State Affairs Group News

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Self-Assessment & Discoverability: Part I

Guest Article
Penelope A. Moyers, EdD, OTR, FAOTA
Chairperson , AOTA Commission on Continuing Competence and Professional Development.

Many health professionals are discovering the value of portfolios in facilitating active engagement in continuing competence or the ongoing growth in one's capacity to practice in the future.[1] However, professionals often raise concern about the ramifications of the legal process of discovery in relationship to a well-documented portfolio. In other words, if a case of malpractice is brought against an occupational therapist or an occupational therapy assistant, can the lawyers for the plaintiff access the portfolio? Is documentation of learning needs a tacit admission of incompetence?

Attorneys can access, as a part of their fact-finding process, almost any document you and your employer keep related to your work performance and development needs, such as personal diaries, notes, employer evaluations, and employee yearly goals. The real issue, however, is the way in which the portfolio data will be interpreted.

During the past year, the Commission on Continuing Competence and Professional Development (CCCPD) has been questioned about issues of legal discovery for members who use AOTA's Professional Development Tool (PDT), particularly the self-assessment portion.

Because using the PDT is voluntary and was designed as a member benefit rather than as a requirement, the practitioner has control of its content. Therefore, the PDT is less likely to create a high level of risk if the practitioner understands how the PDT is best used. The PDT was designed primarily to reflect the growth typical of a continuing competence program. It was not designed to determine competency. After extensive discussion and legal advice, the CCCPD has added the following statement to the PDT:

AOTA stresses that the PDT is not comprehensive or exhaustive and is simply one source of information among many that are available. Using this tool will not necessarily identify all areas in which improvement may be desirable. Conversely, the identification—using this tool—of areas of weakness or of potential improvement should be viewed only as a self-assessment device. The PDT is *not* designed for, or properly used for, the determination of such matters as legal liability or adequacy of professional performance in a given context.

Updates of the PDT will define the self-assessment component as a formative and dynamic process that facilitates the practitioner to move through various stages of professional improvement or development.[2] Self-assessment is an integral part of learning and development and *does not* result in a determination of competency. Instead, self-assess-

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About the 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 OT 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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Workers' Compensation Reforms Impact OT

California has enacted broad workers' compensation reform legislation in 2003 (SB 228) and 2004 (SB 899) in an effort to control costs. These reforms have created a number of challenges and unintended consequences for occupational therapy practitioners who provide services in the California workers' compensation system. Although these reforms only apply to California, the reform legislation could be seen as "model legislation" in other states with troubled workers' compensation systems. Yet if employees cannot get the medical care they need, including occupational therapy, through workers' compensation, then they cannot effectively do their job or fully participate in society.

AOTA and the Occupational Therapy Association of California (OTAC) have joined forces to help members who are experiencing severe and negative financial repercussions because of recent changes in California's workers' compensation system. OTAC's leadership, the OTAC-AOTA lobbying staff, AOTA's State Affairs and Reimbursement staffs, and an ad hoc group of occupational therapy experts in workers' compensation are working diligently to resolve these issues. In addition to pursuing a political solution through the expert services of lobbyists, OTAC and AOTA have hired an attorney to address these issues.

Limits on Visits

2003 SB 228 includes a provision stating that employees covered under the workers' compensation system would not be entitled to more that 24 chiropractic and 24 physical therapy visits per industrial injury effective January 1, 2004. In 2004 the legislature passed SB 899, which includes a provision to impose the same limitation on occupational therapy visits. Although both AOTA and OTAC oppose arbitrary limits on visits, other issues such as prior authorization, utilization review, fee schedule issues, and treatment guidelines will be the priority issues.

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Welcome...

Please welcome the newly elected state occupational therapy association presidents as they begin their term of leadership and service.

- Patrick Bloom, MA, OTR
  Illinois Occupational Therapy Association
- Diane Sauter-Davis, MA, OTR/L
  Maine Occupational Therapy Association
- Mary Bradish, OTR/L
  Nebraska Occupational Therapy Association
- Sharon Kurfuerst, M.Ed, OTR/L, ABD
  Pennsylvania Occupational Therapy Association
- Mack Ivy, MOT, OTR
  Texas Occupational Therapy Association
- Mary J. Hagar, OTR
  West Virginia Occupational Therapy Association

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limitations on the number of visits are not a problem if treatment is not being authorized.

