for compensatory approach (hemiplegia / hemi-dressing)

More on Upper Body Dressing

Calling on Cognitive, Sensory, Perceptual Abilities

Evaluation:Where does performance break down?	Contextualized	De-Contextualized
Becomes dizzy while attempting to put on the shirt	Apply vestibular compensation strategy while donning shirt – incorporating gaze stabilization (i.e., focus on stable environmental target) Modify environment by sitting or using stabilizing surface	Perform vestibular rehab task – Gaze stabilization exercises
Unable to initiate and follow through with the steps of the dressing task	Provide verbal and/or physical cues as needed during dressing task with gradual fading of cues provided Perform dressing tasks with target of patient-centered goal – family visit, job, etc	Computer based tasks to improve attention, concentration, and/or memory Goal setting tasks, organizational skills
Unable to perform the dressing tasks due to difficulty hearing the instructions, seeing the shirt, and/or feeling the shirt (sensory issues)	Practice donning and doffing shirt while providing additional input relative to the area of sensory loss	Specific remedial (computer based, task based, or paper based) activities to facilitate recovery of identified deficit area Instruction in compensatory methods in cases of permanent loss or deficit

Lower Body Dressing

Calling on Physical Abilities

Evaluation: Where does performance break down?	Contextualized	De-Contextualized
Unable to perform the movements necessary to dress lower body Unable to perform the movements necessary to don and doff pants Unable to perform the movements necessary to don and doff shoes Unable to perform the movements necessary to donn and doff socks	Practice donning and doffing pants with a button and zipper, have them practice fasteners, discuss methods to compensate (e.g., start button by threading with one hand) and adapt (e.g., button hook) Practice donning and doffing different types of clothing (e.g., shorts, sweatpants, button pants, heavier clothing/shoes) and increase repetitions Practice donning socks and tying your shoes by grading activity (e.g., crossing legs, bending forward, foot on step stool while sitting) to maximize movement. Discuss and practice compensation techniques (e.g., hemi-dressing) and adaptations (e.g., reacher, sockaid)	Fine motor / dexterity skills – pinching and gripping activities to grasp/ manipulate(pegs, putty); becomes quasi-contextualized if manipulating fasteners (e.g., button, zipper, belt buckle, tie) on a fastener board Strengthening skills /resistive exercises to develop UE strength to 4/5 as needed to perform LB dressing Range of Motion–reaching to the floor to pick up items in different positions (e.g., sitting edge of bed, standing), stretching to increase ROM to cross legs for shoes and socks

Lower Body Dressing

Calling on Sensory/Perceptual Abilities

Evaluation: Where does performance break down?	Contextualized	De-Contextualized
Unable to perform the dressing tasks due to difficulty hearing the instructions, seeing the clothes, and/or feel the clothes (sensory issues)	Practice donning and doffing pants, shoes, socks while providing additional input relative to the area of sensory loss	Specific remedial (computer based, task based, or paper based) activities to facilitate recovery of identified deficit area. Instruction in compensatory methods in cases of permanent loss or deficit
Loses balance while standing to donn and doff pants	Practice dressing LE in different positions grading into standing as balance improves (e.g., sitting edge of bed, standing next to bed, in bathroom next to grab bar, use of walker for balance)	Increase standing tolerance and balance by standing at table to play games, bilateral activities in standing (e.g., passing ball, batting balloon)

More on Lower Body Dressing
Calling on Cognitive Abilities

Evaluation: Where does performance break down?	Contextualized	De-Contextualized
Unable to initiate and follow through with the steps of the dressing task	Provide verbal and/or physical cues as needed during dressing task with gradual fading of cues provided Perform dressing tasks with target of patient-centered goal – family visit, job, etc.	Computer based tasks to improve attention, concentration, memory Paper and pencil tasks, memory games Goal setting tasks, organizational skills
Unable to remember weight bearing restriction	Utilize sign in room to remind Pt of weight bearing restrictions Provide verbal cues with decreased utilization of weight bearing restrictions	Recall of word list

Toileting
Calling on Physical Abilities

Evaluation: Where does performance break down?	Contextualized	De-Contextualized
Unable to transfer fast enough when it is urgent	Repeated practice with knowledge of results (timing) of toilet transfers in bathroom that client is using majority of the time with improving efficiency. Then progress to a bathroom toilet set-up more like home to ease transition home and determine if additional equipment is needed.	In clinic, work on increasing speed of transfers with timer using mat or other chair.
Unable to get pants down or up	In the bathroom, perform part practice once transferred to toilet: doffing pants, sitting down, standing up, and donning pants. Repeated with fading assistance and cueing. Then whole practice at the end including the transfer.	Quasi-contextualized, in clinic, don and doff pants (over current shorts for privacy) while standing at ll bar or in front of the mat. If waist band is the problem using theraband around waist to mimic elastic to push down and pull up.
Unable to wipe due to ROM or balance difficulties	In the bathroom, while sitting on the toilet client can practice repeated reaching and wiping using actual toilet paper. Client has access to the toilet rails, if needed, and supports can be added or subtracted as performance improves in this real-life situation.	In clinic, practice sitting balance while weight shifting and lifting one side of the bottom to reach under. This is repeated many times to improve balance and ROM.

Bathing
Calling on Cognitive and Executive Functions

Evaluation: Where does performance break down?	Contextualized	De-Contextualized
Unable to sequence lather, rinse, repeat Unable to recall body parts washed Unable to inhibit washing body part	Utilize written, laminated cue list in shower to indicate steps and/or body parts to wash Fade cues/prompts during bathing to inhibit task. Use timer to indicate appropriate length of bathing activity	Practice placing numerical/ alphabetical cards in order Memory game via cards or app; creating checklists for structured activities during clinic treatment session Use timer to indicate appropriate length of time with tabletop activity
Unable to safely complete bathing in stance	Stand sinkside in bathroom with washing lower body and can progress to standing in shower with water off and into water on Use of written, laminated signage to remain seated during bathing activity during actual ADL	In clinic, simulate clothespin removal from lower body clothing to simulate reaching lower body with bathing

Bathing
Calling on Physical and Perceptual Functions

Evaluation: Where does performance break down?	Contextualized	De-Contextualized
Unable to complete hemi-bathing techniques	Utilize hemi-technique strategies during bathing in shower with facing cues/prompts and/or written guides Engage in seated, upper body bathing in bathroom for hemi-technique carryover with fading of cues/prompts and/or use of visual/written guides	Utilize beanbag or washcloth while seated in clinic (Quasi-contextualized) Applying lotion via washcloth while seated in clinic to address hemi-techniques
Unable to visually locate shampoo or soap at left (or right) side of shower	Place anchor in tub, or sinkside, for visual scanning to locate items during bathing in shower/tub or at sinkside. Fade cues with bottle placement as anchor to scan/locate.	Complete tabletop scanning with visual anchor or letter cancellation handout

Swallowing Food During Meal

Evaluation: Where does performance break down?	Contextualized	De-Contextualized
Unable to swallow due to decreased airway protection	During meal, have Pt complete chin tuck with each drink of liquid and bite of food During meal, have Pt utilize effortful swallow with each drink and bite of food	Practice utilizing chin tuck without food and swallowing saliva Completing pitch glides
Difficulty recalling swallow strategies	Recall list of strategies at initiation of meal. Keep list of strategies visual for Pt to have as environmental/written cue. Utilize verbal or environmental cue when Pt has difficulty recalling and utilizing swallow strategies	Recalling task instructions following delay
Difficulty with self feeding due to ataxia	During meal, have Pt self feed with use of assistive devices (weighted spoon, hand clip, nosey cup, plate guard)	In clinic, practice using a bowl and spoon to scoop rice and move to another bowl (quasi-contextualized)
Difficulty with trunk strength to maintain safe upright posture for eating	During meal, at table, have Pt sit upright during PO intake utilizing verbal and tactile cues to maintain desired position.	In clinic have Pt sit edge of mat for goal of 20 minutes

Wheelchair Breakdown and Reassemble
Calling on Cognitive and Perceptual Functions

Evaluation: Where does performance break down?	Contextualized	De-Contextualized
Unable to remember steps to breakdown and reassemble	With w/c present patient can verbally direct staff in removal and application of w/c parts in a repetitive manner allowing cognitive and auditory repetition to improve recall. This will remove physical fatigue during this practice.	Make up a worksheet and have patient list out the steps required. If the task is for wheelchair breakdown/ reassemble, then task is quasi-contextualized. But if the task is not related to this goal, it is decontextualized.
Visually/perceptually unable to orient pieces in correct orientation to attach easily	With wheelchair pieces in hand perform part practice to orient pieces correctly and then connecting them to the w/c with fading cues or assistance as needed. Repeat.	In the clinic work on selecting correct orientation of items on worksheet or using items in the clinic-varied shaped pegs, cones, weights, bolts and nuts in freestanding tool kit.

