Diversify your experiences. How else will you know what you like and don’t like?
How else will you know what you want to do and in what setting?

I think exposing yourself to a variety of people and environments is even more
important for individuals interested in pursuing a career in healthcare. To begin, it’s
necessary to know what a patient experiences. A great way to heighten your sensitivity to
another is to live in someone else’s shoes and deal with every aspect of the patient care
process, from billing to pharmaceuticals. Having completed a SNAP application enables
you with a nuanced understanding of food insecurity.

Moreover, healthcare depends on teamwork. There’s not enough time or money in the
world to become a professional in every specialty. Members within an interdisciplinary
healthcare team bring forth their unique perspectives and expertise to an individual’s
care. Effective teamwork is facilitated when each team member appreciates the value
that others contribute. Students who are exposed to clinicians outside their field of
study are advantaged with not only a stronger grasp of their personal role within
healthcare, but also a refined ability to interact effectively with other clinicians in their
future practices.

Through the generous time of Children’s Specialized Hospital’s clinicians, I’ve been
fortunate enough to dip my toes into other healthcare fields in addition to nutrition,
namely rehabilitation technology and animal-assisted, recreational therapy. This
magazine is an accumulation of experiential wisdom passed down and personal
narratives matched to names. I hope in reading this, you’ll leave with a greater respect
for the clinicians who dedicate their lives to pediatric rehabilitation and specialty
pediatric care.

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DEDICATION

I am indebted to the gracious time that Katie Ahlers and Burton, Janice Baunach, Theresa Defosse, Paul Guida, and David Savage shared with me. Thank you all so much for answering my many questions and welcoming me to shadow you. Special thanks to Jill Harris, Claire Marchetta, and Jessica Polk for their unconditional support and eagerness to help!

A DAY WITH JANICE BAUNACH, RD, CLINICAL DIETITION III

THE PAST, PRESENT, AND FUTURE: A LOOK INTO JANICE BAUNACH'S CAREER AND THE TRAJECTORY OF THE DIETETICS FIELD

How to Become a Dietitian:

The career path to become a registered dietitian (RD) has traditionally required a minimum of five years of higher education and training. The most direct path begins by taking the required nutrition, psychology, chemistry, and biology courses at a four-year university with an ACEND (Accreditation Council for Education in Nutrition and Dietetics) accredited DPD (Didactic Program in Dietetics). Following a DPD, through a process analogous to medical residency matching, a dietetic student applies to be matched to a DI (dietetic internship) for approximately one year of clinical training.

While a DPD verification statement, which confirms completion of a DPD, and an undergraduate bachelor’s degree do not expire, dietetic internship programs often place a recency of education requirement for admissions. Most dietetic students plan on completing their DI immediately following graduation from a DPD, however. DI programs are few and competition is high. The national match rate averages 50%, and it is common for students to apply twice before completing their training.

Each DI is unique in its focus and rotations; many DI programs are hospital- or university-based, but distance programs, where an individual finds their own preceptors (“mentors”) to fulfill clinical training requirements, are increasing in prevalence to compensate for the low match rate. Though flexible and convenient for individuals who are interested in traveling to multiple states for their training, distance programs are not preferred by some applicants. Traditional programs offer their unique advantages as well. Traditional programs vary among themselves in focus – clinical, community health, or food service management – but they all generally incorporate continuing education or graduate-level classes, a variety of clinical rotations in robust healthcare settings, and staff-relief experiences. Though they are in the process of training, dietetic interns maintain a full-time schedule that conforms to that of the rotation unit’s staff, likening them to a full-time clinician later into their internship experience.
Following a DI, dietetic interns sit for the examination for registered dietitians to qualify for licensure as an accredited registered dietitian. The term ‘nutritionists’ is also used to describe dietitians, however, with the growing field of nutrition, health coaches and other practitioners have begun recognizing themselves as ‘nutritionists.’ ‘Dietitian’ is the most specific title for an individual with licensed credentials to practice nutrition counseling. In addition to healthcare settings, dietitians also work in supermarkets, teach in community health programs [i.e. WIC, SNAP farmers’ markets] advocate for public policy changes, and advise food manufacturers.

