COURSE SYLLABUS
Spring Semester 2009

COURSE TITLE: CMSI 312 Interdisciplinary Seminar in Neurodevelopmental Disabilities, Part II

COURSE DESCRIPTION:

CMSI 312 is part two of an advanced graduate level seminar sequence offered through the Vermont's Interdisciplinary Leadership Education for Health Professionals (VT-ILEHP) Program, which is required for all VT-ILEHP long-term trainees and fellows. It is a Spring Semester graduate course cross-listed in several departments and offered through Continuing Education for three graduate credits. The five competency areas emphasized throughout the VT-ILEHP core curriculum guide the specific content: neurodevelopmental and related disabilities; interdisciplinary process and collaborative teaming; cultural competence; family-centered care; and leadership in Maternal and Child Health. The VT-ILEHP faculty has actively and collaboratively developed the scope and sequence of the course content. This course is offered to community health professionals and related service providers, as well as students and faculty not directly involved in the VT-ILEHP Program. As an advanced course in interdisciplinary research and practice, this would not be a course typically taken by undergraduate students. Students who do not have graduate status are required to get the instructor's permission to take this course.

COURSE COORDINATORS:

Jean Beatson, Ed. D., RN
Clinical Director & Associate Training Director
VT-ILEHP Program

Patricia Prelock, Ph.D., SLP-CCC
Training Director
VT-ILEHP Program

COURSE INSTRUCTORS: Core and Affiliated Faculty of the VT-ILEHP Program with recognized expertise in particular content areas.

<u>CORE FACULTY</u>

Jean Beatson (Nursing)
James Calhoun (Psychology)
Stephen Contompasis (Pediatrics; Program Director)
Marty Dewees (Social Work)
Mary Alice Favro (Speech Pathology)
Tiffany Hutchins (Research)
Dorigen Keeney (Nutrition)
Julianne Nickerson (Family Support)
Deborah O'Rourke (Physical Therapy)
Marie Christine Potvin (Occupational Therapy)
Patricia Prelock (Speech Pathology)

Peggy Sands (Physical Therapy)
Susan Willis (Nutrition)

OTHER PARTICIPATING FACULTY & GUEST PRESENTERS

Jody Brakeley (VCHIP & CSHN)
Leah Burke (Genetics)
Church Hindes (VNA)
Blanche Podaski (Stern Center)
Jacqueline Rose (Refugee Resettlement Program)
Don Schwartz (CSHN)
Kay Van Woert (Vermont Family Network)

COURSE DAY & TIME: Thursdays, 5:30-8:15 pm

LOCATION: 427 Waterman

VT-ILEHP OFFICE: 1 S. Prospect St., 4th floor Rehab wing (UHC), room 4318
656-4291 (Jean Beatson, Clinical Dir. & Associate Training Dir.)
jean.beatson@uvm.edu
656-1915/2529 (Patricia A. Prelock, Training Director)
patricia.prelock@uvm.edu
656-3187 (Steve Contompasis, Program Director)
stephen.contompasis@uvm.edu
656-0204 (Kerstin Hanson, Program Support)
kerstin.hanson@uvm.edu

OFFICE HOURS: Please call or e-mail for an appointment.

VT-ILEHP MISSION STATEMENT:

The mission of the **Vermont Interdisciplinary Leadership Education for Health Professionals (VT-ILEHP) Program** is to improve the health of infants, children, and adolescents, with or at risk for, neurodevelopmental and related disabilities and their families through the development of culturally competent, family-centered, community-based leadership professionals.

VALUES WHICH FORM THE FOUNDATION FOR THE VT-ILEHP PROGRAM:

We believe that all individuals have a right to health. Systems that promote health should provide for universal access and accessibility, personal and family choice and promotion of independence within the community.

We believe that the family provides the foundation for the health of our children and that programs supporting the health of children need to support the health of the family and provide services that are family-centered and family oriented.

We believe that all supports should be integrated within the community and that individuals and families needing supports should exercise control over funding, delivery and quality of supports.

We believe in a strength's approach to assessment and support rather than a problems approach.

We believe in prevention and health promotion in order to manage crisis intervention.

We encourage diversity throughout our community, in our classrooms, play, neighborhoods, marketplaces, and workplaces.

We believe that communities should be fully accessible for every citizen.

Religious Holidays: Students have the right to practice the religion of their choice. Each semester students should submit in writing to their instructors by the end of the second full week of classes their documented religious holiday schedule for the semester. Faculty must permit students who miss work for the purpose of religious observance to make up this work.

GENERAL COURSE OBJECTIVES:

1. To increase the knowledge of VT-ILEHP trainees/fellows, faculty, graduate students and community professionals of primary, secondary and tertiary aspects of *prevention* and health promotion for children with special health needs and their families. (ASHA Standard III-D; VT Standard 1: Learning, Principles #1)

2. To increase the knowledge of VT-ILEHP trainees/fellows, faculty, graduate students and community professionals of various models of interprofessional *collaboration and teaming* and service provision in the health care of children with special health needs and their families. (ASHA Standard IV-G, #3; VT Standard 3: Colleagueship, Principle #10; VT Standard 4: Advocacy, Principle 11)

3. To increase understanding and skill in developing partnerships with families, and learn how *families and professionals* can *work collaboratively* in providing family-centered, high quality integrated services. (ASHA Standard IV-G, #3; VT Standard 3: Colleagueship, Principle #10; VT Standard 4: Advocacy, Principle #11)

4. To increase the *cultural sensitivity and competence level* of VT-ILEHP trainees/fellows, faculty, graduate students and community professionals in their interactions with families and their children with special health needs including disability, age, gender, religion and *culture*. (ASHA Standards III-D & IV-F; VT Standard 2: Professional Knowledge, Principles #2 & 3)

5. To increase the knowledge and skill of VT-ILEHP trainees/fellows and interested graduate students and community professionals in methods of information acquisition, public policy problem identification, and *research* in Maternal and Child Health. (ASHA Standard III-F)

6. To *critically analyze and evaluate* cutting edge issues (e.g., *managed care, informed consent, confidentiality*, new technologies, etc.) that are currently impacting the lives of children and families. (ASHA Standards III-E, F, G, H; VT Standard 2: Professional Knowledge, Principle #9; VT Standard 4: Advocacy, Principles #12 & 13)

SPECIFIC COURSE OBJECTIVES:

Specific course objectives have been defined for each seminar topic. These objectives and the learning activities designed to meet these objectives will be provided to each student the evening of the individual seminars by the interdisciplinary team responsible for the seminar's planning.