Wheelchair Breakdown and Reassemble
Calling on Balance and Physical Functions

Evaluation: Where does performance break down?	Contextualized	De-Contextualized
Physically unable to grasp the wheel or footrest for removal/application	Have w/c parts within reach. With assistance initially and cueing as needed then faded have the client begin grasping and lifting w/c parts including leg rests, arm rests, back rest, and wheels- if needed to be removed for placing w/c in vehicle(depends on style of w/c and ability to lift certain weight)	In clinic, work on grasping items in clinic- cones, weights, cup, bolts and nuts in freestanding tool kit that are similar weight to parts of the w/c.
Off balance when leaning over to remove leg rests and wheels	With client sitting in car or where w/c will need to be disassemble work on reaching lifting w/c parts into car. Using supports in that environment work on strategies to allow client to perform reaching without loss of balance with repetition of part and whole practice with fading assistance and cues.	In clinic, work on sitting on the mat with items on floor in front of patient asking them to reach and place them on the mat. As balance and compensations improve move objects away to increase difficulty.

Car Transfer

Calling on Physical Functions

Evaluation: Where does performance break down?	Contextualized	De-Contextualized
Unable to pivot onto car seat	In car, practice the pivot with assistance as needed then decreased as client can perform more independently. Problem solve with client to use environmental supports with varied hand positions to maximize independence with this transfer.	In the clinic, work on squat pivot transfers onto the mat that is adjusted to similar height as the car.
Unable to stand up from low car seat	In car, perform part practice of the sit to stand with assistance, as needed. Problem solve with client to use environmental supports with varied hand positions to maximize independence with this transfer. Repeated practice of part task then perform entire task. Use client's own car if possible, otherwise clinic/hospital vehicle. Specificity of practice is important for carryover.	In the clinic, performing sit to stands from low surfaces similar to the car seat (mat or steps)
Unable to lift leg into the car	Practice in the car working within the environment and explore changes to improve success (reclining back seat, moving seat all the way back, reposition bottom to improve LE clearance). Then perform repetitive part practice of lifting the lower extremity in and out. Then entire transfer near the end of training to put it all together.	In clinic, work on hip flexor strengthening with weights and set up an obstacle for client to lift the lower extremity over to clear height.

Car Transfer
Calling on Cognitive Functions

Evaluation: Where does performance break down?	Contextualized	De-Contextualized
Unable to remember steps to perform	Perform all the car transfer steps with enough cues for success then repeat with fading cues.	Make up a worksheet and have patient list out the steps required. Verbally report steps over and over. If the task is for car transfer, then task is quasi-contextualized. But if the task is not related to this goal, it is decontextualized
Unable to manage and/or sequence car door from standing with adaptive device or from wheelchair level	Perform door management at various car doors (patient car, therapist(s) car(s)) through forward chaining.	In the clinic, perform door management at office door or cabinet door in standing or while seated.

Crossing Street

Calling on Physical, Cognitive, Perceptual Abilities

Evaluation: Where does performance break down?	Contextualized	De-Contextualized
Unable to decide when to cross	Standing by a streetlight and watching traffic, 1st verbalizing safe times to cross then actually crossing with faded cues as needed to remain safe and continue scanning the environment.	Use activity sheets to work on safe and unsafe situations. If the situations related to crossing the street, then task is quasi-contextualized. If not, then task is decontextualized.
Doesn't walk fast enough to get across the street in time	Work on crossing less busy streets initially working on speed needed to cross. Then move to the larger street that requires the higher speed to cross in time. Repeat crossing the street for therapy intervention.	Work on walking speeds in the hall. Repeated 10-meter walk test with knowledge of results to improve speed or walking on treadmill with increasing speeds.
Doesn't scan to the left prior to crossing the street	While standing at the street crossing, have client turn his head and identify where the oncoming cars are and verbalize color/make/model. Have client also identify turning traffic prior to street crossing. When scan complete then crossing occurs.	In hall, while standing and walking, have client name pictures on the left side.
Becomes dizzy when turning head in preparation for crossing the street	While standing by the street, work on target acquisition to compensate for dizziness in this busy background environment. Modify speed of head turn to allow scanning with less dizziness.	In clinic, working on head turns for habituation and gaze stabilization with gradually increasing speed and distractions

Medication Management
Calling on Cognitive and Physical Functions

Evaluation: Where does performance break down?	Contextualized	De-Contextualized
Unable to recall times to take medication	Utilize phone timers and or medication apps to notify Pt of medication administration time Utilize watch timer for medication administration time Utilize schedule to check off when medication has been taken	Have Pt complete worksheet with instructions for Pt to notify therapist when 15 minutes has passed and re-state plan for scheduled break
Difficulty with organization of medications	Utilize pill box or medication chart with verbal cues	Organize beads by color
Difficulty opening bottles	Making modifications or add assistive device: Dycem, modifying bottle type, easy-off caps	Strength: Hand-strengthening exercises Fine motor coordination: Place pegs in pegboard Bilateral coordination: Pull pegs out of cup

Scheduling Appointments by Phone

Calling on Cognitive, Language, and Perceptual Functions

Evaluation: Where does performance break down?	Contextualized	De-Contextualized
Difficulty making appointments due to problems with 'remembering to remember'.	Utilizing planner or phone set reminder for Pt to make medical appointment. Following making of appointment, use calendar to record information re: appointment details. Set reminder in phone to attend appointment.	Give Pt instructions to perform a task at the end of the therapy session, using external cue as compensatory aid
Difficulty making appointment due to dysarthria	Utilize speech intelligibility strategies and practice script for calling to make medical appointment. With therapist assist, have Pt make appointment	Practice speech intelligibility strategies while reading rainbow passage or magazine article
Difficulty dialing phone number due to left neglect	With use of visual anchor have Pt dial phone, phasing out verbal and visual cues as appropriate	Adding up math problems using visual anchor

Scheduling Appointments by Phone

Calling on Physical Functions

Evaluation: Where does performance break down?	Contextualized	De-Contextualized
Difficulty pushing or isolating buttons due to weakness and coordination	Practice using stylus with u-cuff to select buttons on phone.	Practice using stylus with u-cuff to select letters on worksheet
Difficulty holding phone due to UE weakness and coordination	Have Pt practice picking up phone and holding to ear for given period of time. With therapist assist call to set up appointment	In clinic, have Pt don wrist weights and stack blocks