Janice Baunach, Pediatric RD:

When running track in high school, Janice Baunach developed an interest in eating for performance. Her undergraduate studies at Simmons College led her to study Human Nutrition, with a hope to pursue sports nutrition. During her dietetic internship at the University of Rhode Island, Janice had a short rotation with a sports dietitian. Following her DI, she relocated to the University of Pittsburgh, where she received her master’s degree in Exercise Physiology. Soon afterwards, Janice traveled around Asia while teaching a health and wellness course for a semester in Sea program through UPitt. Her initial positions involving patient care took place with Early Interventions, the Jersey Shore Wellness Center, and the Visiting Nurse Association (VNA) of Central Jersey. But for the last seventeen years, she has worked at Children’s Specialized Hospital. While her practice is outside the realm of sports nutrition, Janice maintains an active lifestyle as a cyclist.

Currently, Janice’s role is divided between two Children’s Specialized locations: the outpatient clinic at Hamilton and the outpatient and long-term care facility at Toms River. Some patients she sees include children with sensory aversions or feeding behavior issues. Sensory aversions may involve hypersensitivity to odor, texture (sliminess, crunchiness), or visual (volume, colors). Feeding behavior issues include oral dysphagia, limited variety of foods, consistency of foods, over-pickiness, and undereating. Other patients include children with cerebral palsy or those who have demonstrated a failure to thrive.

A unique responsibility is greeting the patients and obtaining their height and weight, which is more traditionally done by nursing staff. Janice directly uses these measurements and gains additional time to speak with her patients’ parents.

The future of dietetics:

With time and a new generation, the medical field will be more accepting and respectful of dietetics. Jan Marshall, RD, Clinical Nutrition Coordinator at Children’s New Brunswick inpatient facility, is currently working to enable Children’s dietitians with order-writing privileges.

For those interested in pursuing a career in dietetics and pediatrics, Janice offers a few tips:

1. Useful certifications to consider: Certified Diabetes Educator (CDE), Renal/Kidney, Pediatrics. Take note of the word “consider” – Janice no longer renews her CDE because the patients she works with at Children’s Specialized Hospital tend to not have diabetes. Similarly, she found no need to renew her board certification in pediatric nutrition. The lack of reimbursement by Children’s for taking the certification exam indicates to her that its value is not high enough to merit a renewal. Janice is satisfied about having passed it once to confirm that she has the adequate knowledge, but some of the materials that are tested, such as acute situations (i.e. gunshot wounds), are irrelevant to her practice and not worth the renewal process.

2. An outpatient clinical setting is the best of both worlds for her. Janice has the advantage of working with other clinicians without the entrepreneurial work that a private practice entails. At the same time, she faces less of the bureaucracy and bookkeeper care that inpatient settings may involve. Outpatient clinical provides more avenues for her to apply her own creativity and personal nutrition philosophy when counseling.

3. It’s important to learn about cultural views on foods and health to better meet and understand patient needs. One population that makes up a large proportion of Janice’s patients is the Orthodox Jewish community; consequently, Janice has found it necessary to be very familiar with kosher dietary regulations, even creating a separate list of kosher certified supplements to recommend.

4. If you are interested in working in pediatric nutrition, there is no need to complete a pediatrics-focused dietetic internship. Not only did they not exist when Janice was a nutrition student, but most of the learning related to pediatric dietetics is accrued on the job.
What do dietetics, marketing, and criminal investigation have in common?

One-way mirrored observation rooms.