COURSE READINGS: Additional journal articles used to supplement the required text can be found as part of the electronic reserve in Bailey-Howe Library.

To access the electronic reserve, students go to the UVM home page (www.uvm.edu) and click on the Featured Link on the right hand side for Libraries. At the Library page click on Course Reserves in the green section up on top towards the right. You will then see the following if you scroll down:

To perform a Course Reserve search:

1. Select an item from one (or more) of the following drop-down lists: Instructor, Department, Course. (Selecting all 3: Prelock/Beatson, CMSI, CMSI 312 is recommended)

2. Click the Search button to begin your search.

3. Select a record you wish to view by clicking on it. Each record includes a complete citation, the reserve location for the item, and its call number.

4. If the record contains a call number, (e.g. HF549.T56, XC 445, or ZZZ 754), you will need to go to the Reserve Desk at the Bailey Howe Library or Dana Medical Library, depending on the location, and ask one of the staff there for the item.

If "E-Reserve" is indicated in the call number field, the item is available electronically. Note: all of the required readings should be available electronically.

To get an item on electronic reserve, click on the title of the article, at the next screen click on the Internet address in the record. You will be prompted to type your user name and password. Use your UVM email/network user name and password. Note that you

need to have Adobe Acrobat, version 7.0 or higher, loaded on your computer in order to view items on Electronic Reserve. If you do not have Adobe Acrobat Reader on your computer, you can download it: http://www.adobe.com/products/acrobat/readermain.html

REQUIRED TEXT:

Law, M. (2002). *Evidence-based rehabilitation: A guide to practice.* Thorofare, NJ: Slack Incorporated.

Vargas, C. M. & Prelock, P. A. (Eds.) (2004). *Caring for Children with Neurodevelopmental Disabilities and their Families: An Innovative Approach to Interdisciplinary Practice.* Lawrence Erlbaum Associates, Inc., Publishers.

REQUIRED BOOK FOR BOOK REVIEW:

Ehrenreich, B. (2001). *Nickel and Dimed: On (Not) Getting By in America.* NY: Henry Holt and Company.

COURSE REQUIREMENTS:

1. **Attendance and Participation in Class Discussions.** Students are expected to attend all classes and actively participate in class discussions. Required readings can be found on Blackboard and electronic reserve. Any additional required readings will be announced and provided two weeks prior to each class. Students are expected to come prepared to class and ready to relate the assigned readings and any questions posed by the presenters to the topic of discussion for that class session.

   Taking personal responsibility for your learning is a priority value in this. Students are expected to be respectful of their peers and instructors in their comments during class, their communication around course requirements and content knowledge, and their responsiveness to e-mail requests, assignments and/or other contacts made. Instructors will also demonstrate respect for the viewpoints of students and will provide timely and responsive feedback to student assignments and questions.

2. **Article Review.** Students are required to reflect, in writing, on the required readings for one of the topics presented during the semester. This means that students are to read all the required readings provided by the seminar team for a particular topic and integrate the information from these readings to address the following:

   a. Compare and contrast the theoretical or conceptual frameworks espoused in each article? **(5 pts.)**
   b. Have any of the theoretical or conceptual frameworks presented in the articles led to evidence-based practice as described within the article or within your

own discipline? Please explain. **(5 pts.)**

c. What are the implications for interdisciplinary practice with children with neurodevelopmental disabilities and their families based on the articles you read? **(5 pts.)**

Students may choose any topic areas they wish to use for their article review. The review is <u>due the class following the presentation of the topic</u> and is worth 15 points.

2. **Evidence-Based Practice Critique.** Students are required to select one research article from the readings listed in the course syllabus or in their discipline specific area that focuses on evidence-based practice. Students are to determine through a comprehensive critique of the research presented in the article if, in fact, the findings would be considered valid. Students may select a quantitative or qualitative research article to review.

   For review of the format for evaluating **quantitative** studies, please read Appendix C & D (pgs. 306-321) in your Law (2002) text.

   For review of the format for evaluating **qualitative** studies, please read Appendix E & F (pgs. 324-338) in your Law (2002) text.

   To access these same Law materials on line, please follow these links:

   http://www.fhs.mcmaster.ca/rehab/ebp/

   Quantitative review form - quanreview.pdf
   Quantitative review guidelines - quanguidelines.pdf
   Qualitative review form - qualreview.pdf
   Qualitative review guidelines - qualguidelines.pdf

   NOTE: If you use an article that is not in the syllabus, but from your discipline, please attach the article to your critique.

   Each review form requires yes/no responses and explanations for 8 major areas. Responses for each of the first 7 areas are worth 2 points (7 x 2-14) and the last area is worth 6 points for a total of **20** points. **This assignment is <u>due on February 12, 2009</u>.**

3. **Book Review.** The purpose of this assignment is to increase students' awareness and understanding of the specific challenges experienced by those living in poverty, as well as to learn about available resources. Students will be reading:

Ehrenreich, B. (2001). *Nickel and Dimed: On (Not) Getting By in America.* NY: Henry Holt and Company.

Students are to prepare a book review of no more than 5 pages, which includes the following:

a. Description of the individual and their circumstances, including the ways in which your perceptions regarding low wage workers changed as a result of reading this book **(5 points)**

b. Consider how this experiment would play out in Chittenden County. Create a hypothetical monthly budget for one person limiting yourself to 7.50/hour **(10 points)**

c. Reflection on the most important thing you learned while reading the book which is likely to change your practice in serving the working poor **(10 points)**

This assignment is worth a total of 25 points and is <u>due on</u> <u>March 19, 2009</u>.