Book a Reservation Online

Calling on Cognitive & Perceptual Abilities

Evaluation: Where does performance break down?	Contextualized	De-Contextualized
Difficulty problem solving how to utilize computer for internet search	Utilizing a computer, navigate sequence of steps to use search engine of Pt's preference (google, ecosia, bing) and search for information on desired topic.	Complete worksheets with instructions on how to utilize computer and search engine (quasi-contextualized)
Patient becomes distracted by pop-ups	While the patient is working on a reservation and becomes distracted by pop-up, identify the distraction, discuss a method to compensate (e.g. block pop-ups) and implement the strategy	Work on a cancellation task
Patient has difficulty navigating the webpage, seems to be missing listings on the left side of the page	While the patient is working on a reservation and is not reading the information on the left of the screen, implement a strategy to encourage scanning across screen [e.g. anchoring]. Explain the strategy to the patient and encourage use with future activities (with prompting as needed).	Practice visual scanning and compensating for left inattention using worksheets and other clinic tasks
Patient is able to identify 3 criteria for making a choice (e.g. time, location, price), but only takes one of criteria into account when making the choice	Develop and apply organizational strategy for narrowing down the choices based on the relative importance of the criteria. Utilize a sorting function on the website listing to order the choices relative to the most important criterion, and then apply strategy for reviewing the remaining criteria.	Complete clinic-based complex problem-solving task that requires taking multiple factors into account

Making Bed

Calling on Physical Abilities

Evaluation: Where does performance break down?	Contextualized	De-Contextualized
Loses balance when sidestepping around bed	Practice sidestepping around hospital bed or practice bed with fading from upper extremity support Progress to carrying bedding with one hand to bilateral hands to fade support, as needed Progress to bending to reach across for linens items with sidestepping to increase dynamic balance needs	Work on sidestepping within the parallel bars, carrying pillow or bolster unilaterally with opposite hand supporting on parallel bar, lowering/lifting parallel bars with sidestepping, carrying stack of towels bilaterally while sidestepping in parallel bars.
Unable to pick up corner of mattress to tuck bedding under	At practice bed or hospital bed, address lifting corner of mattress with one hand to tuck flat sheet at each corner. Progress to lifting, then pulling/stretching fitted sheet onto corner of mattress.	In clinic, pick up pillows, stacks of paper, etc., to locate and/or hide items, such as cards, photos with opposite hand.

Making Bed

Calling on Cognitive and Perceptual Abilities

Evaluation: Where does performance break down?	Contextualized	De-Contextualized
Unable to sequence fitted sheet, flat sheet, comforter, and pillow with pillow shams	Practice identifying linens and in sequential order at hospital bed or practice therapy bed Fade from one (fitted sheet) to two (fitted sheet with flat sheet) to three (adding comforter) Increase challenge with adding pillow	In clinic, stacking sequence cards to represent order of steps to completion of an activity.
Only placing bedding on right side of bed	Practice at hospital bed or therapy practice bed with lighthouse technique or visual anchor to locate head or foot of bed with visual scanning when placing each bedding item onto the bed Progress to moving to different sides of bed to identify left-most anchor	In clinic, visual scanning to left to locate cones at tabletop or even locating edge of left tabletop.

Laundry

Calling on Physical & Sensory/Perceptual Abilities

Evaluation: Where does performance break down?	Contextualized	De-Contextualized
Loses balance when placing items/removing items from front load washer/dryer	At hospital or practice washer/dryer, fade assistance/support with unilateral support, transitioning linens/clothes to top of washer/dryer, transitioning to/from laundry basket at floor, removing unilateral support at washer/dryer.	In clinic, move cones, pegs, or clothespins from bucket on stool under tabletop to bucket on top of the table.
Unable to reach items at bottom of top load or back of front load washer/dryer	In the patient laundry room or practice washer/dryer, practice with reacher to retrieve socks or washcloths at the back of the frontload or bottom of the top load washer/dryer.	In the clinic, picking up items (cones, theraband) at the opposite end of the table or lowered mat table and/or under the clinic table with/without the reacher.
Unable to tolerate standing to move items from washer to dryer without rest break	While doing laundry, gradually increase the amount of time for standing, taking a rest before absolutely needed.	In the clinic, engage in standing at tabletop with puzzles or peg activities.

Laundry

Calling on Physical & Cognitive Abilities

Evaluation: Where does performance break down?	Contextualized	De-Contextualized
Difficulty sequencing steps	In the patient laundry room or at the practice washer/dryer, practice with sequencing checklist to load washer, set dials, and add detergent. Fade from sequencing checklist.	In the clinic, perform sequencing cards to identify scenario photos in the correct order.
Becomes dizzy when looking from left/right, bending, pick up objects from floor	In the laundry room using environmental supports and target acquisition slow task to allow client to perform task with less dizziness. Modify task if needed to sit or use reacher to get items without extreme bending motions. Work on breathing technique while performing the task.	In clinic, habituation with head turns when standing and walking. Bending to reach items off the floor with modified pace and use of mat for support if needed.

Meal Preparation

Calling on Physical Functions and Left Attention

Evaluation: Where does performance break down?	Contextualized	De-Contextualized
Unable to maintain balance while reaching for items	Perform cooking task with patient reaching for items on counter and in to cupboards as needed. Provide assistance as needed for safety	In clinic practice dynamic standing movements with reaching in all planes as tolerated by patient Perform core strengthening program for improved stability during dynamic movements
Unable to maintain standing long enough to complete task secondary to fatigue	Perform cooking task with patient taking intermittent breaks as needed with focus on decreasing frequency and length of breaks as patient progresses	In clinic focus on both static and dynamic tasks, perform as long as patient tolerates to improve endurance and tolerance
Difficulty visually locating ingredients and/or cooking utensils at left of cabinet or refrigerator or stovetop	Anchor placed at left cabinet or refrigerator to cue/prompt for visually scan to anchor when seeking items	Visually scan for list of therapy items at tabletop in the clinic with anchor to left

Meal Preparation

Calling on Cognitive and Executive Functions, Safety Awareness

Evaluation: Where does performance break down?	Contextualized	De-Contextualized
Unable to sequence recipe directions	Follow simple written recipe and progress to more challenging recipes. Have patient write ordered task list and use written list to guide sequencing during task.	Sequence beads per photo design copy and progress into placing sequencing photo cards in order during tabletop task
Unable to attend to multiple items cooking on stovetop (e.g., spaghetti noodles and sauce, soup and grilled cheese)	Initiate with single item prep then progress to second item prep simultaneously. Can use written/auditory cues/reminders or written lists while engaged in activity.	Sort and sequence card deck simultaneously
Poor safety awareness with appliance use (e.g., knife to toaster, spoon in coffee cup)	Set up unsafe situations in kitchen and prompts to correct	Identify unsafe scenarios from photo cards while in the clinic. If the unsafe situations involve meal preparation, then activity is quasi-contextualized

Organizing a Kitchen/Workshop/Studio
Calling on Cognitive Functions

Evaluation: Where does performance break down?	Contextualized	De-Contextualized
Patient has difficulty with organization (i.e., categorization)	While the patient is working on organizing cans in the kitchen pantry, discuss strategy for organizing, e.g. identify the different types of foods, and placing similar items together	Work on an organization task (i.e., sorting coins, sorting cards, matching like items)
Patient has difficulty with problem solving (i.e., fitting different size items on shelves, more items than space)	Practice narrowing down the choices based on the relative importance of the criteria (i.e., size, shape), use paper to sketch out the plan, use tape measure to figure out space available	Complete problem-solving worksheets that requires taking multiple factors into account

Organizing a Kitchen/Workshop/Studio
Calling on Physical Functions

Evaluation: Where does performance break down?	Contextualized	De-Contextualized
Patient loses balance when placing items/removing items from cabinets/shelves	While the patient is working on placing items on the shelf, practice reaching further into shelves while balancing with use of counter, placing heavier items at counter height	Practice leaning forward with outstretched arm from a standing position to improve functional reach
Patient has difficulty reaching higher shelves due to limited range of motion in bilateral shoulders	Have the patient work on increasing ROM by practicing to reach in the cabinets to pick up cans (i.e., starting at lower shelves and then moving to higher shelves) and/or accommodate the task (i.e., practicing using reacher to obtain items, organize items to available ROM)	Complete exercises focusing on increasing range of motion (i.e., finger ladder, stretching)

