CONSIDERATION OF PROPOSED AMENDMENTS TO CALIFORNIA CODE OF REGULATIONS, TITLE 16, SECTIONS 4110, APPLICATION; 4111, PLACE OF FILING; 4112, REVIEW OF APPLICATION; AND 4114, ABANDONMENT OF APPLICATION.

The proposed text is attached for review.

Article 2. Applications

§ 4110. Application

(a) An application for a license or limited permit shall be submitted on the form entitled Initial Application for Licensure, Form ILA, (Rev. 7/2016), hereby incorporated by reference, or by providing the same information via on-line submission, if available, and shall contain the information required by sections 30, 144, 851, 2570.5, 2570.6, 2570.7, 2570.8, 2570.9, 2570.14, and 2570.16 of the Code and Family Code section 17520, accompanied by the appropriate fees.
(b) An application for a license or limited permit shall be deemed 'received' by the board upon receipt of the application and payment of the application fee, whichever occurs last.
~~(b)~~(c) For an applicant applying for licensure pursuant to section 2570.15 of the Code, "substantially equal" means that the applicant has successfully completed the academic requirements of an educational program, including the educational program and supervised fieldwork requirements, for an occupational therapist or an occupational therapy assistant that are approved by the board and approved by the foreign credentialing review process of the National Board for Certification in Occupational Therapy (NBCOT), the American Occupational Therapy Certification Board, or the American Occupational Therapy Association.

Note: Authority cited: Section 2570.20, Business and Professions Code. Reference: Sections 30, 114.5, 144, 850, 851, 2570.5, 2570.6, 2570.7, 2570.8, 2570.9, 2570.14, 2570.15 and 2570.16, Business and Professions Code; and Section 17520, Family Code.

§ 4111. Place of Filing

Applications shall be filed with the board's principal office or via on-line submission, if available.

Note: Authority cited: Section 2570.20, Business and Professions Code. Reference: Section 2570.5, 2570.6, 2570.7, 2570.8, 2570.9, 2570.14, and 2570.16, Business and Professions Code.

§ 4112. Review of Application

Within thirty (30) days after receipt of an application for a license, ~~certificate,~~ or limited permit, the board shall inform the applicant, in writing, whether the application is complete and ~~accepted for filing~~ approved or that it is deficient and what specific information or documentation is required to complete the application.

Note: Authority cited: Section 2570.20, Business and Professions Code. Reference: Sections 115.5, 144, 2570.5, 2570.6, 2570.7, 2570.8, 2570.9, 2570.14, and 2570.16, Business and Professions Code and Section 15376, Government Code.

§ 4114. Abandonment of Application

(a) An application for a license shall be deemed abandoned and the application fee forfeited when:
(1) The applicant fails to complete the application within ~~two~~ one years after it is originally received by the board.
(2) The applicant fails to submit the Initial Llicense fee within ~~sixty (60)~~ 90 days after the date of notification of ~~eligibility~~ approval by the board.

(b) An application for a limited permit shall be deemed abandoned and the application fee forfeited ~~if~~ when:
(1) Tthe applicant fails to complete the application ~~or submit the required fee~~ within sixty (60) days after it is originally received by the board.
(2) The applicant fails to submit the Limited Permit fee within thirty (30) days after the date of notification of approval by the board.

(c) An application submitted subsequent to the abandonment of a previous application shall be treated as a new application.

Note: Authority cited: Section 2570.20, Business and Professions Code. Reference: Sections 2570.5, 2570.6, 2570.7, 2570.8, 2570.9, 2570.14, and 2570.16, Business and Professions Code.

PENDING REGULATIONS

The Regulations Update report is attached.