5. **Applied Assignment:** The goal of this assignment is to require students to apply their knowledge across five competency areas (i.e., *family centered care, cultural competence, interdisciplinary teaming and collaborative process, neurodevelopmental disabilities and leadership in maternal and child health)* in response to a child and family story. The child and family story can be taken from your practice or life, or from the text book. After fully describing the child/family story, students are expected to address the following to complete this assignment:

a. Define the issues in the child and family story that might arise in each of the five competency areas as a team attempts to serve the child and family (**10 points**) (see Chapter 6 for an example of how to identify issues across the five competency areas)

b. Select one of the priority issues identified in a. above and create a plan for addressing this issue (**10 points**)

c. Apply the feasibility framework (for a comprehensive explanation of this framework see Chapter 10 in the required text) to this plan (**10 points**)

d. Once you have identified the feasibility issues (see c. above), write a plan on how you would address these issues as a team leader (**10 points**)

This assignment should be approximately 8-10 pages, not including a comprehensive reference list. References should include no fewer than 10 with at least 7 from scholarly books and peer-reviewed journals. The format of the paper should follow APA (5th edition) guidelines and be double-spaced. Course coordinators encourage students to submit outlines or rough drafts at least 3 weeks before the due date to receive feedback prior to completion of the assignment. **Students will present this assignment to the class <u>on April 30th</u>.**

This assignment is worth a total of 40 points and is due on April 23, 2009.

POSSIBLE APPLIED ASSIGNMENTS FOR CMSI 312

Annotated bibliography. Students may select ONE of the following topic areas to complete a comprehensive literature search (since 1990 to 2009): 1) *Screening practices & early identification of autism; 2) Best practices in early intervention for ASD; 3) Parent training in ASD; or, 4) Joint attention training for young children with ASD*. Students will be evaluated on the following:

1) Description of the comprehensive literature search that was done—including key words used (*1 pt.*), data bases searched (*1 pt.)*; a listing of the resulting articles (*1 pt.);* and, complete reference in APA 5th edition for the selected articles described in #2 below (*1 pt.);* Total=>4 points

2) Selection of 12 excellent quantitative research articles relevant to the selected topic from the literature search that will be read and each summarized in the following manner:
NOTE: Students will use the critical review form for quantitative studies (adapted from Law et al., 1998—see attached) to help them make a determination of those 12 studies with sound research that support the targeted topic area.
   a) **Discuss** the purpose of the study, the study design, participants included, and critical results reported *(1 pt.)*
   b) **Interpret** the value of the stated outcomes and relevance for contributing to assessment or intervention practices for addressing the needs of young children with ASD *(1 pt.)*
   c) **Evaluate** any caveats or concerns you have in utilizing the study's results to inform practice. *(1 pt.)*

Students should complete a brief paragraph for each of the 3 items (discuss, interpret & evaluate) for each of the 12 articles and should be no longer than one page single-spaced for each article. This portion of the assignment is worth *36* points (*3 points* for each article x 12 articles).

Training Module Development: Autism Screening Tools. Students select ONE of the following 4 screening tools: *Social Communication Questionnaire, the Pervasive Developmental Disorders Screening Test II, the Gilliam Autism Rating Scale and the Child Behavior Checklist* (18 months-5 years) and develop a training module for use by early intervention providers. The goal is for these providers use screening tools in order to gather sufficient and valuable information to accompany referrals for a more comprehensive diagnostic assessment. The training module should include the following:

1) Summary of the tool & its psychometric properties=>2-3 pages (10 pts.)
2) Explanation of its use & value as a screening tool for discriminating children with and without autism=>1 page (5 pts.)
3) Instructions on administration & scoring with video clip of procedure=>1-2 page (5 pts.)
4) Hypothetical case examples, creating one profile for a child likely to have autism and one profile for a child unlikely to have autism=>3-4 pages (10 pts.)
5) Ten test questions—five at the beginning of the module to 'assess' the user's understanding of the material contained within the module and then five questions at the end to assess the learner's understanding of the screening tool. The test questions should be multiple choice answers & a rationale should be provided for the

correct answer. The questions could be based on a case study related the to use of the tool=>2 pages (10 pts.)

Development of Parent Training in Joint Attention. Students will review the current literature on the importance of joint attention to play, social communication and perspective taking. They will then develop training for parents (or primary care providers) to facilitate initiation of and response to joint attention with their child with ASD. The parent training should include the following:

1) Description of joint attention (including response to and initiation of), highlighting the importance of joint attention to play, social communication and perspective taking with appropriate literature citations=>2 pages (5 pts.)
2) Summary of the current literature on the evidence for joint attention training as a valuable intervention for children with ASD=>2 pages (10 pts.)
3) Development & video-demonstration of family-friendly procedures to facilitate joint attention in young children with ASD=>2 pages with video clip of procedure (15 pts.)
4) Practice activities to implement joint attention with a child in the home setting & strategies to problem solve challenges=>2 pages (6 pts.)
5) Ways to keep data on progress & determine intervention success=2 pages (4 pts.)

IMPORTANT NOTES FOR STUDENT CONSIDERATION:

1. Any student in this course who has a disability that may prevent him/her from fully demonstrating his/her abilities should contact the course coordinator as soon as possible so we can discuss accommodations necessary to ensure full participation and facilitate your educational opportunity.

2. There will be a 10% reduction in grade for each assignment turned in late except for extraordinary circumstances as determined by the instructor and communicated in advance.

3. As instructor feedback is critical to your ongoing learning and evolution in thinking critically, writing and integrating information, late assignments must be turned in prior to the due date of the next assignment unless there are extraordinary circumstances as determined by the instructor. An assignment not turned in prior to the next assignment due cannot be accepted for credit and will be given a zero.

Students should submit in writing to their instructors by the end of the second full week of classes their documented religious holiday schedule for the semester. Students who miss class work for the purpose of religious

observance should make arrangements with the course instructors to make up any work that they might miss.