Home Maintenance: Lawn Care

Calling on Balance, Cognitive Functions

Evaluation: Where does performance break down?	Contextualized	De-Contextualized
Unable to kneel to/from ground to pull weeds or plant flowers	Engage in kneeling in outdoors with environmental supports, fading level of assistance, and/or fading/transitioning level of support height (e.g., folding chair to step stool)	Practice kneel to/from stand with and without environmental supports in clinic (e.g., mat table, chair)
Difficulty sequencing starting push mower	Verbalize and practice sequence for starting push mower, using push mower	In clinic, sequence photo cards to identify appropriate steps to managing lawn mower (quasi-contextualized)
Unable to maintain balance with push lawn mower over grass	Use push mower to address balance with transitioning/grading activity from sidewalk to grass while turned off; then, increase challenge by turning on mower on sidewalk then grass	Push box with handles (sander) along tabletop in clinic to address balance
Difficulty with balance when walking from grass to/from sidewalk or driveway or across pavers	To avoid tripping when walking outdoors, modify outdoor terrains, including sidewalks, pavers, gravel, grass, dirt. Transition from walking without carrying items to carrying items, such as rake, broom, trash bag.	To avoid tripping when walking outdoors – in clinic, practice walking over changing terrain (plush mats, weights and cones hidden under mats)

Home Maintenance: Changing Batteries

Calling on Physical, Cognitive, Perceptual Functions

Evaluation: Where does performance break down?	Contextualized	De-Contextualized
Challenged with coordination/small item manipulation	Removing and placing batteries into items, such as clock, remote, child's toy, flashlight with compensatory strategies, assistive devices, and fading cues	Placing pegs into pegboards
Difficulty following battery direction per design on remote, toy, or smoke detector	Provide enlarged visual for battery layout or markings on battery-operated item	Follow design card with tangrams for visual perception
Challenge with determining correct battery size	Sorting batteries by shape and/or size with battery organizer with fading cues	Sorting cones or pegs by color

Home Maintenance: Sweeping Floors

Calling on Balance and Attention

Evaluation: Where does performance break down?	Contextualized	De-Contextualized
Loss of balance with head down	Progress balance activities with fading assist and cues through: Sweeping small area with broom Increasing size of area with standing in place and enhanced weight shifting with sweeping items Transition to taking steps with broom and sweeping around room Address adapted or compensatory strategies with decreased assist for long-handled dustpans vs. short-handled dustpans to manage balance and activity tolerance	Address static balance with head down during tabletop games Increase dynamic balance, with swiping or swinging dowel rod across floor in clinic Push small items into paper tray on floor to address balance and/or with discussion of adapted or compensatory items
Challenge with locating space to left during sweeping	Implement visual scanning strategies to scan entire area with either anchor or Lighthouse strategy to sweep all items in area/room	Address visual scanning for clinic items placed on floor

Home Maintenance: Taking Out Trash
Calling on Physical Functions

Evaluation: Where does performance break down?	Contextualized	De-Contextualized
Loses balance when bending over to pick up trash bag or trash from the floor	Collect trash items from floor and place into trash bag with fading support for balance. Use long-handled reacher as strategy to retrieve items from floor to minimize bending and increase safety.	In clinic, bend to pick up items from chair height then floor height
Unable to close and tie bag unilaterally due to hemiplegia	Practice hemi-techniques with trash bag by gathering unilaterally, tying bag into knot unilaterally, and/or managing pull ties on trash bag	Engage in compensatory strategies with hemi-technique by gathering towel unilaterally in a manner similar to cinching bag closed
Difficulty carrying item while walking	Carry trash bag across multiple terrains, including steps. Modify by adjusting weight of trash bag to adjust for balance dynamics.	Carry pillow in pillowcase across gym and/or up/down steps in clinic

Home Maintenance: Changing Lightbulb
Calling on Upper Extremity Function, Balance, Safety Awareness

Evaluation: Where does performance break down?	Contextualized	De-Contextualized
Unable to remove light bulb with one hand due to hemiplegia	Practice removing light bulb from tabletop lamp, then, progress to floor lamp to fade prompting for unilateral technique	In clinic, manipulating theraputty with sound hand
Difficulty maintaining balance while reaching above head to remove lightbulb	Step and stand on small step stool to change tall floor lamp or ceiling light with fading support	In clinic, step and stand-on step block with reaching to take cones from therapist to address safety/balance and reaching
Poor safety awareness with managing electrical equipment	Discuss and implement safety strategies while changing table lamp or floor lamp light bulb during treatment session	Utilize safety cards to address safety with touching hot light bulb or managing electronic appliances with dry hands (quasi-contextualized)

Gardening
Calling on Physical Functions

Evaluation: Where does performance break down?	Contextualized	De-Contextualized
Unable to ambulate through grass while carrying objects in order to reach garden	Ambulate through grass/uneven terrain outside with support/assistance as needed. As able, progress to carrying object in one hand (shovel, trowel, etc) then bilaterally as able.	In gym area practice walking on uneven surfaces (mats, cushions, etc) with progressions as able
Unable to achieve kneeling/ sitting position secondary to instability	Perform transfers on and off of grass outside. Can progress from having external support (ex: bench) to no support If needed, discuss modifications of installing elevated garden beds at home	Practice squats, low surface transfers (stools of various heights), lunges with emphasis of knee placement on floor. Perform floor transfer when able on firm surface
Unable to maintain balance while reaching to tend to plants	Perform reaching task to tend to plants while kneeling/seated in grass outside	Practice dynamic seated movements with reaching as tolerated by patient Perform core strengthening program for improved stability during dynamic movements
Becomes dizzy while turning head to look from plant to plant	While outside perform object stabilization/acquisition tasks with head turns as tolerated with increased velocity as symptoms allow Progress from part to whole task performance as tolerated	Habituation exercises with head turns in all directions as tolerated

Gardening

Calling on Cognitive and Executive Functions

Evaluation: Where does performance break down?	Contextualized	De-Contextualized
Unable to recall information for optimal plant growth conditions (immediate memory)	Print out instructions for optimal planting conditions and instructions for plant spacing and care	Paragraph detail recall with subsequent questions related to information
Unable to remember need to water plants	Keep schedule/check off chart in high traffic area and have Pt check off when completed watering Program alarm and reminder on phone Use spaced retrieval to help patient link environmental cue to watering	At the start of session, provide an instruction for the patient to recall at the end of the session
Difficulty following directions for planting due to decreased attention to detail	Have Pt read instructions on seed packet and complete 1 step at a time with cues for attention to detail	Finding errors worksheet

Nature Walk
Calling on Physical and Cognitive Functions

Evaluation: Where does performance break down?	Contextualized	De-Contextualized
Unable to ambulate on uneven terrain safely	Ambulate through grass/uneven terrain outside with support/assistance as needed with increased velocity and turns introduced as appropriate	In gym area practice walking on uneven surfaces (mats, cushions, etc) with progressions as able
Unable to maintain attention to task in dynamic environment	Walk outside in dynamic environment on uneven terrain with cues as needed to maintain attention and safety, decrease cues as able while maintaining patient safety	Perform tasks with minimal distractions with increased frequency and quantity as patient progresses
Unable to correctly navigate trails Unable to correctly interpret signs for directions	Ambulate outside with map and directions to follow with cues as needed. Begin with clear outline prior to performance with progression to cues mid-performance and then post-performance as able	In clinic work on ability to follow/interpret various written commands and or signs

Shopping (Mall/Grocery Store)

