

State Policy

Update

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Safe Driving Bill in Massachusetts Recognizes the Value of OT

■ M. Eleanor Meyer, MS, OTR/L

On July 2 Massachusetts Governor, Deval Patrick, signed into law legislation, crafted with the assistance of multiple interested parties including the Massachusetts Association for Occupational Therapy (MAOT), that will impose stricter limitations on cell phone use and license renewal and allow for immunity to health care providers reporting unsafe drivers.

In response to a series of fatal car accidents in the state caused by impaired drivers, MAOT stepped forward to offer its service in helping to file legislation that would better identify drivers at higher risk of causing accidents due to cognitive or physical impairments. MAOT proposed the formation of a special commission to study how physical and cognitive impairments may affect the ability to operate a motor vehicle. Led by Bill Shea, OTR/L and Dina Flannery, OTR/L the association proposed the development of programs within the registry to evaluate the impaired driver, including standards of what is an adequate evaluation. Also included in the bill were dissemination and availability of alternate means of transportation for seniors, driver re-education programs for impaired drivers, as well as immunity for occupational therapy practitioners who report unsafe drivers. License renewal timelines and methods,

including online versus in-person, were reviewed as well. As the legislative process progressed, some of these initiatives were dropped and the bill was combined with another bill directed at restricting cell phone use while driving.

affect that person's ability to safely operate a motor vehicle," (2009 MA H.B. 4795) may file a report to the registrar requesting medical evaluation of the individual. The report must include observations or evidence of the

The final bill is a political and professional compromise and a significant act in recognizing the value occupational therapy has to the well-being and safety of the residents of Massachusetts.

Taking effect October 2010, drivers of all ages will be banned from texting which includes e-mail, Internet searching, and other non-calling activities on a phone, laptop, or hand-held electronic device while driving or waiting at a traffic stop. Drivers 75 and older will be required to renew their licenses in person every 5 years, as opposed to the current law, which is every 10 years. Renewals must be done in person at a registry office, and individuals must pass a vision test administered by the registry or provide a vision screening certificate signed by an optometrist or ophthalmologist.

Health care providers including physicians, nurses, occupational therapy practitioners, and physical therapists who have, "reasonable cause to believe that an operator is not physically or medically capable of safely operating a motor vehicle or has a cognitive or functional impairment that will

actual effect of a condition or impairment on the operator's ability to safely drive. The health care provider or law enforcement officer reporting in good faith shall be immune from civil liability that might otherwise result from making the report. The commissioner of public health, in consultation with the registry and "other medical experts on cognitive or functional impairments," (2009 MA H.B. 4795) will have 30 days after receipt of the report to determine the operator's capacity for continued licensure.

Though lacking some of MAOT's original language and intent, the final bill is a political and professional compromise and a significant act in recognizing the value occupational therapy has to the well-being and safety of the residents of Massachusetts.

M. Eleanor Meyer, MS, OTR/L, is public relations representative, MAOT



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New York State Remains Busy on Multiple Fronts

■ **Jeffrey Tomlinson,**
OTR, MSW, FAOTA

Over the course of the year there have been many legislative and regulatory events that affect occupational therapy practice in New York. While the New York State Occupational Therapy Association has focused the majority of their resources on a 9-year effort to update the practice act, many other issues, initiated primarily by the executive branch, have required immediate attention.

Practice Act Amendments Bill Stalled

The New York State Occupational Therapy Association (NYSOTA) spent the first 5 months of the year focused primarily on negotiating bill language with representatives of the Medical Society of the State of New York and the New York State Ophthalmological Society. The Medical Society had issued a memorandum of opposition to the occupational therapy bill near the end of the 2009 legislative session, effectively stopping the bill's progress for that year. Although the memorandum contained much misinformation that was easily resolved, negotiations focused primarily on language regarding referrals and prescriptions. Currently, in New York State, an occupational therapy treatment program can be provided only

on a referral or prescription by a physician, physician assistant, or a nurse practitioner. The NYSOTA bill had sought amendments that would allow occupational therapy treatment to be provided upon referral by an optometrist, and prevention services to be provided without a need for a referral or prescription at all. After five different meetings, an agreement was reached allowing an occupational therapy "restorative" treatment program to be provided upon referral by all licensed health professionals with prescriptive authority. This language has been interpreted to allow habilitation and maintenance therapy without a referral or prescription. In addition, NYSOTA worked separately during these negotiations with the executive secretary of the state board for occupational therapy to secure an official statement that occupational therapy may be provided for prevention purposes without a referral or prescription.