Official Medical Fee Schedule
To curtail costs associated with workers' compensation, the California legislature passed SB 899, which effectively reduced all payments to providers by 5% as of January 1, 2004. Although the legislation requires payments to be no lower than Medicare rates, historical errors and inconsistencies in the Official Medical Fee Schedule physical medicine and rehabilitation CPT code definitions have resulted in payments that are lower than Medicare, as well as erroneous denials of reimbursement for some occupational therapy services.
The legal firm of Hooper, Lundy & Bookman, Inc. has sent a compelling letter to the California Department of Industrial Relations asking the department to prospectively and retrospectively fix the Official Medical Fee Schedule in regard to errors concerning occupational therapy services.

Medical Treatment Guidelines
2003 SB 228 requires the workers' compensation director to adopt a "a medical treatment utilization schedule, that shall incorporate the evidence-based, peer-reviewed, nationally recognized standards of care recommended by the commission…and that shall address, at a minimum, the frequency, duration, intensity, and appropriateness of all treatment procedures and modalities commonly performed in workers' compensation cases."

2004 SB 899 defines the treatment "reasonably required to cure or relieve" an employee as being based on the guidelines adopted by the Administrative Director or the American College of Occupational and Environmental Medicine (ACOEM) guidelines. The bill also requires the guidelines to be evidence-based, nationally recognized, and peer reviewed.

The California Department of Industrial Relations has hired the RAND Corporation to evaluate utilization guidelines and make recommendations regarding their adoption for the California workers' compensation system. AOTA and OTAC will be working to provide input from the occupational therapy community into this process.

One major hurdle is that ACOEM is the only referenced set of practice guidelines being recognized under workers' compensation in the statute. Although AOTA and OTAC may have the opportunity to suggest occupational therapy treatment guidelines, they will need to be evidence-based to be recognized under the law.

Both AOTA and OTAC are committed to supporting our members in California as the workers' compensation system changes. We will be advocating with the state agencies, state legislators, and the governor's office to ensure that: (a) the full range of occupational therapy will continue to be available to recovering injured workers; and (b) services provided by practitioners will be reimbursed at fair rates.

Your membership in AOTA and state associations provides us with the resources we need to advocate on your behalf at the state level. ■

California State Capitol Building
Sacramento, California

Subscribe to the State Policy Issue Email Listserv

The State Affairs Group established the State Policy Issue Listserv to provide a forum for discussions about occupational therapy in state policy. We are inviting individuals to participate in the discussion, including: state OT association presidents, legislative chairs, and lobbyists, OT practitioner members of state OT Boards/Councils, state agency staff and AOTA staff. It is hoped that the state issues listserv will foster communications between members, state OT boards, regulators and state OT associations about policy issues.

To subscribe via email: send an e-mail message to **lyris@listserv.aota.org.** In the "**subject**" line type: "**subscribe stateissues**" followed by your name or contact Chuck Willmarth (ext. 2019) to be added manually. ■

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Legal and Ethical Practice: A Professional Responsibility

Guest Article
Deborah Yarett Slater, OT
AOTA Practice Associate

If your employer asks you to provide daily maintenance for a patient's hearing aid after he or she has been instructed and is independent in its care, or to include lower-extremity lymphedema management in your treatment program until the vacant physical therapy position is filled, is it legal? Is it ethical? Is it within the occupational therapy scope of practice? Staffing patterns, emerging practice settings, alternative treatment modalities, programmatic models of care, and blurring of single-discipline supervisory models have left occupational therapists and occupational therapy assistants seeking clarification in defining their roles and their legal and ethical responsibilities. When there is divergence between legal and ethical obligations and illegal and unethical actions, where does the final authority reside?

Recently, many of the questions that come to AOTA share a general theme: "My supervisor is asking/demanding that I do______ (fill in the blank with a treatment intervention). They think it's insubordination if I refuse, but I think I'm being asked to do something unethical. Or is it just unreasonable? Who is right?"

