LETTERS TO THE EDITOR

AER Explains Its Role in Vision Rehabilitation

We are writing in response to the October 1995 special issue on low vision of the American Journal of Occupational Therapy in order to provide an expanded picture of rehabilitation services for consumers who are blind or visually impaired and to offer occupational therapists the opportunity for collaboration with vision rehabilitation specialists.

Contrary to the image portrayed in the special issue, persons with visual impairments are neither only those over the age of 65 nor those with low vision. Visual impairments can be diagnosed at birth and throughout life and span the spectrum of acuity and visual function, which ranges from minimum distortion, such as nearsightedness, to total blindness. Visual impairment is not just the loss of one sense; it affects the functioning of all remaining senses and one's ability to learn through traditional methods. Low vision aids and devices must be professionally prescribed and require specific training for consumers to successfully use each device for each task.

Vision rehabilitation and education services in the United States began in the 1800s. University preparation programs train rehabilitation teachers, orientation and mobility specialists, low vision specialists, and special education teachers or teachers of children with visual impairments. Rehabilitation teachers use special techniques and adaptations to guide and instruct persons with severe visual impairments to permit independent daily life. They work with consumers in all settings, and instruction is either with the individual person or with a small group, depending on individual evaluation and teaching goals. Instruction can include, but is not limited to, the following:

- Communication skills (e.g., braille, listening, adaptations for reading and writing, abaci, computers)
- Personal management skills (e.g., clothing care and grooming, medications management, eating, social)
- Home management skills (e.g., meal preparation, home mechanics, labeling and record keeping, safety)
- Leisure activities skills (e.g., hobbies, games, handicrafts, community activities)
- Home orientation and movement skills
- Training in use of optical devices (e.g., magnifiers, telescopes, closed-circuit television systems, similar prescribed devices)
- Guidance and counseling (e.g., adaptation to vision loss, community resources, support groups, family support)

Rehabilitation teachers and all vision professionals have national certification through the Association for Education and Rehabilitation of the Blind and Visually Impaired (AER). Some occupational therapists with additional training have qualified for rehabilitation teacher certification. Rehabilitation teachers work in multidisciplinary teams, often with occupational and physical therapists, and their services are reimbursed by insurances and Medicare.

For those readers interested in increasing their knowledge about vision rehabilitation, two professional journals are available: the Journal of Visual Impairment and Blindness from the American Foundation for the Blind and RE:view from AER. AER also has information about university programs and certifications. We welcome a dialogue with occupational therapists who are interested in better serving their consumers who have low vision. We hope to expand our collaborative efforts to provide the quality services to all consumers who are blind or visually impaired. It is through mutual respect and communication for each profession that consumers will receive maximum benefits.

Mary Beth Caruso, CRT
Barbara Hunt, EdD, CRT
Lisa-Anne Soucey, CRT
Lynne Luxton, EdD, CRT
Alexandria, Virginia

Position Paper on Occupational Therapy Aides Gives Wrong Message

Increasing health care costs and increasing societal need for rehabilitation medicine services, including occupational therapy, coupled with changing American values and changing political climate have put pressures on many of us to be more productive with fewer resources. Managed care increases the need to take maximum advantage of our limited therapy sessions and to demonstrate successful therapy outcomes. Third-party payers also must be repeatedly convinced that we provide a necessary and valuable rehabilitation service for the client. Although these efforts are continuous, the fact that many private practitioners are gaining entry into networks as providers demonstrates our value to society. Our state organizations and the American Occupational Therapy Association (AOTA) have worked hard to maintain visibility in Washington, DC, to keep us included in major legislation as health care providers.

However, an old problem cloaked in new language looms ahead. Twenty years ago, Edith Winston and many others on Long Island spearheaded efforts for New York State licensure. We were concerned about having untrained persons provide medical treatment and services called "occupational therapy" and how this affected our profession. We were also concerned that consumers often were paying for ineffective, and possibly harmful, services. Consumers were unaware that their so-called therapists could be minimally educated and could legally pro-

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vide something called "occupational therapy," which in fact was often not occupational therapy. Hospitals and other agencies could list occupational therapy as a service they provided without having staff members who were certified or graduates of occupational therapy programs. Occupational therapists practicing today are the beneficiaries of past leaders' work and commitment to our profession.

Given concerns about rising costs, we are being increasingly pressured to use expensive labor better to make better use of the occupational therapist's time. Certified occupational therapy assistants certainly are qualified to practice occupational therapy under the supervision of a licensed occupational therapist and can assist many occupational therapy practitioners (registered occupational therapists and certified occupational therapy assistants) who can being skilled tasks in specific situations under the direction and intense close supervision of the occupational therapy practitioner. (AOTA, 1995, p. 1023). Supervising registered occupational therapists are responsible for the actions of the aide. The Position Paper also addresses issues of statutory requirements, the need for occupational therapists to seek guidance from state regulatory boards regarding licensure issues, particularly where no mention is made regarding aides. It also speaks to reimbursement concerns. For example, according to this Position Paper, Medicare does not provide reimbursement for services of an occupational therapy aide without requisite supervision, and in cases where state law is more restrictive than Medicare policy, state law supersedes Medicare policy.

However, this Position Paper skirts the issue of professional ethics regarding treatment. It provides limitations regarding what the aide can do but does not say that aides cannot provide treatment. Skilled tasks in my estimation is a cop-out. It can mean adjusting a wheelchair seat belt, which is clearly reasonable for an aide to do, as well as providing transfer training or range of motion exercises. Ambiguity in the cost-conscious 1990s is dangerous. It encourages managers to pressure occupational therapy practitioners, often their employees, to define skilled tasks in each setting without any protection for the practitioner who seeks to provide the highest quality treatment for his or her client. Although I appreciate the need for AOTA to work cooperatively with managed care organizations to support cost-effective, quality occupational therapy, I also expect AOTA to protect occupational therapists as a profession. AOTA should be vocal about the need for high educational requirements for occupational therapy practitioners to provide quality care, nor denigrate those standards by proposing that some clients can be well treated by aides.

We do not need a Position Paper to tell practitioners that aides can perform unskilled tasks. This gives a tacit approval to agencies to increase caseloads by hiring aides instead of trying to maximize the use of certified occupational therapy assistants and working to develop innovative ways to provide services such as group versus individual therapy or video instruction to supplement treatment where possible. However, such innovations will not necessarily generate high revenues because reduced fees may be paid for group treatment, and managed care organizations may not pay for video instruction as treatment.

What will happen to quality treatment after we support the use of aides for treatment, especially in a managed care environment? Will clients be told that agencies are charging them for occupational therapy but are providing aides to perform euphemistic skilled tasks (most probably redefined on billing forms as treatment) supervised by a licensed therapist? How many aides will this therapist closely supervise? Although some may say that the occupational therapist needs to make the decision about how best to use aides to extend services, is it realistic to place therapists in an unequal position of power when the financial stakes are so high for agencies and third-party payers? With limited numbers of visits allotted for care, our clients will be charged for occupational therapy services that use up rationed visits. Treatment sessions that could address multiple problems with reevaluation and altered treatment will now turn into practice sessions that often could have been performed at home or on units under the supervision of generic aides, without an attached bill.

I firmly believe that this Position Paper is a serious error for our profession. I hope this letter helps us debate the issues involved, including the ethical issue inherent in this policy statement. ▲

Beverly P. Horowitz, DSW, OTR/L
Touro College, Dix Hills, New York

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