REGULATIONS UPDATE REPORT

Pending Rulemaking files: In-Process

Rulemaking File Subject	Section(s)	Status	Close of public comment period	Date Pkg Sent to DCA	Date Pkg Rtn'd from DCA	Final Pkg Due to OAL	Actual Submit Date To OAL	Date language goes into/ went into effect
Fees	4130	Language published April 25, 2016. Modified text adopted August 2016.	05/09/2016	10/21/2016	03/17/2017	03/24/2017	03/22/2017	07/01/2017
Continuing Competence	4161 4162 4163	Language published June 24, 2016. Language adopted August 2016	08/08/2016	11/03/2016	06/16/2017	06/23/2017	06/20/2017	07/01/2017
Notice to Consumer	4176	Language published July 1, 2016. Second modified text adopted October 2016.	08/15/2016	03/29/2017	06/27/2017	06/30/2017	06/29/2017	
Petition for Reinstatement or Modification of Penalty	4149.5	Language published August 26, 2016. Modified text adopted December 2016.	10/10/2016	06/09/2017		08/25/2017		

REGULATIONS UPDATE REPORT

Pending Regulatory Amendments: Process Not Yet Started

Rulemaking File Subject	Section	Priority	Status	Comments
Probation Monitoring costs	4147.2	1	Board approved language for noticing.	*Subject to new approval process*
Continuing Competence – timely submission; prohibition on using PDUs twice	4162	2	Board approved language for noticing.	
Filing of Addresses	4102	3	Board approved language for noticing.	*Subject to new approval process*
Accept PT license for Hands/PAMs approval	4151 4152	4	Board approved language for noticing.	*Subject to new approval process*
Language for OT to request to supervise more than 2 OTAs	tbd	tbd	Practice Committee to prepare language; draft language to be presented to the Board at Spring 2017 meeting.	*Will be subject to new approval process* Language would implement BPC 2570.3(j)(2).
Patient record retention requirements when a business is closed/sold/inherited or has a change of ownership; or if practitioner is no longer in private practice	tbd	tbd	Practice Committee to prepare language; draft language to be presented to the Board at Spring 2017 meeting.	*Will be subject to new approval process* Language provides specificity to language in BPC 2570.185.

PUBLIC COMMENT FOR ITEMS NOT ON THE AGENDA

Hello Esteemed Board Members,

I was wondering if the Board can issue a policy statement/position on whether suture removal is within the scope of practice for OTs with their hand therapy advanced practice approval.

I have been unable to find a decision put forth by CBOT regarding this issue, and according to NBCOT it is a state regulatory issue and they have sent me back to you. We have come across many hand surgeons who have written instructions for us to remove sutures 14 days post op, but are unclear if we are within our scope to do so. I am aware that many clinics who have CHTs or OTs with their advanced practice approval are removing sutures after receiving on the job training. While I don't see anything prohibiting us from doing it, having this position outlined by CBOT would add to strengthen our profession should CBOT be in agreement.

The Physical Therapy Board of California has addressed this same question for PTs on their website. They have determined that it would fall under the same category as staple removal; while this is not normally associated with PT, if the PTs have been trained adequately and the facility has a written protocol outlining training as such, it is within their ability to do so. (Copy follows)

It would be wonderful if we could have a definitive answer for our profession, in the hopes of eliminating any gray area that could potentially be challenged by a colleague or consumer. Please add this to a future agenda for discussion and a decision.

BUSINESS, CONSUMER SERVICES, AND HOUSING AGENCY - GOVERNOR EDMUND G. BROWN JR.

Physical Therapy Board of California

2005 Evergreen St. Suite 1350, Sacramento, California 95815

Phone: (916) 561-8200 Fax: (916) 263-2560

Internet: www.ptbc.ca.gov

STAPLE & SUTURE REMOVAL

Is staple removal within the scope of practice of a physical therapist?

The subject of staple removal was considered by the Practice Issues Committee of the Physical Therapy Board of California (Board) at their meeting of August 1995. The Practice Issues Committee opined that physical therapists may not perform invasive procedures; specifically in this instance, that of stapling a wound closed.

The removal of staples, on the other hand, is a non-invasive procedure, which would ordinarily come under the heading of nursing services, and is not normally associated with the practice of physical therapy; however, physical therapists may provide any non-invasive physical rehabilitation procedure they have been adequately trained to perform. Should a facility elect to train physical therapists to do staple removal, the facility would need a written protocol to be included in their policies and procedures manual, and to be used in the training of each physical therapist who will perform this procedure.

