Outcomes/ Best Practices Committee Discussion Call Summary

Tuesday, August 28, 2018

12:15-1:00 pm EDT

DISCUSSION TOPIC: Ideas, strategies, and clinical rationale for use of Aquatics in the Pediatric Population

1. Introductions

   IPRC member organizations who participated in the discussion

   - Blythedale Children's Hospital
   - Children's Healthcare of Atlanta
   - Cleveland Clinic
   - Good Shepherd Rehabilitation Network
   - HSC Pediatric Center
   - Joe DiMaggio Children's Hospital
   - Kennedy Krieger Institute
   - Cindi Hobbes, IPRC Director and Facilitator

2. Group Discussion:
   a. What population(s) have you experienced the most success with this treatment medium?
      - Autism, Guillain-barre syndrome, mitochondrial disease – has not found any population to be inappropriate
      - Chronic pain, Complex Regional Pain Syndrome
      - Torticollis, Selective Dorsal Rhizotomy (OP protocol)
      - Juvenile rheumatoid Arthritis, Osteogenesis Imperfecta

   b. What populations have been most challenging to treat in the pool? Other challenges?
      - Children with ataxia/ those that fixate at the hips
      - Children with decreased cognition or impulsivity, high spasticity, high tone
      - Amplified Pain
      - Seizure disorders
      - Fluctuating Pool temperature
      - Respiratory compromise/ those at risk for aspiration

   c. Problem Solving/Treatment ideas for these challenges?
      - Use water gait belts/noodles for upright control
      - Warmer water will help manage spasticity/tone
      - Try proprioceptive activities for kids with dystonia before functional activities

        -weight bear on floatation device

        -ankle/wrist weights

-pushing/pulling on walls
-sensory activities prepare arousal and manage tone

- Active Kicking, bilateral coordination activities
- Use the resistance of the water to achieve trunk rotation
- Use laminated charts/activities to create a picture schedule and secure it to a kickboard so it can be in the pool
- Reinforce safety rules (Examples)
  - No Running in Pool Area
  - Therapist must get into water first
  - Must ask the adult who brought you if it is safe/permission to get into the water

d. What is the clinical rationale used for selecting aquatics vs. land based therapy?

- Is there something that can be achieved in the pool that cannot be achieved on land?
- Use the properties of the water to achieve your desired goal (buoyancy, resistance, ease of movements)
- Is there a change in status on land after engaging in therapy in pool? If so, continue. If not, discontinue.
- Pool can be a way to engage/motivate children in therapy – especially for those who are have had therapy for a long time
- Can try pool if not making progress on land
- Need to know your philosophy for treating in the pool
  -Therapeutic pool/handling
  -Assisting with learning to swim

e. How do you determine frequency for aquatic therapy? What are the determining factors? Strategies used to define an episode of care?

- ORG A: Each aquatic episode is 8 weeks. If therapist feels child would continue to benefit, they can return in 6 months.
- ORG B: Typically 8-10 weeks
- Some organizations getting push back from families and physicians for longer episodes/continued pool therapy.
- Organizations working to transition children to HEP and to community pools for extended follow through. They train family members in the pool during sessions so they are confident to carry over in community.
- Can be challenging to find appropriate, affordable, community pool options in some communities.

f. What special considerations/inclusion/exclusion criteria for aquatic therapy are used at your organization?

- Continence: Some orgs require continence so only older children are able to receive aquatic therapy. Some do not require continence and use disposable

    swim diapers and tight reusable swim diapers to contain any fecal incontinence.
  - Traches – exclusion criteria for some organizations. Others have specific protocol for those clients (Respiratory therapist poolside).
  - Seizure disorders – must be well managed for inclusion in the pool.

g. What disciplines hold treatment sessions in the pool? Co-treats? Group sessions? Scheduling trends?
  - Most organizations have PTs or PTAs primarily as pool therapists. Some OTs and Rec Therapists as well. * Discussed the need to document discipline. There is no "Aquatic Therapist"
  - Many organizations coordinating disciplines for dressing/ADL sessions before or after aquatic session. Coordinate with nursing staff for inpatients so that child does not shower/dresses appropriately for pool.
  - Cancellations rates: Increased rate of cancellations noted for pool sessions vs. land sessions (for illness and inclement weather); Increased cancellations during summer months (suspect due to greater access to community pools)
  - Combat cancellations with Strict Participation agreement
  - Most organizations providing 1:1 therapy.
  - Groups: CIMT groups in pool (typically land and aquatic based), chronic pain groups (3 week sessions), water aerobic/water yoga groups, relaxation group, autism groups (school based group)
  - Co-treats in the pool are infrequent – only for specific cases

h. How do you engage family members/caregivers in aquatic therapy sessions?
  - Invite family members into the pool (especially as nearing discharge from pool)
  - Provide HEP for carryover into community
  - Allow families to take photos, videos of sessions/activities

i. Is there any special documentation used for these sessions?
  - What properties of water were used therapeutically in session
  - Therapeutic approach to session

j. What codes are being billed for aquatic sessions?
  - Ther Ex
  - Gait training
  - Aquatic Therapy

Summary compiled by: Cindi Hobbes