Calling on Physical and Cognitive Functions

Evaluation: Where does performance break down?	Contextualized	De-Contextualized
Unable to ambulate while performing head turns to scan for items	Ambulate through store searching for objects on list. Can have patient push cart or carry basket	In gym area practice static stand with head turns. Progress to task during ambulation and increase velocity as able
Unable to maintain attention to task in dynamic environment	Initially shop during quiet time of day, then move to busier time Ambulate in store while pushing grocery cart with cues as needed to maintain attention and safety, decrease cues as able while maintaining patient safety	Perform tasks with minimal distractions with increased frequency and quantity as patient progresses
Unable to correctly navigate store Unable to correctly interpret signs for directions to locate objects	Ambulate with list of items with cues as needed. Begin with clear outline prior to performance with progression to cues mid-performance and then post-performance as patient able	In clinic work on ability to follow/interpret various written commands and or signs. Progress to multi-step as able

Gym exercise with Avid Weight Lifter
Calling on Cognitive and Physical Functions

Evaluation: Where does performance break down?	Contextualized	De-Contextualized
Unable to recall exercise sequence or weights	In a gym (public or employee fitness gym) perform the same circuit multiple times with a check list and weight chart to fill out while exercising	Work on recall using activity sheet. Provide a written sheet of exercises with order (quasi-contextualized)
Unable to perform same exercises safely as prior to injury	In a gym (fitness gym) discuss patient goals and the prior exercises he performed. Work on developing a circuit that they can perform safely. Modify the exercises and within the environment to challenge this patient's strength safely. Example if seated exercises is needed then leg press machine instead of squats with a bar. Or squat rack instead of squats with a bar if balance is an issue.	In the clinic, with theraband start giving client basic exercises to begin strengthening UE and LE
Difficulty transferring to machines or benches	At the gym, work on components of transfers that are difficult and use environmental supports to train safe transfers. As transfers improve begin to faded assistance and cueing.	In clinic, use low mats to transfer to and perform repetitive practice
Unable to grasp weights or machines on one side	Actually, using the grip assist cuff on weight machines in the gym. Assisting the patient in how to attach it to various machines and weights. Practice with fading assistance and cues.	In clinic, show client how to use a grip assist cuff on weights in the clinic.

Gym exercise with Fitness Focus
Calling on Cognitive and Physical Functions

Evaluation: Where does performance break down?	Contextualized	De-Contextualized
Unable to monitor heart rate or recall target zone	In a gym (fitness gym) perform aerobic activity of choice and problem solve how to maintain safety while taking heart rate. Work with activity watch to assist with heart rate monitoring.	Practice taking heart rate while on clinic bike or treadmill (quasi-contextualized)
Can't get on the floor for abdominal exercises	In a gym (fitness gym) explore abdominal exercise options- may be able to use an incline bench with legs that secure. Or with the equipment in the gym there may be a way to have the client safely transfer to the floor using equipment- or low bench as an intermediate transfer.	In the clinic, on raised mat work on abdominal strengthening. Work on transferring to the floor from the mat table to floor mat.
Difficulty transferring onto spin bike	At gym (fitness gym), work on actual spin cycle transfer using environmental supports and repetitive practice to improve performance.	In clinic, practice getting on and off clinic cycle(lower seat to floor then spin cycle)

Golfing

Calling on Physical Abilities

Evaluation: Where does performance break down?	Contextualized	De-Contextualized
Loses balance when starting to swing	Part to whole practice with fading assistance: With ball in front, external focus helps improve task performance. First work on maintaining balance while holding the club forward touching the ground; Hover club over ground; Swing club with gradual increasing swing distance and velocity; Perform whole task at slow speed and then up to full speed hitting the ball. Provide supports as needed	Work on static balance with head down. Progress to being able to hold a stick (acting as a golf club), lift a stick, and then rotate torso with a stick in hand in the gym. Gradually increasing speed of movement as tolerated.
Becomes dizzy when looking down and turning head to line up the shot	Part practice with emphasis on target acquisition with eyes, then head turn as a compensation to control dizziness with this task. Complete whole task performance.	In clinic, habituation with head turns (horizontal and vertical) with gradually increasing speed
Trips when walking through grass and when walking from the putting green to the grass, while carrying club	Practice walking on grass without a club first, then add the club, then practice walking from green-like (or actual green) to grass with club	In clinic, practice walking over changing terrain(mats, weights hidden under) while carrying object

Golfing
Calling on Cognitive Abilities

Evaluation: Where does performance break down?	Contextualized	De-Contextualized
Difficulty adding up score of game	Practice adding up score of golf game (mini golf/putt putt game with therapist) record each participants score while completing game on score card and have Pt total at end of task	Complete math problems worksheet (addition and subtraction)
Navigating course	Utilize golf course map and have Pt verbally and visually demonstrate sequence of holes	Trail making worksheet

Frequently Asked Questions

1. Is it possible to engage patients in contextualized therapy when their medical status is acute or fragile (i.e., weak, debilitated, agitated, poorly responsive, etc.)?

   Safe and effective therapy relies on critical decision-making and clinical judgment on the part of the therapist. Only you can make that determination at the time you are delivering therapy. However, even if a patient is unable to engage in holistic activities, consider contextualizing tasks or placing component tasks within a contextualized approach.

2. If a patient is too weak to stand upright, should I forego therapeutic exercises to strengthen their legs and instead immediately start them walking, in hopes that strength and coordination will follow?

   You certainly can consider this as an option. Multiple approaches are not mutually exclusive.

3. If everyone on the therapy team is working on function, won't there be too much redundancy and duplication of services, which also means "double counting" of services?

   Redundancy is not problematic for services. Interdisciplinary therapists approach function from differing perspectives, allowing patients to practice and relearn skills in a variety of contexts that ultimately can promote optimal performance. Contextualized treatment should encompass as many aspects of a patient's preferences, interests, and life goals as is possible within the treatment setting.

4. I do not have enough time in the day to plan for "real-life" tasks. How can I increase contextualized treatment if I do not have the time to plan?

   Our clinical work groups created a translation menu for you to use. This menu allows for quick formulation of how to provide contextualized treatment for a particular therapy activity or patient goal.

5. Documenting contextualized treatment sessions takes more time. How can I keep my nonproductive time within reason?

   Our clinical documentation group reviewed current documentation and identified relevant information to document for contextualized treatment sessions. The identified data elements were the same regardless of the treatment approach taken by a therapist; that is, therapists currently document the relevant clinical data, but not consistently. The group created templates that can be incorporated into existing templates or created as shortcuts (e.g., smart phrases) for therapists to use. Using standard templates and standard narratives eliminates the need for a therapist to deliberate on what to document or to worry about forgetting to document a necessary session detail.

6. Contextualized treatment requires real-life tasks, tools, settings, resources. How can I deliver contextualized treatment in an inpatient hospital setting?

   The clinical work groups identified tasks, tools, and resources and have recommended the creation of kits at each site for ease of access.

7. How can I capture patient progress with a contextualized treatment approach?

   The clinical documentation group did not identify any different methods for documenting patients' responses based on differing therapeutic interventions. In other words, therapists use similar measures to assess success/failure/progress regardless of whether or not the session is using a contextualized treatment approach or some other approach. Session notes generally include level of assistance and level of performance. These two data elements are recommended for consistent inclusion in the daily note templates.

8. How do I perform contextualized treatment with the current COVID-19 restrictions?

   Whether you are using a contextualized approach to treatment or some other approach, all COVID-19 precautions should be in place: facemask, eye shields, hand sanitizers, room ventilation. You should also follow your facility's infection control policies and procedures governing patient safety. Location may limit availability of safety measures, but should not restrict activity if safety measures are in place. Consider therapy as a means to train patients to function safely in environments in the age of COVID-19. Also, consider alternative ways to incorporate family in treatment planning such as the use of televideo and telephone instead of face-to-face encounters.

9. What do I do if my patient or family does not want to participate in contextualized treatment?

   It is our experience that patients and families prefer a contextualized treatment approach to other approaches because of the inherent relevance they see in the treatment. However, on the rare occasion that a patient or family declines to participate then we recommend you share the research evidence and educate them on this approach. If they continue to decline then you have done all you can and all that is left is for you to document their response and shift your treatment plan to their preferences.