The occupational therapy practice act amendments bill, 2009 NY S.B. 4538/2009 NY A.B. 7719, was amended to include the new negotiated language. The bill eventually passed the Senate but was never placed on the Higher Education Committee agenda in the Assembly despite intense lobbying of the committee's chair.

NYSOTA will now focus its lobbying efforts on the Assembly Higher

Education Committee and the assembly leadership.

OTAs Faced a Sudden Shift in School Policy

In April 2010, the New York State Department of Health entered into an agreement with the federal Health and Human Services Department regarding Medicaid coverage for school and preschool supportive health services. The agreement included requirements that occupational therapy services must be provided by a New York State licensed and registered occupational therapist and a certified occupational therapy assistant (COTA) "under the direction of" such a qualified licensed and registered occupational therapist, within his or her scope of practice under New York State law.

NYSOTA did not learn of this new agreement until informed of it by some members in June. In New York there are many occupational therapy assistants who either never took the occupational therapy assistant examination by the National Board for the Certification of Occupational Therapy or have chosen not to maintain their certification.

The new Medicaid agreement, effective retroactively to September 2009, reached the school districts at a time of great financial crisis, with state and local budgets facing large deficits that left schools with decreased funding. As

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The American Occupational Therapy Association's State Affairs Group

Purpose

The State Affairs Group is responsible for all of the Association's state legislative and regulatory activities. This department monitors and provides analysis of proposed legislation and regulations affecting occupational therapy in the states, conducts outreach and provides assistance to state OT associations on key state issues such as professional regulation/scope of practice. The department also provides day-to-day liaison with state OT regulatory boards on professional trends and issues such as supervision and continuing competence requirements.

Resources

Department staff provide research, technical assistance, and consultation on a wide range of state legislative and regulatory issues, and function as a clearinghouse for information useful to state regulatory boards. Staff members work with the state regulatory boards, analyze proposed legislation and regulations on key issues, provide testimony and recommend appropriate strategies for handling issues that affect the profession.

Staff and Contact Information

Please contact us if there are any issues that you would like to learn more about or require technical assistance. The department also invites suggestions for future newsletter articles.

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New York State Remains Busy on Multiple Fronts

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a result, the school districts throughout New York are making every effort to maximize their Medicaid reimbursement for related services. In interpreting the new Medicaid agreement, many school districts have ended their use of OTAs, based on language in the new agreement that requires the use of “COTAs” certified by NBCOT, as well as the agreement’s definition of “under the direction of” a licensed occupational therapist. The definition lays out specific supervision requirements that are consistent with supervision regulations currently under development by the state board for occupational therapy in New York.

Although NYSOTA strongly urges its members and all other occupational therapy practitioners in New York to achieve and maintain the highest com-

petencies and subsequent credentials, we felt that the new Medicaid agreement provided no advanced warning for the profession, nor any grandfathering clause. NYSOTA quickly went to work and, with the assistance of Chuck Willmarth at AOTA, we argued that the Medicaid agreement language far exceeded what was required by federal statute. In addition, we argued that the occupational therapy practice act provided for the certification of occupational therapy assistants by the Commissioner of the State Education Department.

NYSOTA’s efforts were successful. In August the New York State Department of Health and the State Education Department issued a memorandum clarifying the credential requirements for occupational therapy assistants.

The memorandum states that “Occupational therapy assistants providing school supportive health services must be certified by the New York State Education Department.” This has resulted in some OTAs being able to continue their current employment in schools.

NYSOTA is now working with individual cases regarding the implementation of the supervision requirements set forth in the agreement. In such a tense and difficult financial environment, school districts are being very cautious in their efforts to comply with the new Medicaid agreement.