EVALUATION:

Article Review:	**15 points**
Evidence-Base Practice Critique	**20 points**
Book Review	**25 points**
Applied Assignment	**40 points**
TOTAL:	**100 points**

Graduate Students

100- 99 points	A+
98 - 94 points	A
93 - 90 points	A-
89 - 87 points	B+
86 - 84 points	B
83 - 80 points	B-
79 - 75 points	C
below 75 points	F

JANUARY 15, 2009

The UN Convention on the Rights of the Child & Health Care

Faculty Coordinators: Deb O'Rourke
Marty Dewees*

Required Readings

Hendriks A. (2007). UN Convention on the Rights of Persons with Disabilities. European Journal of Health Law 14 (2007) 273-298. pdf on blackboard or https://webmail.uvm.edu/horde/imp/view.php?actionID=compose_attach_preview&id=2&messageCache=17f1320bf70d1951c5172ab0aa29fc21

Hodge, D.R. (2008). Sexual trafficking in the United States: A domestic problem with transnational dimensions. *Social Work, 52*, 2, 143-152.

Levetown, M., & and the American Academy of Pediatrics Committee on Bioethics (2008). Communicating with children and families: From everyday interactions to skill in conveying distressing information, *Pediatrics*, 121, e1441 - e1460. pdf bb http://pediatrics.aappublications.org/cgi/content/full/121/5/e1441

JANUARY 22

Medical Home Support for Children with Special Health Needs

Faculty Coordinators: Steve Contompasis
Julianne Nickerson*

Required Readings

AAP Council on Children with Disabilities Care Coordination in the Medical Home: Integrating Health and Related Systems of Care for Children With Special Health Care Needs:PEDIATRICS Vol. 116 No. 5 November 2005, pp. 1238-1244 (doi:10.1542/peds.2005-2070) Download from http://aappolicy.aappublications.org/cgi/content/full/pediatrics;116/5/1238

Newacheck, P.W., Strickland, B., Huang, Z, J.M., McPherson, M., van Dyck, P., Weissman, G. (May 2004). Access to the Medical Home: Results of the National Survey of Children with Special Health Care Needs. *Pediatrics, 113, 1485-1492.* Found at http://www.pediatrics.org/cgi/content/full/113/5/S1/1485

Maternal and Child Health Bureau Strategic Plan FY 2003-2007, Final Draft, US Department of Health and Human Services, Health Resources and Service Administration, Maternal and Child Bureau, updated December 2003. Found at http://mchb.hrsa.gov/about/stratplan03-07.htm#1
Please familiarize yourself with all four sections

Part I: Overview of Maternal and Child Health Bureau – Mission Statement, History and Focus, MCH Partners, and Organizational Structure.

Part II: The Plan – Goals, Key Strategies, Performance Measures and Annual Priorities.

Part III: Conceptual Framework for the Plan – The MCHB Vision, MCHB Guiding Principles, MCH Health Services Pyramid, and Key Documents/Linkages.

Part IV: The Planning Cycle – Needs Assessment; Development of Goals, Key Strategies and Annual Priorities; Program and Resource Allocation; and Performance Measures and Evaluation.

Also please go to the Medical Home website from the American Academy of Pediatrics and search around --there is much to see and lots of interesting stuff. That site is:
http://www.medicalhomeinfo.org/
(Publications, tools, and a number of the other tabs are very interesting)

JANUARY 29

Pain in Children with Neurodevelopmental Disabilities

Faculty Coordinators: Deborah O'Rourke*
Mary Alice Favro

Required Readings

Bottos, S., & Chambers, C. (2006). The epidemiology of pain in developmental disabilities. In T.F. Oberlander & F. J. Symons (Eds.), *Pain in Children and Adults with Developmental Disabilities* (pp. 67-87). Baltimore: Brookes Publishing Co.

Breau, L., McGrath, P.J., & Zabalia, M. (2006). Assessing pediatric pain and developmental disabilities. In T. F. Oberlander & F. J. Symons (eds.), *Pain in Children and Adults with Developmental Disabilities* (pp. 149-172). Baltimore: Brookes Publishing Co.

White-Koning, M., Arnaud, C., Dickinson, H., Thyen, U., Beckung, E., Fauconnier, J. et al. (2007). Determinants of Child-Parent Agreement in Quality-of-Life Reports: A European Study of Children with Cerebral Palsy, *Pediatrics*, 120, e804-e814.
http://pediatrics.aappublications.org/cgi/content/full/120/4/e804

FEBRUARY 5

Down Syndrome

Faculty Coordinators: Marie-Christine Potvin*
Patty Prelock
Julianne Nickerson

Guest Faculty: Kathleen Lynch
Gracie Lynch
Eileen Haupt

Required Readings

Roberts, J. E., Price, J., & Malking, C. (2007). Language and communication Development in Down Syndrome. Mental Retardation and Developmental Disabilities Research Reviews 13: 26 – 35.

Van Cleve, S. N., Cannon, S., Cohen, W. (2006). Part II: Clinical Practice Guidelines for Adolescents and Young Adults With Down Syndrome: 12 to 21 Years. *Journal of Pediatric Health Care, 20* (3), 198-205.

Vicari, S. (2006). Motor Development and Neuropsychological Patterns in Persons with Down Syndrome. *Behavior Genetics, 36* (3), 355-364.

Resources Used in Class

Schwier, K. & Hingsburger, D. (2000). *Sexuality: Your Sons and Daughters with Intellectual Disabilities.* Baltimore, MD: Paul H. Brookes Publishing Co.

National Down Syndrome Society – Dream video (www.youtube.com/watch?v=-_-P4t2jR1g)

Managing Secondary Conditions: Down Syndrome (2002 - video). Retrieved from UVM/CDCI library

FEBRUARY 12

Ethics & Issues in Genetics

Faculty Coordinators:	Jean Beatson*
	Marty Dewees
Guest Faculty:	Leah Burke
	Robert Macauley

Required Readings

Gagen, W.J., & Bishop, J.P. (2007). Ethics, justification and the prevention of spina bifada. *Journal of Medical Ethics, 33,* 501-507.

Hudson, K.L., Holohan, J.D., & Collins, F.S. (2008). Keeping pace with the times: The Genetic Information Nondescrimination Act of 2008. *The New England Journal of Medicine, 358,* 2661-2663.