10. Contextualized treatment was not included during my didactic or clinical training. How do I learn more about it and how can I promote it with my students?

    Read, learn, train! Educational webinars, clinical videos, and therapy tools within the dissemination package will be available. Above all, ask questions and challenge yourself and your peers to make inpatient rehabilitation a contextualized environment.

11. I understand and appreciate contextualized treatment, but how do I advocate for this at my place of work?

    We recommend you share the research evidence on the benefits of contextualized treatment with both clinical teams and clinical leaders at your place of work. Clinicians can advocate for contextualized treatment by implementing and promoting the use of content contained within the Dissemination Package. Clinical leaders can advocate for contextualized treatment by offering resources for educational webinars, through acquisition of therapy tools to support the contextualized approach, and through discussions of evidence-based rehabilitation treatment approaches during case reviews.

Real Life Activities for Rehabilitation

Introduction: The more we know about our patients, the better we can tailor therapy to them. Your loved one's therapy team will be completing evaluations of current cognitive and physical abilities, but we did not know them prior to their injury. Please help us get to know your loved one by filling out the questionnaire below with as much detail as possible about what your loved one did prior to their injury.

1. **What does your loved one do on a daily basis? What are they responsible for from day to day?** (For example: *Jim wakes up to his alarm (on his iPhone), takes a shower, gets dressed, drops off the kids at daycare, drives to work, he works an 8-10 hour day at a desk, etc).*

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2. **What does your loved one do for fun/leisure?** *Examples: Word search, fishing, going for walks, computer/internet, reading, meditating, video games, writing, gardening, music, etc.*

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3. **What social activities does your loved one enjoy?** *Examples: Bingo, book club, eating out, shopping as a group, going to parties, religious events, volunteer work, political organizations, facebook, etc.*

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4. **What physical activities does your loved one enjoy?** *Examples: Bowling, working out, basketball, golf, swimming, cycling, yoga, equestrian, skiing, etc.*

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KITS to Assist with Contextualized Treatment

a. Medication management
   - weekly and 4x/day/week pill box
   - multiple med bottles with various lids
   - various bead sizes
   - magnifying glass

b. Gardening
   - pots (various sizes)
   - soil bag
   - spade
   - knee pad
   - seed packets
   - watering can

c. Golfing
   - putting green
   - golf set/bag

d. Laundry
   - laundry basket
   - detergent
   - linens (patient clothes or towels, bed linens, washcloths)

e. Grocery shopping
   - grocery bags
   - empty and full food items
   - grocery cart
   - grocery basket
   - conveyor belt
   - cash register with scanner and labels

f. Petcare
   - litter box with litter, scoop, and fake cat poop
   - pet food with bowl & scoop in large container
   - pooper scooper
   - pet leash
   - collar
   - lint rollers

g. Home maintenance:
   - tool box
   - tool belt
   - sanding paper in bag
   - sanding blocks
   - wood tiles & 2x4
   - hammer
   - flashlight
   - washers, bolts & nuts organizer
   - nails and brads
   - electrical wire connectors

- electrical tape (various colors)
- wire stripper, cutter, & length scale
- level
- electrical wire (various colors)
- scraper
- screwdriver
- wrench
- dial lock
- small pain roller handle and 2 rollers
- paint brushes
- large paint roller
- door knob kit
- socket set
- paint pan
- extension cord

b. Lawn care:
   - lawn mower
   - leaf blower
   - rake
   - push broom

c. Outdoor rec
   - tent
   - cornhole & various yard games
   - bike with helmet
   - fishing poles and tackle box

d. Battery operated bin
   - flashlight
   - remote control
   - timer
   - children’s toy
   - batteries and organizer

DOCUMENTATION EXAMPLES

PROPOSED TEMPLATE 1:

- ensures provider has prompts for our identified required data elements; when a prompt is not relevant to a patient or the content of a therapy session, a simple "N/A" can be entered
- can include standardized response sets, if desired (see prompt labeled Strategies for example)
- tends to be the most efficient way (reduced time) to complete documentation

Patient Goal: [insert/enter patient's stated goal]
Prior Level of Function / Level of Familiarity / Level of Desire: [insert/enter patient level of functioning prior to injury; otherwise, enter patient's stated desire to learn new skill/function]
Target of Treatment: [insert/enter the functional skill, component skill, or impairment/deficit that you are targeting for change]
Task/Activity Used in Session: [insert/enter the task/activity selected to perform during the session; may list multiple tasks/activities]
Location of Session: [insert/enter the location of the therapy session]
Strategies Employed: [insert/enter strategies implemented by the therapist to assist or improve patient's performance]

[Response Options: Anchoring, Backward Chaining, Environmental Supports, External Focus, Fading of Verbal Supports, Fading of Physical Supports, Forward Chaining]

[Interventions Employed]:
Patient Response – Level of Assistance/Effort: [insert/enter description of the level of engagement by the patient (e.g., physical assistance needed, subjective statements, level of interest, etc.).
Patient Response – Level of Performance: [insert/enter description of any changes in patient's performance relative to prior level of function and relative to previous therapy sessions using tasks/activity]

EXAMPLES of how this could read as session notes:

EXAMPLE-OT:
Patient Goal: Dress independently each morning.
Prior Level of Function / Level of Familiarity / Level of Desire: Performed independently prior to injury.
Target of Treatment: Upper body dressing.
Task/Activity Used in Session: Donning/doffing bra and pullover shirt with 2 buttons. **Location of Session:** Patient's hospital room.
Strategies Employed: Fading of verbal supports to assist the patient.
[Interventions Employed]: One-handed technique, cognitive strategies for safety awareness.
Patient Response – Level of Assistance/Effort: Required physical assistance <50% of the time to don/doff articles and 75% effort was provided by the therapist for buttoning.
Patient Response – Level of Performance: Performed UE dressing with moderate to maximum assistance, significantly below PLOF and improved from maximum assistance required for all components yesterday.

EXAMPLE-PT:

Patient Goal: Walk independently in the kitchen using a rolling walker
Prior Level of Function / Level of Familiarity / Level of Desire: Performed independently without a rolling walker prior to injury.
Target of Treatment: Mobility, safe ambulation in kitchen
Task/Activity Used in Session: Appropriate walker placement and scanning for safe navigation and reduced speed of rolling to improve quality of gait in this crowded environment.
Location of Session: Kitchen, with the patient ambulating between refrigerator, counter, and table
Strategies Employed: Fading of physical supports to assist the patient.
[Interventions Employed]: Manual positioning/contact/cueing/ external focus on environment; education.
Patient Response – Level of Assistance/Effort: Demonstrated safe walker position, but required physical assistance >40% of time and verbal cueing 100% of the time to reduce gait speed and scan environment.
Patient Response – Level of Performance: Performed walking with minimum physical assistance, significantly below PLOF and improved for safe, appropriate walker positioning relative to performance over the past few days.

EXAMPLE-SLP:
Patient Goal: Communicating desired preferences for meal selections.
Prior Level of Function / Level of Familiarity / Level of Desire: Performed with supervision prior to injury due to pre-existing dementia.
Target of Treatment: Communication, self-expression.
Task/Activity Used in Session: Breakfast meal selection.
Location of Session: Therapy office.
Strategies Employed: Environmental supports in the form of a picture board.
[Interventions Employed]: Errorless learning for naming of foods/drinks.
Patient Response – Level of Assistance/Effort: Appropriate selection of breakfast items with 100% accuracy when using pointing to select items, and 10% accuracy when verbalizing selected picture due to perseverative expression (i.e., “toast” was verbalized for all items).
Patient Response – Level of Performance: Patient’s expressive communication is totally dependent, significantly below PLOF, and consistent with his performance over the past week.