*Jeffrey Tomlinson, OTR, MSW,
FAOTA is legislation and government
relations chair, NYSOTA*

AOTA and OTAC Give Testimony at Division of Workers’ Compensation—Physician Fee Schedule Stakeholder Meeting

■ **Laura Stewart, OTR/L, CHT;
Elizabeth Gomes MS, OTR/L;
and Judy Thomas**

In June 2010, the state of California Division of Workers’ Compensation (DWC) proposed to change its fee schedule to resource-based relative value scale (RBRVS) system. The Occupational Therapy Association of California (OTAC) applauded this positive change, which will align the California Workers’ Compensation billing system to the national system. At the same time, OTAC is concerned about California Division of Workers’ Compensation adopting Medicare MPPR schedule. OTAC worked closely with the American Occupational Therapy Association (AOTA) on this issue by sending letters and voicing our concerns to the CA WC board. Elizabeth Gomes, MS, OTR/L, representing OTAC, attended the hear-

ing in northern California on August 17, 2010, and voiced our opposition at the hearing. Provided below is the testimony that was given by Elizabeth Gomes:

.....

Thank you for the opportunity to comment on the proposed changes to the California Workers’ Compensation Fee Schedule. The American Occupational Therapy Association (AOTA) and the Occupational Therapy Association of California (OTAC) is pleased that the California Division of Workers’ Compensation (DWC) will be updating the codes that are part of the fee schedule to include the most recent CPT definitions. However, we would like to reiterate our grave concerns about adoption for California’s Workers’ Compensation Program of Medicare policies unrelated to the relative values used in the Medicare Physician Fee Schedule (MPFS)

formula. AOTA and OTAC do not believe California should be driven by these policies that have been developed to address issues in Medicare, not in workers’ compensation. The programs are very different.

We especially have strong opposition to the multiple procedure payment reduction (MPPR) policy as proposed by the Centers for Medicare & Medicaid Services (CMS) in the July 13 proposed rule for the Medicare Physician Fee Schedule and have provided rationale for this position below.

Our overall concern is that use of Medicare policy decisions to define coverage and payment for a dissimilar health care system is fraught with potential problems. Medicare’s proposed policies are derived from interpretation of Federal law, how the program is designed and implemented

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AOTA and OTAC Give Testimony at Division of Workers' Compensation–Physician Fee Schedule Stakeholder Meeting

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and motivated many times by budget considerations not relevant to workers' compensation clients or the program's goals. The vast differences in ages, diagnoses, and treatment plans make such comparisons inappropriate and perhaps harmful to the workers' compensation program's goals: getting individuals back to work efficiently and effectively.

AOTA and other national therapy and provider organizations are in the process of submitting evidence to CMS to rebut the erroneous assumptions on which the MPPR Medicare policy proposal was based. The therapy coalition would be happy to share these comments with you, when complete.

An important aspect of understanding the flaws in this CMS proposal is that it appears to ignore the work of the American Medical Association Relative Value Update Committee (AMA RUC). AMA RUC decisions as related to therapy codes are reviewed below and underlie the rationale for our strong opposition to this proposed policy in Medicare and our opposition to its use in California workers' compensation.

Rationale for Opposition to Implementation of the Multiple Procedure Reduction and other Medicare Policies

CMS Assumption: There is duplication in practice expense because multiple services and/or units are billed in the same visit.

Facts: Multiple units have been assumed in determining the values of codes for therapy. All physical medicine and rehabilitation CPT codes (97XXX) have gone through the rigorous RUC and Practice Expense Advisory Committee (PEAC) processes. At the time these codes were valued, a typical visit (per AMA definition) was presumed to be 45 minutes, during which there are one therapeutic modality and two

therapeutic procedures furnished. The practice expense (PE) inputs were deliberately reduced to avoid duplication of the activities listed in the CMS chart.

Medicare coverage and payment policy, which is driven by many different economic and political issues, and changes frequently, has no proven applicability to treatment of injured workers.

The therapeutic procedure inputs were divided in half and the modalities were given 0 inputs because they would not be performed alone but always in conjunction with a procedure code.

Since the therapy codes were already appropriately reduced to account for multiple units, there is no reason for further reductions.

The AMA performed a similar review of these codes in the spring 2010 and concurred with the analysis provided by therapy and physician organizations, maintaining the current values.

CMS Assumption: The median number of therapy units per day is four.

Facts: The data may not have been calculated in a fair manner. In computing the median, CMS combined all professional therapy services (i.e. OT, PT and SLP), meaning that if a person received OT and PT in the same day, those units were aggregated. Also, CMS acknowledged that they excluded all of the visits during which only one unit was paid. Furthermore, not all practice settings were represented in the data (only physician offices and therapy private practices). Finally, the data that CMS did provide showed that the mean for the private practice setting data is 3.5.