In many cases, supervisors or administrators have different expectations and understandings of "what is OT" than do occupational therapists or occupational therapy assistants themselves. Further, even if an intervention is within the legal scope of practice of occupational therapy, *should* it be done by that practitioner with that client? Questions about personal competency and doing the right thing to benefit the client must also be considered. How can practitioners understand their legal scope of practice and their responsibility to uphold the profession's ethical principles, while communicating the appropriate role of occupational therapy to their consumers, colleagues, administrators, and payers?

> *"It is every occupational therapist's and occupational therapy assistant's professional responsibility to have a copy of his or her state licensure law (or other regulatory document) and to be familiar with its contents, as well as to access updates as they occur. "*

Common Concerns
The following are samples of the types of questions relating to ethics, legal issues, and scope of practice that are often received at AOTA:

- In my facility, PT was treating a patient for balance deficits and hit the outpatient $1,590 cap. Can I pick up the patient for OT and continue to work on balance but with OT goals?
- What can I do with respect to video fluoroscopy, functional capacity evaluations, and other particular programs or interventions?
- The PT in my facility is leaving. Can I treat lower-extremity lymphedema (I'm trained and credentialed in this area) until they hire a new PT?
- My state Practice Act does not specifically state that occupational therapists work with back-pain clients or provide back treatment. As a result, one of our major payers won't pay for back treatment. How can I prove that this is appropriate occupational therapy intervention?
- Is trachea suctioning within the occupational therapy scope of practice because I have a client who needs it? What about monitoring oxygen saturations?
- Do occupational therapists have to be certified to provide dysphagia services?
- I work in a rural area where staffing is difficult. I'm the only OT, working with several PTs. To provide continuity for my clients when I'm sick or on vacation if I can't find an OT replacement and the physician has referred for OT/PT, can I write in my evaluation that the patient will be treated by PT if indicated by the OT?
- Are lymphedema and wound care within the occupational therapy scope of practice? If so, do I need certification - what type and where do I get it?
- What are the legal and ethical implications of working in a driving program and the competency and level of training required for staff?

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-ment answers the question, what can I do to prepare or increase my capacity for the competency demands of the future?

Of interest to the CCCPD is the temptation for practitioners to avoid self-assessment and additional learning because of an over concern about discoverability. We recommend that practitioners carefully consider their practice situation and weigh the benefits and risks of engaging in self-assessment. It is likely that the benefits far outweigh the risks. In fact, failure to take action to facilitate continuing competence will more than likely increase the chance of incurring a malpractice claim as the result of practice errors arising from inadequate knowledge and poor training.[3,4] Carefully planning one's learning activities prevents problems related to poor training.

Documenting ongoing learning, including self-assessment, is important for showing that one is more than likely qualified to assume specific roles and to undertake required job tasks. Practitioners must be responsible for undertaking their own learning and for obtaining the supervision needed to be confident in their level of competency. The employer has the responsibility to make sure ongoing learning and development of their employees occurs before assigning tasks beyond their expertise. Therefore, self-assessing learning needs and formulating a learning plan are important strategies for increasing the likelihood of competency. ■

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Grassroots Advocacy Works

AOTA staff have worked with a number of state occupational therapy associations over the past 4 years to prevent attempts by physical therapists to inappropriately expand their scope of practice in state laws and regulations. The expanded scope of practice that these states have proposed echoes the language promoted by the American Physical Therapy Association (APTA) in its *Guide to PT Practice* and by the Federation of State Boards of Physical Therapy in their Model Practice Act. AOTA has expressed opposition to this unqualified expansion, which encroaches on traditional areas of occupational therapy practice such as "functional training in self-care and in home, community, or work integration."

The most recent efforts were in the District of Columbia, where the DC Board of Physical Therapy Practice attempted to add new scope of practice regulations. The strategies that DC occupational therapy leaders used to mobilize grassroots forces in opposition to those proposed regulations brought about a successful outcome and can provide a helpful model for other states that may face similar challenges.