On June 25th, I had the opportunity to observe two feeding team evaluations when shadowing Jonice. Feeding team evaluations are conducted by a team of clinicians (Speech Language Pathologist, Occupational Therapist, Psychologist, staff member, and Dietitian) to evaluate a patient's feeding experience. During an evaluation, the feeding team and parents will discuss medical history, feeding history, feeding concerns, developmental milestones, and a three-day, parent-reported dietary intake. Afterward, the clinicians will leave the room to observe the child eating preferred and non-preferred foods from behind the one-way mirror. The team will convene before discussing findings and therapy recommendations with the parents.

The first feeding team evaluation involved a two-year-old patient who, per her three-day dietary intake, seemed to be consuming minimal solid food. Despite her lack of food intake, however, her height and weight trended normally and she did not demonstrate failure to thrive. After a discussion with her parents and observation, the clinicians recognized a behavioral issue with eating. The patient needed to be weaned off of breast milk; she received nearly all of her caloric needs from breastfeeding, and consequently, barely ate real food.
Child-led weaning was attempted by her parents, but minimal eating became worrisome and breastfeeding began again, which disrupted the process of introducing solid foods. Breastmilk alone is not nutritionally sufficient for continued growth. For example, it does not supply the iron needed to meet the recommended daily level of intake for a two year old child.

The feeding team recommended to the parents to wean their child off of breastfeeding and persist through the expected crying. Doing so will better establish a hunger cycle, enabling the patient to be more accepting of a greater variety of foods.

The patient in the following evaluation was a three year old boy whose parents reported him to be a picky eater. He demonstrated difficulty in transitioning to solid foods, only wanting to eat pureed foods. While eating snacks from home, however, the patient took interest in snacks that represented a variety of textures, from pureed to crunchy. The evaluation indicated, once again, a behavioral issue. Therapy with a psychologist was recommended to teach the patient to be more open and flexible towards trying new experiences.

A patient who was scheduled for a tube feeding evaluation did not show up to her appointment despite a phone call confirmation with Janice earlier that day. I related this event to an earlier conversation with a local private practice dietitian, Dr. John Bock, who specializes in nutrition therapy for bariatric surgery.

Tension exists between the desire to increase nutrition counseling access and to preserve the value of the profession. Increasing availability of care, whether by increasing insurance coverage of nutrition counseling or the number of licensed dietitians, risks increased no-shows and decreased salary. It’s possible to de-value a service when it is too easily accessible. Moving forward, the Academy of Nutrition and Dietetics (AND) will require the minimum of a master’s degree prior to taking the examination for registered dietitians in hopes to elevate the respectability of the profession and increase salary. This change will soon mimic the medical school model, where a dietetic internship and graduate-level education will be combined into one coordinated program, eliminating the need for an undergraduate DPP. At the same time, this change will require many years to be fully implemented across the United States. Nutrition and health are urgent issues that need to be addressed today. What are ways in which we can reconcile this tension?
THE RHT TRIO

THERESA DEFOSSÉ
PAUL GUIDA
DAVID SAVAGE

BEHIND THE SCENES

A LOOK INTO PATIENT CENTERED CARE

with Theresa Defosse

I remember when my grandmother sat in her wheelchair, she lacked the strength to stay seated upright. To prevent her from sliding and risking a fall, we used a makeshift belt to strap her into her seat. Grandma was petite, and the chair was too wide.

“It’s not common practice to do fittings in a hospital,” Theresa tells me.

Here at Children’s Specialized Hospital, the Rehabilitation Technology (RHT) team conducts detailed evaluations regarding patient seating, positioning, and mobility needs to ultimately create highly specialized equipment that enhance patients’ strengths, abilities, and mobility. Examples of the equipment that are tailored include manual and power wheelchairs, custom molded seating systems, supportive stands, adaptive bath equipment, and adaptive strollers.
Though specialized and custom-fit equipment such as these are costly, Theresa explains that patients pay a daily rate which covers equipment costs. “Insurance may have to pay more sometimes, but the hospital doesn’t get any reimbursement.”

Theresa is one of the three RHT specialists at CSH’s New Brunswick location, and plays a clinical role by working closely with patients. She has been at CSH for 26 years, reporting, “This was my first full time job out of college.” I spent one afternoon with Theresa and observed what patient fitting sessions look like.