CMS Proposal: The practice expense for all therapy services after the first unit provided on the same day should be reduced 50%.

Facts: The extent, if any, of duplication of practice expense cannot be deter-

mined from any of the data provided by CMS. Based on the values that have been accepted by the RUC and based on a typical patient, there is an underlying assumption that there may be underpayments and overpayments in some situations. For example, billing one unit of a code or a two-unit combination of a modality and therapy will result in an underpayment, as some of the practice expense inputs to the relative values have already been reduced. At some combination of modalities

and procedures, there will be some duplication of PE, which in the aggregate may be offset by underpaid code combinations. However, reducing the PE amount by 50% for each unit after one is clearly unworkable.

Although we don't know how CMS will proceed with this or other policies in the final rule, we believe it would be irresponsible for the DWC to align itself with the vagaries of Medicare policy. The relative value system, which has been tested, updated, and used by many payers, is a rational starting point on which to base the DWC fee schedule. However, Medicare coverage and payment policy, which is driven by many different economic and political issues, and changes frequently, has no proven applicability to treatment of injured workers. We urge the DWC to adopt only those policies that clearly meet the needs of workers' compensation clients, employers and providers in California and serve the interests of the long-term effectiveness of the program.

Laura Stewart, OTR/L, CHT and Elizabeth Gomes MS, OTR/L are members of the OTAC Practice and Reimbursement Committee. Testimony was prepared with assistance from Judy Thomas, AOTA senior policy manager.

Early Intervention Taskforce in Illinois

■ Marcy M. Buckner

In May 2009, the Illinois legislature passed House Joint Resolution 50 creating the Illinois Part C Early Intervention Taskforce (taskforce), in partnership with the Illinois Department of Human Services. The purpose of the taskforce was to undertake a thorough review of the Early Intervention (EI) system and develop recommendations and an action plan to address issues related to workforce, financing, monitoring and evaluation, service delivery, and transitions. Representatives from the occupational therapy (OT), physical therapy (PT), and speech language pathology (SLP) professions provided input and valuable background information about their professions. However, at the conclusion of the taskforce's meetings in May 2010, representatives from OT, PT, and SLP became concerned that they would not be able to review and provide comments on the taskforce's final recommendations that were scheduled to be sent to the Illinois governor and General Assembly on July 1.

In June, the American Occupational Therapy Association (AOTA) partnered with the American Physical Therapy Association, the American Speech-Language-Hearing Association, the Illinois Occupational Therapy Association (ILOTA), the Illinois Physical Therapy Association, and the Illinois Speech Language Hearing Association to send a letter to the secretary of the Illinois Department of Human Services (DHS). The letter requested access to the draft report and the opportunity to provide comments on the taskforce's final recommendations before the recommendations were sent to the governor and General Assembly, because the recommendations could affect access to the unique contributions OT practitioners, PTs, and SLPs provide in the area of EI. Subsequently, all of the state and national associations received access to the taskforce's draft of their final legislative report.

AOTA and ILOTA found that the draft report failed to address issues important to the OT community. AOTA and ILOTA sent a joint letter to DHS highlighting the following areas of concern: workforce issues and barriers to enroll and provide services in the EI program; parental confusion relative to titles, roles, professional training, and responsibilities of providers; service delays; cost saving measures and fiscal implications of the program; safety for the Illinois children participating in the EI program; and access to OT services for children participating in the EI program. Also of concern was that a number of recommendations include

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inaccurate information regarding current best practice, conflict of interest, and eligibility, as well as IDEA Part C terminology errors.

AOTA and ILOTA did support the intent of a number of the taskforce's suggestions. Several recommendations provide for further research or studies by the Illinois Interagency Council on Early Intervention and the Bureau of Early Intervention; however, the required action section under each recommendation does not include participation by all stakeholders in this review process. AOTA and ILOTA support the intent of the studies, but feel that it is imperative for OTs, PTs, and SLPs to participate in the review process outlined in these recommendations.