Hunt, L.M., & Megyesi, M.S. (2008). The ambiguous meanings of the racial ethnic categories used in human genetics research. *Social Science & Medicine, 66,* 349-361.

Recommended Readings

Greene, R., (1999). Genetic Medicine and the Conflict of Moral Principles. *Families, Systems, & Health*. 17, 63-74.

Hamilton, R. J., Bowers, B. J., & Williams, J. K. (2005). Disclosing genetic test results to family members. *Journal of Nursing Scholarship, 37,* 18-24.

Feetham, S. (1999). Families and the Genetic Revolution: Implication for Primary Healthcare, Education, and Research. Families, Systems, & Health, 17, 27-43

Johnson, A.M., Schild Wilkinson, D., Taylor-Brown, S. (1999). Genetic Testing: Policy Implications for Individuals and Their Families. *Families, Systems & Health.* 17, 49-61.

Kenner, C., Gallo, A., & Bryant, K. D. (2005). Promoting children's health through understanding of genetics and genomics. *Journal of Nursing Scholarship, 37,* 308-314.

McGowan, R. (1999). Beyond the disorder: One parent's reflection on genetic counseling. Journal of Medical Ethics, 25, 195-199.

White, G.B. (2000). What we may expect from ethics and the law. American Journal of Nursing. 100, 114-117.

FEBRUARY 19

Understanding Attention Deficit Hyperactivity Disorder: Assessment & Intervention

Faculty Coordinators:	Jim Calhoun*
	Stephen Contompasis
Guest Faculty:	Jody Brakeley

Required Readings

Chronis, AM, Jones, AJ, and Raggi, VL. (2006). Evidence-based psychosocial treatments for children and adolescents with attention-deficit/hyperactivity disorder. Clinical Psychology Review, 26 486 - 502.

Jensen, P. (2001). Findings from the NIMH Multimodal Treatment Study of ADHD (MTA): Implications and Applications for Primary Care Providers. *Developmental and Behavioral Pediatrics, 22 (1).* 60-73.

Jensen et al. (2007). 3-year follow-up of the NIMH MTA study. Journal of the American Academy of Child and Adolescent Psychiatry, 46(8).

Pierce, C. D., & Reid, R. (2004). Attention deficit hyperactivity disorder: Assessment and treatment of children from culturally different groups. *Seminars in Speech and Language, 25* (3), 233-240.

For additional resource information, you can click onto the following websites to review the material:

http://www.aap.org/policy/s0120.html
http://www.aap.org/policy/ac0002.html
http://www.ldonline.org/pdf/adhd_2003.pdf
http://odp.od.nih.gov/consensus/cons/110/110_intro.htm

also recommended:

Tetnowski, J. A. (2004). Attention deficit hyperactivity disorder and concomitant communicative disorders. *Seminars in Speech and Language, 25* (3), 215-224.

FEBRUARY 26

Hearing Loss & Deafness: Health Care Issues & Cultural Competence

Faculty Coordinators:	Mary Alice Favro* Elizabeth Adams
Guest Faculty:	Stacey Jordan

Required Readings

First, view video "Sound and Fury" – available at Bailey Howe (VT-ILEHP has DVD). We will discuss in class.

Blanchfield, B.B., Feldman, J.J., Dunbar, J.L., & Gardner, E.N. (2001). The severely to profoundly hearing-impaired population in the United States: Prevalence estimates and demographics, *Journal of the American Academy of Audiology 12,183-189.*

Hallau, M., (Ed.) *We are Equal Partners: Recommended Practices for Involving Families in Their Child's Educational Program.* Laurent Clerc National Deaf Education Center, Gallaudet University (on line). http://clerccenter2.gallaudet.edu/KidsWorldDeafNet/e-docs/familyinvolv/section-3.html#B

MARCH 5

Health Care Financing for Children with Special Health Care Needs

Faculty Coordinators:	Steve Contompasis Dorigen Keeney*
Guest Faculty:	Church Hindes Barbara Prine

Required Readings

Jacobs L., Marmor, T., & Oberlander, J. (1999). The Oregon Health Plan and the political paradox of rationing: what advocates and critics have claimed and what Oregon did. *Journal of Health Politics, Policy & Law, 24*(1), 161-80.

Sundquist, D. and King, A. (2006) Medicaid Commission Final Report and Recommendations Presented to Secretary Michael O. Leavitt December 29, 2006 (review pages i-xi and 1-24). http://aspe.hhs.gov/medicaid/122906rpt.pdf

Analysis of the Costs and Impact of Universal Health Care Coverage Under a Single Payer Model for the State of Vermont. Prepared for: The Vermont HRSA State Planning Grant, Office of Vermont Health Access August 28, 2001.

MARCH 12 ***SPRING BREAK***

MARCH 19

Transition to Adult Services

Faculty Coordinators: Jim Calhoun*
Julianne Nickerson

Guest Faculty: John Spinney
Linette Over

Required Readings

http://www.uvm.edu/~cdci/tripscy/?Page=TransHome.html&SM=TnsSubmenu.html

Recommended Readings

Blacher, J. (2001). Transition to adulthood: Mental retardation, families and culture. *American Journal of Mental Retardation, 106(2)*, 113-122.

Contompasis, S. H., & Burchard, S. (2004). On the cutting edge of ethical dilemmas: reconciling an adolescent's transition to adulthood. In C. M. Vargas & P. A. Prelock (Eds.), *Caring for children with neurodevelopmental disabilities and their families: An innovative approach to interdisciplinary practice* (pp. 213-244). Mahweh, NJ: Lawrence Erlbaum Associates, Inc.

Hanley-Maxwell, C., Whitney-Thomas, J., & Pogoloff, S. (1995) The second shock: A qualitative study of parents' perspectives and needs during their child's transition from school to adult life. *The Journal of the Association for Persons with Severe Handicaps. 20,* 3-15.