**SIDE-STRETCHER FITTING FOR AN INFANT WITH SCOLIOSIS**

On the quiet infant and toddler floors, Theresa and a nurse gently fit an infant for a side-stretcher made of foam. The side-stretcher’s purpose is to prevent the patient’s scoliosis from progressing after a recent surgery on his side. Theresa is satisfied with the curvature of the foam pieces. “Next step is to make the foam waterproof – I do that with a spray.”

**WHEELCHAIR FITTING FOR A PATIENT WITH SCOLIOSIS:**

An older patient with scoliosis was transitioning from a push-assist wheelchair to a self-propelling, which would enable him to be mobile without the assistance of another person. His physical therapist (PT) hoped to get him on his feet again, walking, and the new wheelchair allows him to take steps while sitting, propelling his chair while strengthening his legs.

When the patient arrived, Theresa and the PT helped the patient into his new chair. Theresa adjusted the positions of multiple parts and accessories, including the arm rests, seat width, laterals, back rest, and back cushion. Given the patient’s scoliosis, a normal pillow would not adequately enable him to sit upright with a proper posture. Theresa grabbed a few foam pieces from the RHT workroom to piece a custom-fit cushion that she would later sew and refine.

“How does that feel? Can you take a few steps?” Every component of the wheelchair is customizable, and Theresa removes the foot rests. Sitting in a stool, she shows how she would like the patient to walk his feet while he sat in his chair. “Don’t bend your right knee too much,” she advised while demonstrating the ideal posture. The patient’s face lit up as he slowly inched from one side of the room to the other.

In addition to mobility, comfort is an important consideration. “Let’s make sure we check for seat sores and redness tomorrow,” she nods to the PT. It’s not always clear whether a patient’s confirmation that a seat “feels good” accurately reflects how he feels or is solely an agreement to the responses from clinicians around him. “I’ll get the chair to you by dinner time, okay?” Recognizing the patient’s level of anticipation, Theresa extends her day to ensure a same-day delivery.

Back in the RHT workroom, she gets to work by cutting memory foam-like fabric for the custom-fit cushion.
I knock on the door labeled ‘Rehab Tech Workroom’ and it opens to Paul Guida’s smiling face. “Hi Hannah, good morning! Come on in.”

Inside, bins of screws and nails are neatly shelved. Tools line the platform that a black power chair sits on. Music from the 50’s and 60’s plays softly.

Paul is the undercover magician doing the background work for the Rehabilitation Technology (RHT) team. “In the morning, I come into work to cleaned equipment that’s all lined up outside. I restock them and then begin on work orders.”

A carpenter by trade, Paul has never received any formal training or attended vocational school; rather, he has learned everything on the job. Prior to CSJ, he spent 34 years as a cabinet maker until the company shut down. “I was looking for a new job, and found an ad in the paper for a carpenter at Children’s. Can you believe it? I’ve been here for five years.”

Once at CSJ, Theresa Defosse, Rehabilitation Technology Coordinator, provided some training, but Paul has continued to accrue most of his skills by learning on the job. “Nobody went to school for this because the field didn’t exist then. With the way things are developing and progressing, electrical, robotic, engineering, or advanced technology experience will be needed.”

Custom-made back cushion in the process for a patient with scoliosis.
To provide an example of the intersection between rehabilitation technology and engineering, Paul recounts a wheelchair that was made by the inventor of the Segway. “It can transform into a Segway, so the patient is standing up on two wheels!”

We begin to make some seating and structural adjustments to the power chair in front of us. The chair is for a two-year-old patient with a halo brace, a medical device that is screwed into the patient’s head to stabilize both the head and neck. “The patient is a lefty, so I moved the joystick to the other side of the chair.”

Paul hands me the left strap for the chest restraint and kindly invites me to help with the screws. As I fumble with the screwdriver, Paul begins with the seatbelt. “Sometimes I need to adjust the maximum speed of the chairs because the kids go so fast!”