AOTA and state associations monitor legislation and proposed regulations that could affect occupational therapy, but knowing about those initiatives before they are proposed allows more time to mount effective grassroots advocacy efforts. In early 2004, AOTA became aware of the DC Physical Therapy Regulatory Board's intent to add new scope of practice language to their regulations and was able to acquire a draft of the proposed regulations. AOTA staff contacted the DC Occupational Therapy Association (DCOTA) president and the AOTA Representative Assembly (RA) member for DC and suggested a meeting to discuss a strategy. The meeting included AOTA staff, the DCOTA president, the DC RA representative, the DC Board of Occupational Therapy chairperson, and Howard University faculty. A plan was established to alert DC licensees, educate them about the possible consequences of the proposed regulations, and provide them with tools to find out more about the regulations and how they could respond. There are only 580 licensees in DC, and most are not members of AOTA or DCOTA, yet 75 showed up for the Town Hall! Meeting organizers were overwhelmed with the positive energy generated by their outreach to licensees as well as the renewed interest in DCOTA and AOTA membership. Attendees were encouraged to join and ask their colleagues to join both organizations to support efforts such as this. At the Town Hall, attendees were informed of the specific PT initiative in DC, similar efforts in other states, and the possible implications for occupational therapy practitioners if the expanded PT scope were to

DCOTA Town Hall Meeting on April 14, 2004

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Other questions often arise around adding services (becoming a durable medical equipment provider; providing complementary or alternative medicine like massage, acupuncture, etc.) to an existing private practice or setting up a separate business in these areas. Is there a conflict of interest when a practitioner has access to a ready-made pool of potential patients or clients who are already in a therapeutic relationship with him or her?

For example, in these cases the practices may complement each other but how can the business owner ensure that the clients' rights of autonomy and informed consent are safeguarded? (*Occupational Therapy Code of Ethics (2000)*, Principle 3 and Principle 6, especially 6B.[1]) As a general principle in evaluating this situation, consider that full and open disclosure of any competing businesses from which the therapist may realize financial gain is important to preserve patient rights, as are policies and procedures to avoid conflicts of interest.

Role delineation between disciplines can be another practice challenge in settings where certain referral patterns exist because of organizational history, and occupational therapy education and clinical training are not well understood. This can be a result of staffing shortages, pressure to maintain productivity within clinical departments, department leadership, and lack of confidence on the part of occupational therapy personnel in understanding and articulating the occupational therapy domain and scope of practice.

As the complexities and venues of practice grow, and new specialty areas emerge, the search for guidelines for appropriate legal and ethical practice will intensify. These questions generally do not have a direct, simple answer. Rather, a reasoning process or decision matrix for addressing these dilemmas is more appropriate and can be applied to a variety of settings and practice challenges. A number of resources are available to answer these questions.

Determining Scope of Practice

The first step in the reasoning process is to understand what is meant by scope of practice. The foundation of a profession's domain has legal, professional, ethical, and educational components. Specifically, a profession's domain or scope of practice derives from three basic elements: (1) a body of knowledge historically included in the educational preparation of the disciplines; (2) a clearly established history of application in practice, as reflected in the professional literature; and (3) the legal framework created by state practice acts. It is important to understand the relationship of these elements to each other because they support our practice and are the basis for delineated scope of practice language in state law.

Education

The Accreditation Council for Occupational Therapy Education (ACOTE) standards define entry-level skills and competencies that students should acquire during the educational and fieldwork process, thereby establishing the baseline occupational therapy body of knowledge.[2] However, many practice areas, particularly as specialization and knowledge grow, require additional training (which may include hands-on practicums) to ensure competency. Competency must be documented and upgraded regularly to maintain a consistent skill level and to provide state-of-the-art care. It is also necessary to meet requirements of regulatory agencies that want proof of current competency, particularly in high-risk procedures. Principle 4 of the Code of Ethics (Occupational therapy personnel shall achieve and continually maintain high standards of competence. [duties][1]) speaks specifically to this ethical obligation. In addition, an ethical mandate to "do good" or do the right thing (Principle 1. Occupational therapy personnel shall demonstrate a concern for the well-being for the recipients of their services [beneficence]) and above all, do no harm (Principle 2. Occupational therapy personnel shall take reasonable precautions to avoid imposing or inflicting harm upon the recipient of services or to his or her property [nonmaleficence]) reinforce the need for basic and continuing education to maintain and enhance knowledge and skills. Guideline 4.2 of *Guidelines to the Occupational Therapy Code of Ethics* provides additional support for competency in less established areas: "When generally recognized standards do not exist in emerging areas of practice, occupational therapy personnel must take responsible steps to ensure their own competence" (p. 882).[3]