The recommendations address a need for additional oversight, but AOTA and ILOTA were concerned that the recommendations do not recognize the layers

of consumer protection and oversight already in place for the OT profession. These layers include direct supervised clinical internship, passing a national board examination, and state licensure through the Illinois Department of Financial and Professional Regulation. Additionally, the Early Intervention Technical Assistance and Monitoring (EITAM) Program currently monitors all providers, including OTs, to assure compliance with departmental policies and procedures.

An ongoing concern for OTs, PTs, and SLPs participating in the EI program in Illinois is the encroachment of developmental therapists (DTs) into the traditional domains of skilled therapy practice. DHS defines DTs' role to include evaluation and assessment, Individualized Family Service Plan development, individual or group therapy services, the design of learning environments and activities that promote a child's acquisition of skills in a variety of developmental areas, and provision of information and support related to helping a child to attain maximum functional level. DTs coordinate

with OTs, PTs, and SLPs in the EI program and, according to DHS, provide assistance with acquisition, retention, or improvement in skills related to activities of daily living such as feeding and dressing; communicating with caregivers; and the social and adaptive skills to enable the child to reside at home or in a noninstitutional community setting.

AOTA and ILOTA will continue to work with the Illinois legislature, the taskforce, DHS, and the state and national OT, PT, and SLP associations to protect the role of OT in the EI program and the occupational therapy scope of practice.

Marcy M. Buckner, JD, is state policy analyst at AOTA

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2010 State Regulatory Entity Survey Results:

Number of Licensed OT/OTAs

State	# of regulated OTs	# of regulated OTAs	2010 Totals
Alabama	1,124	545	1,669
Alaska	266	25	291
Arizona	1,665	520	2,185
Arkansas	981	201	1,182
California	11,148	1,986	13,134
Colorado*	2,308	300	2,608
Connecticut	1,918	616	2,534
Delaware	410	192	602
District of Columbia	504	16	520
Florida	6,708	2,284	8,992
Georgia	2,743	709	3,452
Hawaii*	545	60	605
Idaho	467	122	589
Illinois	5,293	2,058	7,351
Indiana	2,706	1,106	3,812
Iowa	1,034	409	1,443
Kansas	1,359	342	1,701
Kentucky	1,716	509	2,225
Louisiana	1,551	447	1,998
Maine	963	212	1,175
Maryland	2,594	574	3,168
Massachusetts	4,834	1,773	6,607
Michigan	4,585	1,273	5,858
Minnesota	2,828	892	3,720
Mississippi	825	353	1,178
Missouri	2,884	926	3,810
Montana	307	70	377
Nebraska	843	135	978
Nevada	537	147	684
New Hampshire	1,104	240	1,344
New Jersey	4,187	551	4,738
New Mexico	800	277	1,077
New York	10,266	3,846	14,112
North Carolina	2,912	1,245	4,157
North Dakota	420	150	570
Ohio	4,233	2,904	7,137
Oklahoma	754	664	1,418
Oregon	1,428	272	1,700
Pennsylvania	6,283	2,533	8,816
Puerto Rico	649	312	961
Rhode Island	603	314	917
South Carolina	1,399	630	2,029
South Dakota	350	80	430
Tennessee	1,589	767	2,356
Texas	7,103	2,868	9,971
Utah	523	211	734
Vermont	343	112	455
Virginia	2,236	639	2,875
Washington	2,698	581	3,279
West Virginia	513	301	814
Wisconsin	3,239	1,224	4,463
Wyoming	269	93	362
2010 Totals	119,547	39,616	159,163

* OTA Bureau of Labor Estimated Statistics May 2008

AOTA State Affairs Group, March 2010

New EI Resource for OT Practitioners

■ **Sandy Schefkind, Marcy M. Buckner**

AOTA representatives attended the Office of Special Education Programs (OSEP) 2010 Leadership Mega Conference in Arlington, VA, from August 2–5. Barbara Chandler, PhD, OTR/L, FAOTA, and past chairperson of AOTA's EISSIS; and Tim Nanof, MSW, AOTA's Federal Affairs manager, participated in a panel discussion with representatives of the American Speech-Language-Hearing Association, National Association of Social Workers, and American Physical Therapy Association to discuss early intervention (EI) issues such as professional preparedness, service delineation and team approaches, and evidence-based practices. AOTA staff prepared and presented the document *AOTA Practice Advisory on Occupational Therapy in Early Intervention*.