The training protocol must be sufficient to ensure the facility's patients that the procedure is being done in a safe and efficient manner by personnel who are trained specifically to remove staples. The training should also include procedures for problem situations resulting from staple removal, and for notification of proper medical personnel.

The Board has received multiple inquires as to whether suture removal would be considered a non-invasive procedure such as staple removal. After consulting with a physical therapist expert consultant, it has been determined that the removal of sutures would fall under the same category as the removal of staples as indicated above.

Note: This document is not a declaratory opinion of the Physical Therapy Board of California.

Occupational therapists (OTs) are responsible for all aspects of occupational therapy service delivery, including services provided by occupational therapy assistants (OTAs) under an OTs supervision; OTs are responsible for the safety and efficacy of the delivery of occupational therapy services.

Occupational therapy is the scientifically-based use of purposeful and meaningful goal-directed activity that allows individuals to achieve maximum independence, prevents or minimizes disability, and maintains the health of individuals who are limited by physical injury or illness, psychosocial dysfunction, developmental or learning disabilities or the aging process. Per the occupational therapy practice act (OTPA) occupational therapy consultation "provides expert advice to enhance function and quality of life."

Although the statutory provisions set forth in the OTPA don't specifically mention whether wound care is within the scope of practice of OTs and OTAs, the Board has opined that the practice of occupational therapy includes wound care management. Since proper wound care can affect an individual's ability to participate in daily life activities, it's noted that appropriate wound care can improve or enhance an individual's quality of life.

Thus, OTs and OTAs providing wound care is not only within the occupational therapy scope of practice, but absolutely appropriate, as long as practitioners comply with the Board's Ethical Standards of Practice, set forth in California Code of Regulations (CCR), Title 16, Division 39, Article 8, section 4170(d), which states: Occupational therapy practitioners shall perform occupational therapy services only when they are qualified by education, training, and experience to do so.

Wound care can include treatment that facilitates healing, prevents edema, infection, and excessive scar formation, and minimizes wound complications. Wound care includes, among other things:

- Assessment of the wound;
- Selection and application of dressings;
- Cleansing of the wound and surrounding areas;
- Use of physical agent modalities;
- Use of topical medications;
- Wound debridement; and
- Patient education.

Please note that in order to use physical agent modalities OTs must demonstrate competence to the Board by providing evidence of completing 30 post-professional contact hours in specified content areas and 240 hours of supervised on-the-job training, clinical internship or affiliation. Once an OT is approved by the Board to use physical agent modalities, the OT may also apply (specified) topical medications. CCR section 4152.1 defines topical medications as "medications applied locally to the skin or underlying tissue where such medications require a prescription or order under federal or state law." Under no circumstance does this section authorize an occupational therapist or occupational therapy assistant to administer a medication via injection.

The medications applicable to the practice of occupational therapy and which may be used by an occupational therapist includes the following:

- Bactericidal agents;
- Debriding agents;
- Topical anesthetic agents;
- Anti-inflammatory agents;
- Antispasmodic agents; and
- Adrenocortico-steroids.

Please note: An OTA may also use physical agent modalities or apply topical medications under the supervision of an OT approved by the Board to use physical agent modalities.

To further support the Board's opinion that wound care is within the occupational therapy scope of practice, we refer you to the CPT codes that can billed under Medicare, including 97597, *removal of devitalized tissue from wound(s), selective debridement*, and 97602, *removal of removal of devitalized tissue from wound(s), non-selective debridement.*

If you have further questions, please contact the Board at 916/263-2294 or send an email to cbot@dca.ca.gov.