Unlike manual wheelchairs, power chairs do not require the users’ assistance or physical strength to be used. Paul points to a battery box under the chair. “Security will come by to pick up the cart of chargers and charge the batteries for each chair every night.”

Given that CSH’s patients and their needs are so unique, the work that Paul does is highly individualized. If there are issues with the equipment or the child grows and requires adjustments, the parents will bring the chairs back in. Similarly, creativity and ingenuity are required. David Savage, the third member of the RHT trio, recently devised a contraption that stretches a patient’s vertebral discs slightly before a spinal cord surgery.

Paul quickly wrapped up the remaining adjustments for the power chair and I headed back to the research office. Later at my desk, I find an email from Paul thanking me for my help and recalling the offhand remark I made about building IKEA furniture with my grandfather. Amidst the footsteps chasing after Burton and the beeping of bed alarms, Paul Guida’s quiet strength continues to hum along to music in the RHT Workroom, humbly influencing the mobility of CSH patients, one chair at a time.

RHT ABROAD
WITH DAVID SAVAGE

Known to the research department as a singer, drum Solos provider, backrubbermaker, and wheelchair forager, David Savage works professionally as the Assistive Technology Specialist in the Rehabilitation Technology (RHT) department. His background involved stage work on Broadway (scenery and rigging), but he made the change to RHT because it offered “better hours and benefits.” In 1999, he began working with wheelchairs, and his interest in international service originated shortly after in 1992, at the RESNA (Rehabilitation Engineering and Assistive Technology Society of North America) conference in Toronto.

There, he met Ralf Hotchkiss, founder of Whirlwind Wheelchair, an organization that teaches people in other countries how to build and maintain wheelchairs for themselves. Dave also met David Werner, author of Where There is No Doctor and Disabled Village Children, two books that outline considerations, knowledge, cultural competency skills, and strategies for international medical service. He even joined a special interest group involved with service projects: this same group holds a cushion-making competition using local resources. Dave has served as a volunteer clinician on two international service trips, and recounted his experiences to me one afternoon.
HAITI
1996

Managed by a former priest in Port-au-Prince, Haiti, St. Joseph’s Home for Boys serves as a temporary living quarter for twelve orphaned boys and a bed-and-breakfast for guests. The twelve boys originally chose to stay in one room, keeping the other rooms for guests, including Dave himself.

Very comfortable with spontaneity and a lack of planning, Dave bought the airfare and hoped someone would pick him up. Despite a terrific accent, he doesn’t speak French, either.

His resourcefulness and ability to improvise served him well in his service work. Lined by broken asphalt or gravel roads, Haiti was not a wheelchair-friendly place.

MAYBE IT’S FUN TO HELP PEOPLE, AND THAT’S OKAY.

Prior to flying, Dave smuggled a wheelchair onto a plane, with old hospital linens in the seat. “Anyone can bring a wheelchair onto a plane.” In his suitcase was a case of expired Ensure. “But they were using four-year old expired penicillin at the hospice in Haiti, so it seemed okay.”

Dave repurposed junk wheelchairs to make them usable and fashioned a pair of crutches from broomsticks, old flip-flops, and wire ties.

When asked what made him decide to go, he thought for a minute. “Maybe it’s fun to help people, and that’s okay.”

ECUADOR
SEPTEMBER 2017

The same adaptability and ingenuity that assisted Dave in Haiti were just as valuable nearly twenty years later during his second service trip to Ecuador. “I can speak Spanish – I studied Spanish and German in high school – but I can’t understand it. It didn’t click with me as anything real until immersion.”

The service trip was planned for eighteen days, but due to Hurricane Irma, the shipment container holding all of the rehabilitation equipment was “stuck in red tape.” Not even bribery could circumvent the bureaucratic regulations delaying their work.

To make the most of their available time, Dave and the other clinicians worked at a school, teaching the locals “how things worked but not so much why. There wasn’t enough time.”

