Response

Mae Hightower-Vandamm was correct when stating that, “Medicare requires . . . graduation from an accredited program”; however, the Medicare regulations written by the Health Care and Financing Administration also defines a “qualified occupational therapist” as an individual who is “registered by The American Occupational Therapy Association” [Code of Federal Regulations (CFR) Title 42 §440.110] or is “eligible for certification by The American Occupational Therapy Association” [CFR Title 42 §405.110].

With these additional definitions, Medicare, and most likely other third party payers, will reimburse occupational therapy services provided by a Career Mobility OTR. Most third party payers will reimburse for the services of a “qualified occupational therapist,” which is usually defined as a licensed occupational therapist where applicable, or as an OTR.

Jim Luchansky (Intern)  
Government and Legal Affairs Division, AOTA

Response to the Presidential Address*

Your proposal to start “. . . a cold war . . . to protect the rights that we now have in the area of practice . . .” sounds ominous. I do not see any benefit in hiding useful knowledge. I believe in an individual’s right to seek knowledge. Other professions have found their knowledge from sources other than occupational therapy.

I do not believe other professionals want to practice occupational therapy without being occupational therapists. Special educators want to teach their students, but most of them were not prepared to teach the type of child they were legislated to teach by PL 94-142. Just as occupational therapy (OT) curricula are trying to meet the needs of a changing OT practice, education curricula are trying to meet the needs for a change in special education.

If we are to stop giving away information, should we also stop selling information to other professionals? Most continuing education courses offered by occupational therapists are also listed as being for physical therapists, special educators, psychologists, or other professionals.

The shortage of occupational therapists in the face of a demand for OT services creates a problem. Rather than a “cold war” and “not sharing knowledge,” we could use other tactics. First, we could appeal to an individual’s professional integrity. Some individuals will borrow OT techniques, but most professionals who are concerned about the welfare of others will realize that occupational therapy cannot be learned in “7 easy lessons.”

Second, we could become better at what we do and communicate this more effectively than we have in the past. We, too, need to learn skills by legitimate means and need to be qualified to carry out the tasks we choose to undertake. How many occupational therapists practicing physical therapy (PT) techniques are licensed physical therapists? How many occupational therapists who are practicing counseling techniques have their certificate in counseling? How many occupational therapists working as therapeutic recreationists have their degree in therapeutic recreation? How many university occupational therapy faculty have had formal education in educational processes? I raise these questions only to point out that people can do worthwhile things from knowledge gained in a variety of ways. Most people who want to practice occupational therapy do so after completing an accredited program. By sharing and communicating people will develop a better understanding and respect for occupational therapy.

Third, we could have a better understanding of the roles within our own professional structure. We need to know what information to “give” to COTAs and OT aides and what responsibilities to delegate to them. The following examples may explain my concern.

An OTR called to ask if a COTA could be supervised by a physical therapist to do PT activities part of the time because the OTR was working part time. A COTA called to ask if a COTA could be supervised by a physical therapist to make splints. An OTR expects an occupational therapy assistant student on fieldwork II to do manual muscle testing and also requires a sound understanding of Brunnstrom’s Clinical Kinesiology (Chapters 3, 4, and 5). I question the reliability of the results of a manual muscle test, a sensory test, a reflex test, and other tests that I knew entry-level COTAs were
required to perform. An OTR feels an occupational therapy assistant student on fieldwork should be able to give passive range of motion exercises to a CVA patient. Then, there are OTRs who refer to COTAs as certified occupational therapy aides.

The OTR, as the senior staff person, should know what responsibilities to delegate to a COTA. COTAs in turn need to be responsible for knowing their role functions as outlined by the AOTA. COTAs need to recognize their personal and educational limitations. They need to take the responsibility of discussing with a supervising OTR who will be accountable when a consumer questions a COTA's performance of a duty that the COTA is not qualified to perform.

Having been involved in the education of COTAs for 8 years, I support your statements expressed in the section, "change of course." We have not been fair to the COTA in the career mobility program. Neither are we being fair to the COTA in the area of practice.

Haru Hirama, OTR, Ed.D.
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