WOUND MANAGEMENT WHITE PAPER

Overview

Occupational therapists and occupational therapy assistants[1] routinely work with individuals and populations who are at risk for or have sustained wounds. In 2000, the U.S. Department of Health and Human Services in its Healthy People 2010 initiative called for a 50% reduction in pressure ulcer incidence by 2010. As a part of the work of the American Occupational Therapy Association (AOTA) in supporting occupational therapists and occupational therapy assistants, this white paper serves to inform internal and external audiences, including employers and payer sources, about the role of occupational therapy related to prevention and amelioration of wounds and their associated costs and impact on daily life activities.

Types, Incidence, and Prevalence

Wounds, or impaired skin integrities, include abrasions, punctures, bites, surgical wounds, diabetic ulcers, pressure ulcers, traumatic wounds, venous stasis ulcers, and arterial ulcers. Certain populations either exhibit or are at risk for wounds and from related complications. These populations include people with spinal cord injuries, cerebral palsy, hand injuries, diabetes, breast cancer, and burns, as well as those with sensory or mobility impairments. For example, more than 60% of nontraumatic lower-limb amputations occur among people with diabetes (National Diabetes Information Clearinghouse, 2005).

Impact on Daily Life

Wounds and related conditions can affect a person's ability to participate in his or her daily life activities. There can be limitations with performing self-care or pursuing work, education, or other life roles. Sequelae of wounds can include depression, decreased social participation, and anxiety. Occupational therapy's perspective on working in this area combines an understanding of both physical disabilities and mental health, with a focus on supporting health and participation through engagement in daily life activities and occupations.

Depending on the location and severity of the wound, a person may have difficulties with any of the following:

- Management of the wound site may be demanding, including applying wound care treatments and products to promote healing as well as managing drainage or odor. Clothing and footwear adaptations may be needed to avoid contact with the wound or wound dressings. Pressure garments for scar management may be used.

[1] Occupational therapists are responsible for all aspects of occupational therapy service delivery and are accountable for the safety and effectiveness of the occupational therapy service delivery process. Occupational therapy assistants deliver occupational therapy services under the supervision of and in partnership with an occupational therapist (AOTA, 2004).

- Pain and discomfort may make sleep challenging or prevent a person from performing everyday activities (e.g., walking, bathing, dressing).
- Limitations in mobility may be related to the wound site or associated pain. Prolonged periods of immobility may lead to further disability.
- Activity restrictions may prevent a person from sitting upright in bed or a chair, which can lead to further disability. Prevention of deep vein thrombosis is a concern after a burn injury.
- Discoloration of the skin, visible scars, extended time required for scar management, and wearing of compression garments may affect self-esteem.
- Economic ramifications due to an inability to work can cause economic stress as well as loss of worker identity.

Occupational Therapy's Role in Wound Healing

Occupational therapy as a profession values engagement in activities that support participation in life (AOTA, 2002). Sustaining a wound, such as a finger amputation, may require direct attention to the wound itself as part of the overall occupational therapy intervention. Intervention also may include accommodations while the wound is healing, such as a handheld shower wand to allow independent bathing while maintaining the integrity of the wound area. Occupational therapy practitioners[2] also are skilled in the prevention of wounds for people with various conditions such as spinal cord injuries, diabetes, hand injuries, and other sensory and mobility impairments. In these cases, individual attention is given to the client's health status, environment supports, patterns of activity, and lifestyle choices so that skin integrity is maintained.

Specific methods and techniques are commonly used during occupational therapy intervention with clients who are at risk for or experiencing wounds. Optimal intervention

> Should not only incorporate standard prevention techniques such as skin checks or pressure reliefs but also, based on a given patient's personal profile, direct attention to additional concerns such as self-advocacy skills in assessing medical services, stress management, and the ability to identify an optimal balance between living a full life and avoiding activity-related ulcers (Clark et al., 2006, p. 1523).

The following are examples of types of interventions and intervention approaches used in the delivery of occupational therapy services (AOTA, 2002). Some interventions focus on the client, others address the way in which activities are performed, and others seek to change the context or environment that surrounds the client and influence performance (this is not an exhaustive list). Interventions also may focus on preventing a wound from occurring.