MARCH 26

Cortical Vision Impairment (CVI)

Faculty Coordinators: Marie-Christine Potvin*

Guest Faculty: Jean Beatson
Susan Edelman
Marie MacLeod

Required Readings

Jan, J. (2004) An international classification of neurological visual disorders in children, http://www.aph.org/cvi/articles/jan_1.html

Groenveld, M., Jan, J., & Leader, P. (1990). Observations on the habilitation of children with cortical visual impairment. Journal of visual impairment and blindness (JVIB), 84, 11-15.

Jan, J. E., Groenveld, M. G., Sykanda, A. M., & Hoyt, C. S. (1987). Behavioral characteristics of children with permanent cortical visual impairment. Developmental medicine & child neurology, 29, 571-576. http://www.aph.org/cvi/articles/jan_3.html

For Further Reading:
Recently released:
Roman-Lantzy, Christine (2007). Cortical Visual Impairment: An Approach to Assessment and Intervention. AFB Press.

CVI Perspectives
DVD produced by American Printing House for the Blind
See http://www.aph.org/cvi/index.html

APRIL 2

Mental Health Issues for Individuals with Special Needs

Faculty Coordinators: Marty Dewees*
James Calhoun

Guest Faculty: Pat Frawley

Required Readings

Dudley, J.R. (2000). Confronting stigma within the services system. *Social Work, 45*, 5, 449-455.

Shoultz, B., Walker, P., Hulgin, K., Bogdan, B., Taylor, S., & Mosley, C. (1999). Closing Brandon Training School: A Vermont story. Reprinted from *TASH Newsletter*, 25, 3, 8-10. Syracuse, N.Y.: Center on Human Policy.

Ware, N.C., Hopper, K., Tugenberg, T., Dickey, B., & Fisher, D., (2007). Connectedness and citizenship: Redefining social integration. *Psychiatric Services,* 58, 4, 469-474.

APRIL 9

Feeding & Nutrition Issues Affecting Children with Neurodevelopmental Disabilities

Faculty Coordinators:	Marie-Christine Potvin*
	Stephen Contompasis
Guest Faculty:	Molly Holland
	Mary Kara Comeau
	Sue Offenhartz

Required Readings

Harriet Holt Cloud, H., H., & Posthauer, M., E. (2004). Position of the American Dietetic Association: Providing Nutrition Services for Infants, Children, and Adults with Developmental Disabilities and Special Health Care Needs. *Journal of American Dietetic Association*, 104 (1). Retrieved from www.eatright.org/cps/rde/xchg/SID-5303FFEA-3D52010C/ada/hs.xsl/advocacy_1737_ENU_HTML.htm (Choose bottom link)

Crist, W., & Napier-Phillips, A. (2001). Mealtime Behaviors Of Young Children: A Comparison Of Normative And Clinical Data. Developmental and Behavioral Pediatrics 22 (5).

Sleigh, G., & Brocklehurst, P. (2004). Gastrostomy Feeding In Cerebral Palsy: A Systematic Review Archive Of Disease In Childhood, 89 (6), 534–9.

APRIL 16

Multicultural Perspectives on Disability

Faculty Coordinators:	Jean Beatson*
	Mary Alice Favro
Guest Faculty:	Jacqueline Rose
	Fatuma Bulle
	Abdullahi Hassan

Required Readings

Jezewski, M. A., & Sotnik, P. (2005). Disability service providers as cultural brokers. In J. H. Stone (Ed.) *Culture and Disability: Providing Culturally Competent*

Services (pp. 31-64). Thousand Oaks, CA: Sage Publications.

NCCC (2004), Bridging the cultural divide in health care settings: The essential role of cultural broker programs. Georgetown University Center for Child and Human Development, http://gucchd.georgetown.edu/nccc/index.html

Vargas, C. M. & Beatson, J. E. (2004). Cultural Competence in Differential Diagnosis: Post Traumatic Stress Disorder and Reactive Attachment Disorder. In Vargas, C. M. & Prelock, P. A. (Eds.), *Caring for Children with Neurodevelopmental Disabilities and their Families: An Innovative Approach to Interdisciplinary Practice* (pp. 77-112). Mahwah: N.J.: Lawrence Erlbaum Associates, Inc., Publishers.

www.xculture.org
Thoroughly read this site

APRIL 23

American-Indian Concepts of Health, Unwellness and Disability

Faculty Coordinators:	Jean Beatson*
	Patty Prelock
Guest Faculty:	Carol Locust

Required Readings

Canales, M.K. (2004). Connecting to Nativeness: The influence of women's American Indian identity on their health care decisions. *CJNR, 36,* 18-44.

Joe, J. R. (2003). The Rationing of Health Care and Health Disparity for the American Indians/Native Alaskan. In B. D. Smedley, A. Y. Stith, & A. R. Nelson (Eds.), *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care* (528-551). Washington, D.C.: The National Academies Press.

Locust, C. The Piki Maker: Disabled American Indians, Cultural Beliefs, and Traditional Behavior. Unpublished monograph. Tucson, AZ: Native American Research and Training Center, College of Medicine, University of Arizona.

For Further Reading:

Locust, Carol. (1997). Counseling strategies with Native American clients. *Directions in Rehabilitation Counseling*, Vol. 9, Lesson 5, pp. 5163.

Locust, Carol. (1996). Walking in two worlds: Native Americans and the VR system. *American Rehabilitation*, Vol. 22, No. 2, pp. 2-12.

Locust, Carol. (1995). The impact of differing belief systems between Native Americans and their rehabilitation service providers. *Rehabilitation Education,* Vol. 9, No. 2, pp. 205-215.

Locust, Carol. (1989). Wounding the Spirit: Discrimination and Traditional American Indian Belief Systems. *Harvard Educational Review,* Vol. 58, No. 3, pp. 315-330.