Given the lack of RHT specialists in the country, Dave taught how to make minor adjustments and to reposition equipment. He prepared for the incoming equipment by fitting some patients ahead of time.

While some cultures and communities may not be very accepting of foreign aid and innovation, Dave found that the Ecuadorians “completely” accepted the equipment, “More so than here. We were the experts from far away.” In a photo he pulls up, he gestures to a photo of a boy in tears. “He just seems thrilled to have it,” referring to the new splint in hand. Scrolling through his archives, he stops at another photo of a man in a wheelchair on a dirt road. Smiling, Dave recalled how rewarding it was to see the man, whom he had fitted for a wheelchair on the road by himself, mobile and independent.
Ecuador lacked resources and specialists, so Dave never met a patient with an actual diagnosis. “I never knew the true problem. This made it more challenging to know what was needed to help and what would be most appropriate. We had to think on our feet.” A microwave was used to heat a splint to be more malleable. Local resources were repurposed. Old clothing was sewed to fabricate a splint and school desks were pushed together to serve as a patient bed table.

Just before the eighteen-day trip was scheduled to end, the shipment container finally arrived. “People expected full wheelchairs, but that was actually when the real work began.” The wheelchairs needed to be built and fitted for. Parents carried their children into the local Lion’s Club facility, which acted as the clinicians’ headquarters. With limited time, a streamlined routine care process was quickly established. “See the kid, see what they needed, get the equipment.” Initially, the work was easier. They saw patients who had already been evaluated; the equipment was prepared in advance and minimal adjustment work was required. As resources dwindled and new patients arrived, the work became more challenging.

Before I left, Dave pulled up photos of the foods he saw and ate while in Ecuador. “Ecuador nutrition. Actually, maybe not. The service trip team was probably given more meat than the locals usually eat.”

Learn more about the organizations mentioned or other international organizations:

- RESNA: https://www.resna.org/
- Whirlwind Wheelchair: https://whirlwindwheelchair.org/
- David Werner: http://davidbwerner.info/
- St. Joseph’s Home for Boys: http://heartswithhaiti.org/haitian-partners/st-joseph-home-for-boys/
- Eleanor’s Project: http://www.eleanoresproject.org/
- Lucy’s Fundacion Manos de Agua: https://www.youtube.com/watch?v=eqRtq3gdsho
- Mission Emmanuel, Dominican Republic: https://www.facebook.com/MissionEmmanuelIDR/
- Project Hope: http://www.projecthope.org/?_ga=2.181025134.817313520.1529589650-1581070902.15295896508_ga=1.140693126.1529589660.EAIaIQobChMIlzY4u_Xk2wIVTluGChtRQCaEAAAYASAAEglvA_D_BwE

Q&A WITH KATIE AHLERS AND BURTON

Katie Ahlers is a senior recreational therapist and handler of Burton, Children’s Specialized Hospital’s facility golden retriever. Katie sat down with me to share about her work and Burton’s role at CSH.

WHAT DOES RECREATIONAL THERAPY LOOK LIKE?

“We use recreational activities to address a physical goal that the patient is working on. For example, if they’re working on strength, endurance, or balance, they can go outside and play basketball. To address cognitive skills, we can play card or board games in the rec room.”

HOW DID YOU BECOME A RECREATIONAL THERAPIST?

“Growing up, I had jobs in camps and knew that I always wanted to work with kids. At first, I pursued education, to teach health and physical education. During a sophomore year field experience, I observed a Phys. Ed. class at an elementary school and realized I didn’t want to work with such large groups of children on a daily basis. I talked with my advisor to see what areas would fit me. I was a former athlete and I wanted to find something in a similar field with classes that overlapped with the ones I had been taking for Phys. Ed. We came upon recreational therapy. The more I got into it, the more I enjoyed it.”
(cont’d)

"To become a recreational therapist, you get a four-year bachelor’s degree while focusing on a branch of recreational therapy. I concentrated in Recreation Administration, and I’ve been at CSH since graduating from school. This is all I know."