[2] When the term occupational therapy practitioner is used in this document, it refers to both occupational therapists and occupational therapy assistants (AOTA, 2006).

Health Promotion (Create, Promote)

Initial Skin Assessment

An initial skin assessment, which involves completion or assisting in the completion of skin assessment on admission to an acute care hospital or other health care facility, could include assessing a wound in any area of the person's body that is affecting self-care. One frequently used skin assessment is the Braden Scale (Prevention Plus, 2001).

Remediation, Restoration (Establish, Restore)

Debridement, Splinting, AROM, and PROM

Specialized training in wound care, debridement, splinting, active range of motion (AROM), and passive range of motion (PROM) associated with rehabilitation after a burn, traumatic hand injury, or hand or finger surgery can prevent adhesions and provide proper positioning for a client during wound healing.

Wound Care

Wound care involves wrapping techniques with bandaging to maintain joint ROM and optimal functioning. It also can include direct wound care during therapy, whirlpool use, and client education on how to care for the wound.

Maintain

Support Surfaces

Making recommendations for support surfaces can include pressure relief surfaces for beds and wheelchairs.

Compensation, Adaptation (Modify)

Adaptive Equipment

Adaptive equipment can allow a client to assist with or perform dressing changes. Training in use of equipment is necessary to complete basic activities of daily living (ADLs; e.g., bathing, grooming, dressing, eating) and instrumental activities of daily living (IADLs; e.g., assistive devices, special mattresses, special wheelchair cushions) that are pertinent to the individual.

Positioning

Positioning involves positioning techniques, postural alignment, distribution of weight, balance, stability, and pressure relief (including splinting).

Disability Prevention (Prevent)

Compression Dressings and Stockings

To promote sustained prevention, occupational therapy practitioners can help clients identify ways to incorporate recommended prevention measures into their ongoing daily routines. This can include the selection and application of techniques to don and doff pressure garments to manage swelling and prevent upper-extremity lymphedema.

Reduction of Friction and Shearing Forces

Education in transfer techniques can minimize risk of skin tears.

Conclusion

Wound management encompasses a range of services, including wound prevention and wound care treatment, as well as client education related to wound care self-management. When these interventions are provided, they are always integrated into a broader occupational therapy program and plan of care. The occupational therapy interventions provided always serve to support engagement in activities that facilitate participation in life.

References

American Occupational Therapy Association. (2002). Occupational therapy practice framework: Domain and process. *American Journal of Occupational Therapy, 56,* 609–639.

American Occupational Therapy Association. (2004). Guidelines for supervision, roles, and responsibilities during the delivery of occupational therapy services. *American Journal of Occupational Therapy, 58,* 663–667.

American Occupational Therapy Association (2006). Policy 1.44: Categories of occupational therapy personnel. *American Journal of Occupational Therapy, 60,* 683–684.

Clark, F. A., Jackson, J. M., Scott, M. D., Carlson, M. E., Atkins, M. S., Uhles-Tanaka, D., et al. (2006). Data-based models of how pressure ulcers develop in daily-living contexts of adults with spinal cord injury. *Archives of Physical Medicine and Rehabilitation, 87.* 1516–1525.

National Diabetes Information Clearinghouse. (2005). *National diabetes statistics.* Retrieved December 18, 2006, from http://diabetes.niddk.nih.gov/dm/pubs/statistics/index.htm

Prevention Plus. (2001). *Key benefits [of the Braden Scale].* Retrieved December 18, 2006, from http://bradenscale.com/bradenscale.htm

U.S. Department of Health and Human Services. (2000, November). *Objectives for improving health (Part A—Focus Areas 1–14): 1.16. Reduce the proportion of nursing home residents with a current diagnosis of pressure ulcers.* Retrieved December 20, 2006, from http://www.healthypeople.gov/document/HTML/Volume1/01Access.htm#_Toc48943281

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Approved by the Board of Directors October 2007 (BDM7-100507)

AGENDA ITEM 16

DISCUSSION AND POSSIBLE ACTION REGARDING FIELDWORK SITES.