PROPOSED TEMPLATE 2 (CANNED TEXT/SMART PHRASE TEXT):

- ensures some content for identified required data elements, written in a traditional and familiar narrative context
- can include standardized response sets, if desired
- can require greater diligence on the part of the provider to ensure the data in the note is tailored to the patient and unnecessary verbiage is eliminated when not needed or relevant to the patient

Patient expressed desired goal to [insert], a [skill/new skill] patient [did/did not] perform prior to injury. Patient's desired goal is to eventually perform this skill [insert patient's desired level of performance]. Treatment session targeted [insert functional skill, component skill, or impairment/deficit that you are targeting for treatment]. [Insert task/activity] selected for the current therapy session and performed in [insert/enter location].

Therapist employed [insert interventions] and implemented [insert strategies] to assist the patient and to improve patient's performance. Patient required [insert description of the level of physical assistance needed] and expressed [insert subjective statements, level of interest, etc.]. Patient performed [insert description] compared to pre-injury ability and [insert description] compared to previous session(s).

EXAMPLE of how this could read as session notes:

EXAMPLE: Patient expressed desired goal to dress independently each morning, a skill patient performed independently prior to injury. Treatment session targeted upper body dressing. Donning/doffing bra and pullover shirt with 2 buttons was selected for the current therapy session and was performed in the patient's hospital room. Therapist employed fading of verbal supports to assist the patient. Patient required physical assistance <50% of the time for donning/doffing articles and 75% effort was provided by the therapist for buttoning. Patient performed UE dressing with moderate to maximum assistance, significantly below PLOF and improved from maximum assistance required for all components relative to yesterday.

EXAMPLE: Patient expressed goal of walking independently in the kitchen using a rolling walker. Treatment session targeted mobility and safe ambulation in kitchen. Appropriate walker placement , scanning for safe navigation, and reducing speed to improve gait quality in crowded environment were selected for the current therapy session and performed in therapy kitchen. The patient ambulated between refrigerator, counter, and table. Therapist employed manual positioning, contacting and cueing for external focus on environment and education, and implemented fading of physical supports to assist the patient and to improve patient's performance. Patient required physical assistance >40% of time and verbal cueing 100% of time to reduce gait speed and to scan environment. Patient performed walking with minimum physical assistance, significantly below PLOF and improved with safe, appropriate walker positioning relative to performance over the past few days.

EXAMPLE: Patient expressed goal of communicating desired preferences for meal selections, a skill patient performed with supervision prior to injury due to pre-existing dementia. Treatment session targeted breakfast meal selection. Therapy session was conducted in therapy office. Therapist employed environmental supports in the form of a picture board. Patient demonstrated appropriate selection of breakfast items with 100% accuracy when using pointing to select items, and 10% accuracy when verbalizing selected picture due to perseverative expression (i.e., "toast" was verbalized for all items). Patient's expressive communication is totally dependent, significantly below PLOF, and consistent with his performance over the past week.

Program Evaluation & Quality Improvement Surveys

Contextualized Treatment Dissemination Package: Baseline Survey

1. Date Completed

Date / Time

Date

MM/DD/YYYY

2. Discipline/Role

- [ ] Administration
- [ ] PT
- [ ] TRec
- [ ] OT
- [ ] PTA
- [ ] OTA
- [ ] SLP
- [ ] Other (please specify)

3. Facility Location

- [ ] RHI
- [ ] OSU
- [ ] St. Rita's
- [ ] Tampa VA
- [ ] Other (please specify)

4. Program of Service

- [ ] Subacute Setting
- [ ] Acute Inpatient Rehabilitation
- [ ] Outpatient Clinic
- [ ] Other (please specify)

5. In your own words, define contextualized treatment therapies.

6. Contextualized treatment can be increased even if it is different or similar from what I use.

- ☐ Strongly agree
- ☐ Agree
- ☐ Neither agree nor disagree
- ☐ Disagree
- ☐ Strongly disagree

7. Contextualized treatment can be delivered in a time efficient way.

- ☐ Strongly agree
- ☐ Agree
- ☐ Neither agree nor disagree
- ☐ Disagree
- ☐ Strongly disagree

8. Outcomes of contextualized treatment can be measured.

- ☐ Strongly agree
- ☐ Agree
- ☐ Neither agree nor disagree
- ☐ Disagree
- ☐ Strongly disagree

9. In *your clinical practice*, indicate how often you used contextualized treatment IN THE PAST YEAR. Indicate the percent of therapy time (across all cases) that you spend using contextualized treatment.

<= 10%	20%	30%	40%	50%	60%	70%	80%	90%	100%
Š	Š	Š	Š	Š	Š	Š	Š	Š	Š

10. In *your clinical practice*, indicate how often you CURRENTLY USE contextualized treatment. Indicate the percent of therapy time (across all cases) that you spend using contextualized treatment.

<= 10%	20%	30%	40%	50%	60%	70%	80%	90%	100%
Š	Š	Š	Š	Š	Š	Š	Š	Š	Š

11. In *your clinical practice*, indicate how often you INTEND TO USE contextualized treatment IN THE FUTURE. Indicate the percent of therapy time (across all cases) that you spend using contextualized treatment.

<= 10%	20%	30%	40%	50%	60%	70%	80%	90%	100%
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12. With patient/family member, indicate how often you shared evidence about contextualized treatment IN THE PAST YEAR. Indicate the percent of your patients and family members with whom you share/shared the evidence.

<= 10%	20%	30%	40%	50%	60%	70%	80%	90%	100%
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13. With patient/family member, indicate how often you CURRENTLY SHARE evidence about contextualized treatment. Indicate the percent of your patients and family members with whom you share/shared the evidence.

<= 10%	20%	30%	40%	50%	60%	70%	80%	90%	100%
Š	Š	Š	Š	Š	Š	Š	Š	Š	Š

14. With patient/family member, indicate how often you INTEND TO SHARE evidence about contextualized treatment. Indicate the percent of your patients and family members with whom you share/shared the evidence.

<= 10%	20%	30%	40%	50%	60%	70%	80%	90%	100%
Š	Š	Š	Š	Š	Š	Š	Š	Š	Š

15. Indicate how you promoted the use of contextualized treatment (ConTx) *to colleagues* IN THE PAST YEAR.

Never mentioned ConTx	Suggested use of ConTx	Provided examples of ConTx	Modeled use of ConTx
Š	Š	Š	Š

16. Indicate how you CURRENTLY PROMOTE the use of contextualized treatment (ConTx) *to colleagues*.

Never mention ConTx	Suggest use of ConTx	Provide examples of ConTx	Model use of Contx
Š	Š	Š	Š

17. Indicate how you INTEND TO PROMOTE IN THE FUTURE the use of contextualized treatment (ConTx) *to colleagues*.

Never mention ConTx	Suggest use of ConTx	Provide examples of Contx	Model use of ConTx
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18. List any issues or concerns you may have with contextualized treatment.

Contextualized Treatment Dissemination Package: Post Presentation Survey

1. Date Completed

Date / Time

Date

MM/DD/YYYY

2. Discipline/Role

- [ ] Administration
- [ ] PT
- [ ] TRec
- [ ] OT
- [ ] PTA
- [ ] OTA
- [ ] SLP
- [ ] Other (please specify)

3. Facility Location

- [ ] RHI
- [ ] OSU
- [ ] St. Rita's
- [ ] Tampa VA
- [ ] Other (please specify)

4. Program of Service

- [ ] Subacute Setting
- [ ] Acute Inpatient Rehabilitation
- [ ] Outpatient Clinic
- [ ] Other (please specify)

5. In your own words, define contextualized treatment therapies.

6. Contextualized treatment can be increased even if it is different or similar from what I use.

- ☐ Strongly agree
- ☐ Agree
- ☐ Neither agree nor disagree
- ☐ Disagree
- ☐ Strongly disagree

7. Contextualized treatment can be delivered in a time efficient way.

- ☐ Strongly agree
- ☐ Agree
- ☐ Neither agree nor disagree
- ☐ Disagree
- ☐ Strongly disagree

8. Outcomes of contextualized treatment can be measured.

- ☐ Strongly agree
- ☐ Agree
- ☐ Neither agree nor disagree
- ☐ Disagree
- ☐ Strongly disagree

9. In *your clinical practice*, indicate how often you used contextualized treatment IN THE PAST YEAR. Indicate the percent of therapy time (across all cases) that you spend using contextualized treatment.