The advisory—available on the AOTA Web site at www.aota.org/practitioners/advocacy/state/resources/statefact-sheets.aspx—provides direction for the practice of occupational therapy

(OT) in EI, and can be used by practitioners in EI settings to help advocate for the profession. The following sections are taken from the advisory.

Scope of Practice

Entry-level OT practitioners are highly qualified professionals licensed or otherwise regulated by their state who have expertise in promoting function and engagement of infants and toddlers and their families in everyday routines by addressing activities of daily living, rest and sleep, play, education, and social development.

The foundation of OT is rooted in concepts promoting participation, optimum development, and family engagement within natural environments—core principles of both OT and EI. As primary service providers of Part C of the Individuals with Disabilities Education Improvement Act of 2004, OT practitioners help promote a young child's development and foster the capacity of the family to advocate for their child while enhancing their caregiving capacity.

OT practitioners collaborate with other EI service providers to promote a child's development in physical, communication, cognitive, adaptive, and social-emotional domains as well as support family members and caregivers in ensuring a child's participation in home and community life.

Professional Preparation

OT practitioners are prepared to provide services and supports in EI because of their rich background in human development, neurology, and anatomy; infant mental health; activity, behavioral, and environmental analysis; and occupational performance. They complete an accredited educational program curriculum, supervised fieldwork, and a national certification examination. These processes form the basis for state credentialing (usually licensure) of practitioners.

According to the Report of the Early Intervention Education Content Ad Hoc Committee (AOTA Task Group 5 Charge 106) published in January

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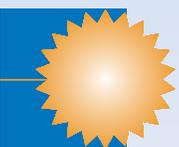
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New EI Resource for OT Practitioners

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2008, further support of the preparedness of OT practitioners to work in EI settings is evidenced by the findings of a survey of academic program directors for occupational therapists and occupational therapy assistants. The survey found that more than 90% of programs included coursework in IDEA and family-centered care. In addition, the survey indicated that 87% to 92% of programs offered Level I (part-time) or Level II (full-time) fieldwork opportunities in EI.

Occupational therapists are also well qualified to function as service coordinators to coordinate, develop, and oversee the implementation of the individualized family service plan (IFSP) to meet the needs of the young child and family. OT practitioners take a holistic, science-driven, evidence-based approach that can be recognized and

utilized in the position and function of service coordinator.

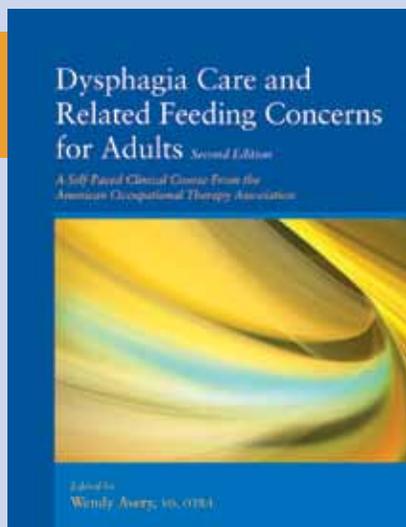
Service Delineation

AOTA endorses the concepts of collaboration, teamwork, and family-centered care. In EI, a variety of team models may be utilized, including a multidisciplinary, interdisciplinary, or transdisciplinary (including primary provider) approach. Federal regulations and state licensure laws require that OT is provided only by a qualified occupational therapist or occupational therapy assistant. However, the very nature of that which OT addresses, engagement in daily occupations, can be fostered in a number of ways identified

The advisory—available on the AOTA web site at www.aota.org/practitioners/advocacy/state/resources/state-fact-sheets.aspx—provides direction for the practice of OT in EI, and can be used by practitioners in EI settings to help advocate for the profession.

by the practitioner and implemented on a daily basis by the family or others. As practitioners of a primary developmental service in EI, OTs are ideally suited to function as primary service providers, as decided by an IFSP team. AOTA endorses many of the principles from the National Early Childhood Technical Assistance Center (www.nectac.org/topics/families/families.asp) to guide the collaboration of OT practitioners on EI teams.

Sandra Schefkind, MS, OTR/L, is the pediatric coordinator at AOTA. Marcy M. Buckner, JD, is state policy analyst at AOTA.



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