Application in Practice

The second component of defining a scope of professional practice is an identifiable history of application. Although certain aspects of occupational therapy practice are well-documented in the literature, others that reflect newer or less traditional approaches to practice or atypical settings are not. Relevant literature or research studies showing the efficacy of certain interventions, combined with practitioner competency, may satisfy the test for inclusion in the occupational therapy scope of practice, especially where statutory language is very broad and nonspecific. This history may be especially important when a particular approach would not be defined as "usual and customary" practice by the average clinician.

However, a more basic consideration, particularly when an administrator or supervisor is requesting that an occupational therapist provide more medically related or maintenance type of interventions, is the appropriateness of such a request. The recipient of such services should require the skills unique to an occupational therapist or occupational therapy assistant, and the treatment plan should focus on objective, measurable goals to be met within a reasonable timeline. This guideline reflects Medicare criteria for appropriate intervention and payment but is also useful as an internal gauge of whether occupational therapy services should be provided and within what parameters.

Legal Framework

State licensure laws legally define a profession's scope of practice or domain. Although occupational therapy is regulated in all states, the District of Columbia, Puerto Rico, and Guam,

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several have less stringent forms of regulation, such as certification, registration, or trademark. The primary goal of all forms of regulation is to protect consumers. However, only licensure defines and legally protects the occupational therapy scope of practice so that those who are not licensed cannot call themselves occupational therapists or occupational therapy assistants and cannot provide services delineated within the occupational therapy scope of practice. Licensure for occupational therapists exists in 46 states and for occupational therapy assistants in 43 states. Certification (Indiana) and registration (Hawaii and Michigan) may contain definitions of occupational therapy but do not define a scope of practice, so others may, under some circumstances, use occupational therapy interventions if they do not call these services "occupational therapy." Colorado has a trademark law that protects the title "occupational therapist" (there is no title protection for "occupational therapy assistant") based on meeting certain educational and training requirements but it does not define occupational therapy or delineate a scope of practice.[4]

It is every occupational therapist's and occupational therapy assistant's professional responsibility to have a copy of his or her state licensure law (or other regulatory document) and to be familiar with its contents, as well as to access updates as they occur. This is also an ethical responsibility, as per Principle 5 of the Code of Ethics ("Occupational therapy personnel shall comply with laws and Association policies guiding the profession of occupational therapy." [justice]) About 15 states have adopted the AOTA Code of Ethics (though not always the most current version, which was last revised in 2000). Other states have language pertaining to ethics or ethical practice within their statutes. State licensure laws define what can legally be done by practitioners licensed in that state, so in that regard licensure laws are the final authority. However, laws can be subject to interpretation, especially because it is virtually impossible (and undesirable) to enumerate in detail every possible appropriate occupational therapy evaluation or intervention.

Members of a state licensure board may assist in clarifying what they consider to be within the occupational therapy scope of practice as defined in the licensure law. A good test is to determine whether most occupational therapy practitioners would, if called to testify in a court case, verify that the area in question is "usual and customary practice" (although this test becomes more difficult as innovative practice areas emerge that are not yet in the mainstream).

In addition to statutory language, educational criteria for accredited occupational therapy programs, support from literature and Association and other documents, as well as competency may assist practitioners in supporting their actions as within an appropriate occupational therapy scope of practice. In the case of less mainstream practice areas, these criteria, as well as alignment with occupational therapy philosophy (as outlined later in this article) will be particularly relevant.

Practitioners also need to understand payer policies and other laws and regulations that govern their practice. This information includes Medicare rules about supervision, documentation, and coding and billing, as well as other legal information that relates to their client population or practice setting. Because these guidelines change frequently, it is important to visit the Centers for Medicare & Medicaid Services (CMS) Web site (www.cms.hhs.gov) frequently, as well as to use announcements and updates on the AOTA Web site (www.aota.org) from the Federal Affairs, State Policy, and Reimbursement Groups. Additional resources, particularly on potential or pending legislation or other activities that affect practice and education can be found in AOTA's monthly electronic AOTA *Scope of Practice Issues Update*. Documents such as the *Occupational Therapy Practice Framework: Domain and Process,*[5] *the Occupational Therapy Code of Ethics (2000)*,[1] *Guidelines to the Occupational Therapy Code of Ethics,*[3] *the ACOTE Standards of Accreditation,*[2] *Standards for Continuing Competence*,[6] *Scope of Practice,*[7] and position papers on the specific topic can provide important guidance in supporting current and evolving practice parameters.