WHAT IS MOST REWARDING ABOUT WHAT YOU DO?

"Definitely the smiles on the kids’ faces, but also having a work buddy. It’s a rewarding job."

HOW DID BURTON COME TO CSH?

"Burton was trained at Canine Assistants in Georgia. I had never thought I’d be working with animals in my career – I knew that hospitals had dogs that visited – but after the visiting dog therapy groups stopped coming to CSH, I began the appeal process to have a facility dog in early 2017. I drew from research to support the positive effects of dogs on anxiety and stress. These are the general benefits of dogs, but I’m now interested in seeing research on how Burton’s presence in session can increase motivation, shorten patient stay, and promote progress."

DID YOU HAVE ANY FORMAL TRAINING WITH BURTON PRIOR TO HIM STARTING WORK, AND WHAT WAS HIS ADJUSTMENT PROCESS TO CSH LIKE?

"I spent one week in Georgia, training with Burton at Canine Assistants, before bringing him here. Jennifer Arnold, at Canine Assistants, uses a ‘Bond-Based Choice Teaching’ approach, which focuses on developing the communication and relationship between a canine and human over teaching a list of tasks.

Burton’s been here for about eight months now. It took him about two to three months to adjust to CSH. He showed some signs of stress, but now he’s comfortable and can’t wait to come into work. I have another dog at home. He’s a Boxer, about two-three years older, and he took about one week to adjust to Burton. They’re best buds. They sleep together and cuddle. My Boxer isn’t as active as Burton, especially with this heat, but Burton always wants to play!"

ARE THERE CHARACTERISTICS OF BURTON’S PERSONALITY THAT MAKE HIM PARTICULARLY SUITABLE FOR HIS WORK?

"Burton has a calm disposition. He’s sensitive to responses from kids, particularly their emotions. He’s capable of providing comfort but is also a goofball. His approach to patients changes if they’re stressed out."

"SINCE I GOT BURTON, EVERYTHING GOT A MILLION TIMES BETTER."

""
(cont'd)

“During last week’s drum group, he was so chill. He was curious for about five to ten minutes, but as he is right now,” she gestured to Burton asleep by the office chairs around us, “he laid on the floor for the rest of the session. Burton’s capable of adjusting to new environments and of knowing that it’s okay, he’ll be safe.”

WHAT DOES BURTON’S WORK LOOK LIKE?

“We have one-on-one scheduled sessions with the kids. Activities range from fetch, scavenger hunts, petting if they’re working on reaching, walks inside and outside of the hospital, support and comfort, and free-time interactions. The number of scheduled sessions varies daily, but there are always free time interactions. Burton’s allowed to be everywhere except the cafeteria and food pantries.

Aside from our creativity, there are no resources to figure out how to involve him in a session. Just the other day, we came up with a “keep away” rope. The patient was working on running and had to dangle the rope ahead of Burton, making sure Burton never caught onto the rope.

Sessions with Burton always require two staff members to make sure the situation is comfortable and safe. There’s one staff member to focus on the patient, and I focus on Burton.”

DO YOU PLAN AHEAD WITH THE OTHER THERAPISTS TO PREPARE FOR WHAT HAPPENS DURING A SESSION?

“Some planning of what’s going to happen occurs, but the level of planning varies. If you’re going outside, there’s much more planning in advance because of the forms that need to be signed. Once you see the patient, as well, you also need to adapt to how they’re feeling that day. We’re always thinking on our feet, being flexible. It’s all patient-centered work.”

HOW HAS YOUR WORK CHANGED SINCE GETTING BURTON?

“Since I got Burton, everything got a million times better, and it definitely got more rewarding. Even though nobody says hi to me anymore, that’s okay, because it’s all about Burton and he’s just a positive impact on everyone who comes across him.”
IMPROVING LIVES.
CHANGING FUTURES.

A world where all children can reach their full potential.