<= 10%	20%	30%	40%	50%	60%	70%	80%	90%	100%
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10. In *your clinical practice*, indicate how often you CURRENTLY USE contextualized treatment. Indicate the percent of therapy time (across all cases) that you spend using contextualized treatment.

<= 10%	20%	30%	40%	50%	60%	70%	80%	90%	100%
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11. In *your clinical practice*, indicate how often you INTEND TO USE contextualized treatment IN THE FUTURE. Indicate the percent of therapy time (across all cases) that you intend to spend using contextualized treatment.

<= 10%	20%	30%	40%	50%	60%	70%	80%	90%	100%
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12. With patient/family member, indicate how often you shared evidence about contextualized treatment IN THE PAST YEAR. Indicate the percent of your patients and family members with whom you share/shared the evidence.

<= 10%	20%	30%	40%	50%	60%	70%	80%	90%	100%

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Never mentioned ConTx	Suggested use of ConTx	Provided examples of ConTx	Modeled use of ConTx

16. Indicate how you CURRENTLY PROMOTE the use of contextualized treatment (ConTx) *to colleagues*.

Never mention ConTx	Suggest use of ConTx	Provide examples of ConTx	Model use of Contx

17. Indicate how you INTEND TO PROMOTE IN THE FUTURE the use of contextualized treatment (ConTx) *to colleagues*.

Never mention ConTx	Suggest use of ConTx	Provide examples of Contx	Model use of ConTx

18. To what extent did you include family members in treatment planning prior to COVID-19 and prior to today's training session? Indicate percent of cases.

<=10%	20%	30%	40%	50%	60%	70%	80%	90%	100%

19. To what extent do you intend to include family members in treatment planning in the future with COVID-19 restrictions in place? Indicate percent of cases.

<=10%	20%	30%	40%	50%	60%	70%	80%	90%	100%

20. To what extent do you intend to include family members in treatment planning in the future when COVID-19 restrictions are lifted? Indicate percent of cases.

<=10%	20%	30%	40%	50%	60%	70%	80%	90%	100%

21. List any issues or concerns you may have with contextualized treatment.

22. As a result of this education and training session, I intend to

- ☐ use contextualized treatment at about the same amount as I currently do.
- ☐ increase the amount of contextualized treatment relative to the amount I currently use.
- ☐ decrease the amount of contextualized treatment relative to the amount I currently use.

23. Based on the definition of contextualized treatment that I learned during today's education and training session, the percent of cases that I previously used contextualized treatment was

<=10%	20%	30%	40%	50%	60%	70%	80%	90%	100%

24. Based on the definition of contextualized treatment that I learned during today's education and training session, the percent of future cases that I intend to use contextualized treatment is

<=10%	20%	30%	40%	50%	60%	70%	80%	90%	100%

Contextualized Treatment Dissemination Package: Post Package Implementation Survey

1. Date Completed

Date / Time

Date

MM/DD/YYYY

2. Discipline/Role

- [ ] Administration
- [ ] PT
- [ ] TRec
- [ ] OT
- [ ] PTA
- [ ] OTA
- [ ] SLP
- [ ] Other (please specify)

3. Facility Location

- [ ] RHI
- [ ] OSU
- [ ] St. Rita's
- [ ] Tampa VA
- [ ] Other (please specify)

4. Program of Service

- [ ] Subacute Setting
- [ ] Acute Inpatient Rehabilitation
- [ ] Outpatient Clinic
- [ ] Other (please specify)

5. In your own words, define contextualized treatment therapies.

6. Contextualized treatment can be increased even if it is different or similar from what I use.

- ☐ Strongly agree
- ☐ Agree
- ☐ Neither agree nor disagree
- ☐ Disagree
- ☐ Strongly disagree

7. Contextualized treatment can be delivered in a time efficient way.

- ☐ Strongly agree
- ☐ Agree
- ☐ Neither agree nor disagree
- ☐ Disagree
- ☐ Strongly disagree

8. Outcomes of contextualized treatment can be measured.

- ☐ Strongly agree
- ☐ Agree
- ☐ Neither agree nor disagree
- ☐ Disagree
- ☐ Strongly disagree

9. In *your clinical practice*, indicate how often you used contextualized treatment IN THE PAST YEAR. Indicate the percent of therapy time (across all cases) that you spend using contextualized treatment.

<= 10%	20%	30%	40%	50%	60%	70%	80%	90%	100%
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10. In *your clinical practice*, indicate how often you CURRENTLY USE contextualized treatment. Indicate the percent of therapy time (across all cases) that you spend using contextualized treatment.

<= 10%	20%	30%	40%	50%	60%	70%	80%	90%	100%
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11. In *your clinical practice*, indicate how often you INTEND TO USE contextualized treatment IN THE FUTURE. Indicate the percent of therapy time (across all cases) that you intend to spend using contextualized treatment.

<= 10%	20%	30%	40%	50%	60%	70%	80%	90%	100%
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12. With patient/family member, indicate how often you shared evidence about contextualized treatment IN THE PAST YEAR. Indicate the percent of your patients and family members with whom you share/shared the evidence.

<= 10%	20%	30%	40%	50%	60%	70%	80%	90%	100%
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13. With patient/family member, indicate how often you CURRENTLY SHARE evidence about contextualized treatment. Indicate the percent of your patients and family members with whom you share/shared the evidence.

<= 10%	20%	30%	40%	50%	60%	70%	80%	90%	100%
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14. With patient/family member, indicate how often you INTEND TO SHARE evidence about contextualized treatment. Indicate the percent of your patients and family members with whom you intend to share the evidence.

<= 10%	20%	30%	40%	50%	60%	70%	80%	90%	100%
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Never mentioned ConTx	Suggested use of ConTx	Provided examples of ConTx	Modeled use of ConTx
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Never mention ConTx	Suggest use of ConTx	Provide examples of Contx	Model use of ConTx
Š	Š	Š	Š

18. To what extent did you include family members in treatment planning prior to COVID-19 and prior to today's training session? Indicate percent of cases.

<=10%	20%	30%	40%	50%	60%	70%	80%	90%	100%
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19. To what extent do you intend to include family members in treatment planning in the future with COVID-19 restrictions in place? Indicate percent of cases.

<=10%	20%	30%	40%	50%	60%	70%	80%	90%	100%
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20. To what extent do you intend to include family members in treatment planning in the future when COVID-19 restrictions are lifted? Indicate percent of cases.

<=10%	20%	30%	40%	50%	60%	70%	80%	90%	100%
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21. List any issues or concerns you may have with contextualized treatment.

22. As a result of the past education and training session I attended >4 weeks ago, I

- ☐ use contextualized treatment about the same amount as I did prior to the training session.
- ☐ increased the amount of contextualized treatment relative to the amount I used prior to the training session.
- ☐ decreased the amount of contextualized treatment relative to the amount I used prior to the training session.

23. Based on the definition of contextualized treatment that I learned during the education and training session, the percent of cases that I previously used contextualized treatment was

<=10%	20%	30%	40%	50%	60%	70%	80%	90%	100%
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24. Based on the definition of contextualized treatment that I learned during the education and training session, the percent of future cases that I intend to use contextualized treatment is

<=10%	20%	30%	40%	50%	60%	70%	80%	90%	100%
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25. Do you have any suggestions for modifying the dissemination materials?