Reasoning Process

The purpose of the preceding discussion is to provide resources and foundational knowledge to understand and articulate legal and ethical occupational therapy scope of practice. However, because many of the questions posed earlier in this article do not necessarily have a straightforward, definitive answer, a framework for decision making may be useful to assist in the reasoning process. The following are some questions for self-reflection:

- Was this body of knowledge part of my educational curriculum?
- Am I competent to provide this intervention based on past education or current or continuing education?

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Fulfill Your Civic Occupation - Vote!

The deadlines for voter registration vary by state, and you may still be able to register. To find out, visit the AOTA Legislative Action Center at http://capwiz.com/aota/e4/ to see **Elections & Candidates**. Already registered? Find out more about **the candidates** running for office in your state or election area. Remember, every vote counts!

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go into effect. They were given a sample comment letter to send to the PT Board during the official comment period along with talking points that could be used in crafting their own comments. They were also encouraged to enlist the efforts of their OT and non-OT colleagues in supporting their concerns and writing to the Board.

At the Town Hall, licensees were encouraged to attend the next PT Board meeting to voice their concerns. An e-mail alert from DCOTA using AOTA grassroots software also alerted members to the Town Hall and provided the text of the proposed scope of practice regulations. More than 30 occupational therapy practitioners attended the PT Board meeting, sending a clear signal from the OT community to the PT Board and the department overseeing them, that the proposed regulations were problematic. Several attendees were given the opportunity to speak at the meeting. They addressed concerns about the language and the impact on consumers should the rules be adopted. They gave examples of the limited focus and scope of physical therapy regarding activities of daily living and cognition in their work settings and in their educational programs.

A second mailing went out from DCOTA to licensees, providing them with an update, the sample letter, talking points, and proposed language, and encouraging them to send comments to the PT Board. AOTA, DCOTA, Howard University, the OT Board, and many licensees sent written comments. The department had never before had such a strong response to proposed regulations from any profession. On June 25th, final PT regulations were published in the *DC Register* without the specific language that raised concerns of encroachment on the scope of practice of occupational therapy. The positive outcome was the result of successful grassroots advocacy efforts coordinated by AOTA and DCOTA. ■

The New IDEA Partnership Project

Guest Article
Leslie Jackson, MEd, OT
AOTA liaison to the Unified IDEA Partnership

AOTA is one of 55 national organizations collaborating with the National Association of State Directors of Special Education and the Council of Chief State School Officers to assist with the implementation of the Individuals with Disabilities Education Act (IDEA). This new Unified IDEA Partnership Project brings together parents, educators, service providers, administrators, policymakers, and advocates to help states improve education outcomes for children and youth with disabilities. The Partnership is funded by the U.S. Department of Education, Office of Special Education Programs. AOTA had been a primary partner on the previous ASPIIRE (Associations of Service Providers Implementing IDEA Reforms in Education) Partnership project. The new project will build on national level collaborative relationships begun in the previous IDEA Partnerships.

The Unified Partnership will focus on increasing the capacity of state agencies and schools to appropriately address the learning and behavioral needs of children with disabilities. One of AOTA's roles will be to act as a conduit for collaboration between its members and Partnership activities. AOTA's primary goal on this project is to foster and promote integration of occupational therapy into state and local level initiatives, especially for issues not typically considered within OT's realm by other school personnel (such as children's behavior). Partnership work will be organized around issues, such as the intersection of IDEA and the No Child Left Behind Act, and will provide ample opportunity for involvement by occupational therapy practitioners, state affiliates, university faculty, scientists, and Special Interest Sections (SISs). OT participation in Partnership activities will help position the profession to share its expertise on broader issues affecting children and youth with and without disabilities.