Locust, C. (1985). American Indian Concepts Concerning Health and Unwellness. Unpublished manuscript. Supported by the National Institute on Disability and Rehabilitation Research, U. S. Department of Education.

http://gucchd.georgetown.edu/nccc

APRIL 30

Applied Assignment Presentations & Seminar Discussion

Faculty Coordinators: Jean Beatson*
Patty Prelock

STUDENTS ARE REMINDED OF THE UNIVERSITY OF VERMONT'S COMMON GROUND FOR BEHAVIOR AS A STUDENT IN A COMMUNITY OF LEARNERS

Our Common Ground

The University of Vermont is an educationally purposeful community seeking to prepare students to live in a diverse and changing world. We who work, live, study, teach, do research, conduct business or participate in the University of Vermont are members of this community. As members, we believe in the transforming power of education and agree to help create and foster an environment where we can discover and reach our true potential.

We aspire to be a community that values:

- **Respect:** We respect each other. We listen to each other, encourage each other and care about each other. We are strengthened by our diverse perspectives.
- **Integrity:** We value fairness, straightforward conduct, adherence to the facts and sincerity. We acknowledge when things have not turned out the way we had hoped. As stewards of the University of Vermont, we are honest and ethical in all responsibilities entrusted to us.
- **Innovation:** We want to be at the forefront of change and believe that the best way to lead is to learn from our successes and mistakes and continue to grow. We

are forward-looking and break new ground in addressing important community and societal needs.

- **Openness:** We encourage the open exchange of information and ideas from all quarters of the community. We believe that through collaboration and participation, each of us has an important role in determining the direction and well-being of our community.
- **Justice:** As a just community, we unite against all forms of injustice, including, but not limited to, racism. We reject bigotry, oppression, degradation and harassment, and we challenge injustice toward any member of our community.
- **Responsibility:** We are personally and collectively responsible for our words and deeds. We stand together to uphold our common ground.

As part of the Unit Faculty for the University of Vermont that prepares speech-language pathologist, teachers, and counselors as educators in school settings, the following conceptual framework is shared across educators at UVM to ensure quality learning and teaching:

Conceptual Framework

"The heart and mind of programs"

Unit faculty at the University of Vermont aspire to prepare a committed reflective practitioner, instructional leader and change agent, collaborating with other professionals to make a positive difference in schools and in the lives of all learners.

Through Reflective learning and practice, the UVM prepared educator is grounded in . . .

Constructivism

Knowledge is socially constructed through dialogue and community-based practice (constructivism).

Collaboration

Teachers and other school professionals work collaboratively to problem-solve with stakeholders (collaboration, inter-professional practice, reflective practice, excellence).

Human development & empowerment

Education facilitates development of human potential (developmentally appropriate practice, strengths perspective, empowerment).

Inclusion

All students can learn and have value in their communities (inclusion).

Multiculturalism/culturally responsible pedagogy

Learning communities demonstrate respect for and honor diversity; pursue knowledge and affirmation of our diverse cultures (multiculturalism, culturally responsive pedagogy, equity).

Equity & justice

Education should advance social justice and democracy (equity).

. . . and meets these standards - KSD Standards for Beginning Teachers and Others School Professionals in Initial Programs

- Demonstrates content knowledge and skills
- Understands learners and differences
- Understands learning
- Translates curriculum into instruction
- Creates equitable, inclusive learning environments
- Assesses student learning
- Practices culturally responsive pedagogy
- Demonstrates collaborative and interpersonal skills
- Engages in reflective practice
- Integrates technology
- Acts consistently with the belief that all students can learn
- Engages in self-directed learning and professional development for growth

Faculty beliefs have shaped their professional commitments that are expressed in Outcome Statements for Candidates.

The professional educator in **initial** preparation programs at The University of Vermont . . .

1. Knows content/subject matter, understands connectedness with other disciplines, and translates curriculum into materials and instructional strategies appropriate for subject matter and learners. (Critical Thinker)

2. Understands all learners as individuals, in the context of families and social groups, and uses standard's based instruction to create equitable safe and supportive learning environments that promote acceptance and belonging. (Problem Solver)

3. Understands learning and ways of evaluating and enhancing it, including through the application of technology. (Instructional Leader)

4. Knows social, cultural, historical, legal and philosophical context of schools in a democracy and practices equitable and culturally responsive pedagogy appropriate for subject matter and learners. (Reflective Practitioner)

5. Can create inclusive learning environments which meet diverse learning needs, incorporate and reflect all learners' experiences, and facilitate students' learning, including about their own biases and understandings. (Reflective Practitioner/Change Agent)

6. Demonstrates effective collaborative and interpersonal skills in problem-solving with students, families, colleagues and related professionals. (Inter-professional Practitioner)

7. Engages in professional development and continually examines own assumptions, beliefs and values. (Reflective Practitioner)

8. Demonstrates the belief that all students can learn and that they can take responsibility for their own learning; demonstrates high expectations for all students and takes responsibility for helping them aspire to high levels of learning. (Student Advocate)

Evidence-Based Practice Resources

Centre for Evidence-Based Physiotherapy
http://www.pedro.fhs.usyd.edu.au/CEBP/index.htm

Centre for Health Evidence (CHE)
http://www.cche.net/che/home.asp

Centre for Evidence-based Medicine
http://www.cebm.utoronto.ca/

Evidence Based Medicine Toolkit
http://www.med.ualberta.ca/ebm/ebm.htm

The Good, the Bad & the Ugly: or, why it's a good idea to evaluate Wed sources
http://lib.nmsu.edu/instruction/eval.html

OT seeker http://www.otseeker.com/

PEDro, The Physiotherapy Evidence Database http://www.pedro.fhs.usyd.edu.au/
The PEDro Scale is taken from the Frequently Asked Questions section and can be accessed at: http://www.pedro.fhs.usyd.edu.au/FAQs/faqs.htm