The Unified Partnership project has begun work in several areas. Of particular interest to state affiliates are the mini-grants for 11 states to address specific training needs for parents and professionals. These states (FL, HI, MD, MI, NH, NY, ND, OH, OR, SC, UT) will receive $10,000 to use with already existing state resources to focus on state-identified issues, such as literacy/early reading, transition, over-representation of minority students in special education, and early childhood inter-agency collaboration. AOTA will work with the Partnership, in consultation with the state affiliates, SISs, university program directors and other AOTA members, to identify occupational therapy practitioners, scientists, and educators who want to participate in these and other project activities over the 4 years remaining on the project. AOTA's project liaison will be communicating directly with the presidents of the above mentioned states to identify potential occupational therapists (or occupational therapy assistants as appropriate) to represent OT. Details on other opportunities will be shared with through AOTA's publications, listservs, and the Web site as they become available. ■

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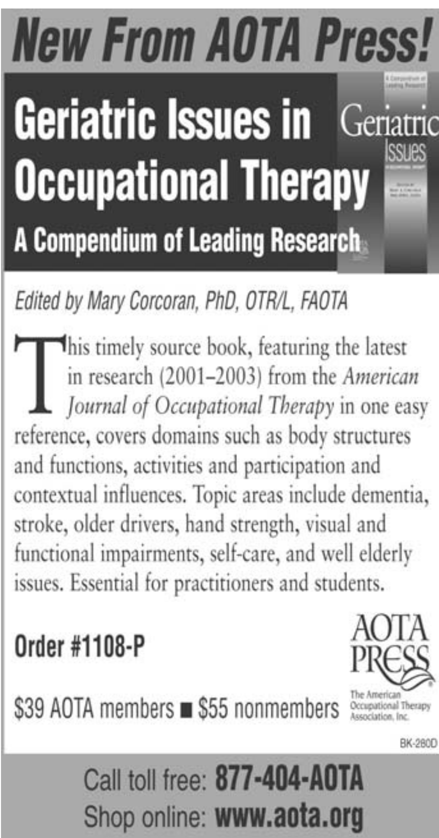
- Is my knowledge in this area current and adequate to provide competent services?
- Is this intervention or practice usual and customary among occupational therapy practitioners, and would many of them agree? If not, is it defensible and consistent with the occupational therapy scope of practice utilizing criteria previously outlined?
- Have I sought clarification from the state licensure board in interpreting less well-defined areas of the occupational therapy scope of practice?
- Have I sought resources like AOTA position papers or official documents relating to this area of practice (or done a literature search to provide evidence for my practice interventions?)
- Is this occupational therapy? How does this relate to the philosophy of occupational therapy? Am I using occupation to promote engagement in meaningful activities and participation in life roles?



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- AOTA *Scope of Practice Issues Update:* Subscriptions via e-mail are free to AOTA members who request one by e-mailing scope@aota.org. For back issues, go to http://www.aota.org/members/area4/links/link13.asp
- Centers for Medicare & Medicaid Services: www.cms.hhs.gov
- *Reference Guide to the Occupational Therapy Code of Ethics,* Edited by J. Scott, 2003. Bethesda, MD: American Occupational Therapy Association. $22 for members, $31 for nonmembers. Call toll free 877-404-AOTA or shop online at www.aota.org. Order #1139C-MI)

The last question may be the most critical. Despite the fact that an intervenetion is legal and ethical, it still may not be in line with the philosophical tenets of the occupational therapy profession. As articulated in the Framework, "Occupational therapy has a unique focus on occupation and daily life activities and the application of an intervention process that facilitates engagement in occupation to support participation in life" (p. 609).[5] As the profession's roles and contributions to society continue to evolve, the concepts outlined in the Framework can prove invaluable in facilitating the reasoning process to respond to scope of practice challenges.

Conclusion

The evolution of new patient populations, intervention strategies, and practice settings inevitably poses challenges to ensuring that practice is in line with legal, ethical, and philosophical guidelines and regulations. The occupational therapy profession has much to offer if occupational therapy practitioners, regardless of their roles and practice settings, have the knowledge and understanding of the underpinnings that define our profession and are able to clearly articulate it to consumers, colleagues, and outside publics. ■

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