PEDro Scale

1. eligibility criteria were specified — no ❑ yes ❑ where:
2. subjects were randomly allocated to groups (in a crossover study, subjects were randomly allocated an order in which treatments were received) — no ❑ yes ❑ where:
3. allocation was concealed — no ❑ yes ❑ where:
4. the groups were similar at baseline regarding the most important prognostic indicators — no ❑ yes ❑ where:
5. there was blinding of all subjects — no ❑ yes ❑ where:
6. there was blinding of all therapists who administered the therapy — no ❑ yes ❑ where:
7. there was blinding of all assessors who measured at least one key outcome — no ❑ yes ❑ where:
8. measures of at least one key outcome were obtained from more than 85% of the subjects initially allocated to groups — no ❑ yes ❑ where:
9. all subjects for whom outcome measures were available received the treatment or control condition as allocated or, where this was not the case, data for at least one key outcome was analyzed by "intention to treat" — no ❑ yes ❑ where:
10. the results of between-group statistical comparisons are reported for at least one key outcome — no ❑ yes ❑ where:
11. the study provides both point measures and measures of variability for at least one key outcome — no ❑ yes ❑ where:

The PEDro scale is based on the Delphi list developed by Verhagen and colleagues at the Department of Epidemiology, University of Maastricht (*Verhagen AP et al (1998). The Delphi list: a criteria list for quality assessment of randomised clinical trials for conducting systematic reviews developed by Delphi consensus. Journal of Clinical Epidemiology, 51(12):1235-41*). The list is based on "expert consensus" not, for the most part, on empirical data. Two additional items not on the Delphi list (PEDro scale items 8 and 10) have been included in the PEDro scale. As more empirical data comes to hand it may become possible to "weight" scale items so that the PEDro score reflects the importance of individual scale items.

The purpose of the PEDro scale is to help the users of the PEDro database rapidly identify which of the known or suspected randomized clinical trials (ie RCTs or CCTs) archived on the PEDro database are likely to be internally valid (criteria 2-9), and could have sufficient statistical information to make their results interpretable (criteria 10-11). An additional criterion (criterion 1) that relates to the external validity (or "generalisability" or "applicability" of the trial) has been retained so that the Delphi list is complete, but this criterion will not be used to calculate the PEDro score reported on the PEDro web site.

The PEDro scale should not be used as a measure of the "validity" of a study's conclusions. In particular, we caution users of the PEDro scale that studies which show significant treatment effects and which score highly on the PEDro scale do not necessarily provide evidence that the treatment is clinically useful. Additional considerations include whether the treatment effect was big enough to be clinically worthwhile, whether the positive effects of the treatment outweigh its negative effects, and the cost-effectiveness of the treatment. The scale should not be used to compare the "quality" of trials performed in different areas of therapy, primarily because it is not possible to satisfy all scale items in some areas of physiotherapy practice.

Notes on administration of the PEDro scale:

All criteria — **Points are only awarded when a criterion is clearly satisfied**. If on a literal reading of the trial report it is possible that a criterion was not satisfied, a point should not be awarded for that criterion.

Criterion 1 — This criterion is satisfied if the report describes the source of subjects and a list of criteria used to determine who was eligible to participate in the study.

Criterion 2 — A study is considered to have used random allocation if the report states that allocation was random. The precise method of randomization need not be specified. Procedures such as coin-tossing and dice-rolling should be considered random. Quasi-randomization allocation procedures such as allocation by hospital record number or birth date, or alternation, do not satisfy this criterion.

Criterion 3 — *Concealed allocation* means that the person who determined if a subject was eligible for inclusion in the trial was unaware, when this decision was made, of which group the subject would be allocated to. A point is awarded for this criteria, even if it is not stated that allocation was concealed, when the report states that allocation was by sealed opaque envelopes or that allocation involved contacting the holder of the allocation schedule who was "off-site".

Criterion 4 — At a minimum, in studies of therapeutic interventions, the report must describe at least one measure of the severity of the condition being treated

and at least one (different) key outcome measure at baseline. The rater must be satisfied that the groups' outcomes would not be expected to differ, on the basis of baseline differences in prognostic variables alone, by a clinically significant amount. This criterion is satisfied even if only baseline data of study completers are presented.

Criteria 4, 7-11 *Key outcomes* are those outcomes which provide the primary measure of the effectiveness (or lack of effectiveness) of the therapy. In most studies, more than one variable is used as an outcome measure.

Criterion 5-7 *Blinding* means the person in question (subject, therapist or assessor) did not know which group the subject had been allocated to. In addition, subjects and therapists are only considered to be "blind" if it could be expected that they would have been unable to distinguish between the treatments applied to different groups. In trials in which key outcomes are self-reported (eg, visual analogue scale, pain diary), the assessor is considered to be blind if the subject was blind.

Criterion 8 This criterion is only satisfied if the report explicitly states *both* the number of subjects initially allocated to groups *and* the number of subjects from whom key outcome measures were obtained. In trials in which outcomes are measured at several points in time, a key outcome must have been measured in more than 85% of subjects at one of those points in time.

Criterion 9 An *intention to treat* analysis means that, where subjects did not receive treatment (or the control condition) as allocated, and where measures of outcomes were available, the analysis was performed as if subjects received the treatment (or control condition) they were allocated to. This criterion is satisfied, even if there is no mention of analysis by intention to treat, if the report explicitly states that all subjects received treatment or control conditions as allocated.

Criterion 10 A *between-group* statistical comparison involves statistical comparison of one group with another. Depending on the design of the study, this may involve comparison of two or more treatments, or comparison of treatment with a control condition. The analysis may be a simple comparison of outcomes measured after the treatment was administered, or a comparison of the change in one group with the change in another (when a factorial analysis of variance has been used to analyze the data, the latter is often reported as a group × time interaction). The comparison may be in the form hypothesis testing (which provides a "p" value, describing the probability that the groups differed only by chance) or in the form of an estimate (for example, the mean or median difference, or a difference in proportions, or number needed to treat, or a relative risk or hazard ratio) and its confidence interval.

Criterion 11 A *point measure* is a measure of the size of the treatment effect. The treatment effect may be described as a difference in group outcomes, or as the outcome in (each of) all groups. *Measures of variability* include standard deviations, standard errors, confidence intervals, interquartile ranges (or other quantile ranges), and ranges. Point measures and/or measures of variability may be provided graphically (for example, SDs may be given as error bars in a Figure) as long as it is clear what is being graphed (for example, as long as it is clear whether error bars represent SDs or SEs). Where outcomes are categorical, this criterion is considered to have been met if the number of subjects in each category is given for each group.