ST. CATHERINE UNIVERSITY

601 25th Ave. S. Minneapolis, MN 55454
651-690-7700 www.stkate.edu

March 25, 2017

Dear Ms. Miller and Members of the California Board of Directors;

I recently had the opportunity to review the video proceedings of your December 8, 2016 board meeting and wish to address your Board to clarify some statements made regarding the OTA Program for St. Catherine University. The conversation was initiated by Ada Boone Hurl, and I apologize if I have misspelled her name.

The St. Catherine University OTA program has been continuously accredited since 1964. In 2014, we were approved by ACOTE to extend our accreditation to include an "online with labs" program, with the labs initially located in Virginia. We were approved to expand to California beginning summer 2016. We completed the authorization process and we are fully authorized by the State of California to admit students in California, to have an online presence in the state, and to provide labs and fieldwork in the state. Our didactic and lab instructors are also licensed to teach in the state. Ms. Miller, you stated that you know the high ethical standards of the university, and I appreciate the comment, as this is a point of pride for our program.

I am disappointed that the Board and members of the OT community feel you were caught unaware by our presence in the state. I understand from Dr. Penelope Moyers, the Dean of our School of Health, as well as Tom Hutton, our Academic Fieldwork Coordinator, that both have been in communication broadly in the state. Tom has even attended the state conference, sat at a table in the exhibit hall, and participated in social events with active members of the OT Association. The program has been written up in newsletters that go out to our alumnae, including those living in California. I am open to ideas on how we can better communicate what we are doing.

I'd like to describe our program, briefly. We are 80% online, with our didactic content provided via technologies such as storyline, video, and gaming strategies that promote active engagement of the student with course content. 20% of the content is provided in face-to-face labs that take place in clinical rehab sites across the state – specifically hands-on skills and competency testing. Currently these sites happen to be provided by Genesis, but that is not a requirement and a variety of sites are currently being assessed for appropriateness. Students experience 2 Level I and 2 Level II placements. We admit students three times per year, and at the time of this Board meeting we were approved to admit a maximum of 24 students each admission cycle, so no more than 72 students in an academic year.

To this point, we have admitted 78 students in California over 4 semesters. 42% of the students admitted during this time (33 students) are actually from California; the remaining come from all over the nation, and from as far away as Minnesota, Missouri, Kansas, and Texas. We are attracting students who have barriers to attending a traditional occupational therapy assistant program – single parents, second career, first generation, those who need to work full-time, rural, etc. It might be interesting to note that 43% of our students identify as student of color and 18% are men. So we are meeting a workforce need to increase diversity in our profession, and we are meeting our university's social justice mission of attracting students who traditionally have been unable to attend college.

I would like to clear up an assumption about our partnership with Genesis. This was the context in which the concerns about our program emerged. Our partnership with Genesis extends only to providing lab sites and to advertising on their job board for clinicians interested in adjuncting. We get no priority fieldwork placements and we are in fact, limited by Genesis as to how many students they will take from us in any

given semester. Priority, according to Genesis, is given to local colleges and universities with whom Genesis has had long-term relationships. We are also being asked to pay for fieldwork sites just like everybody else, and the university's response has been to not use the few sites that Genesis is willing to open to us. There was a rather flippant comment made about how expensive the university is, and "what's another $1,000". We take our student debt load very seriously, and are not using Genesis because we are reluctant to add additional cost to their already high tuition.

I'd like to briefly address fieldwork. Your concerns appear to stem mostly from lack of fieldwork sites, and how students get their supervision (for consumer protection). Less than half of the students attending California lab sites live in California. Students are placed for Level II fieldwork as close to where they live as possible, so they do their Level II fieldwork in their home states. Our belief is that if we place students near their homes (especially in rural areas), they are more likely to stay in those areas to work. To further reduce strain on fieldwork sites, we have adopted a Level I group fieldwork model. We place our students in small groups in settings that do not currently employ occupational therapy professionals, but where OT could have a significant role, including community settings and areas of emerging practice. We provide student supervision through local OT clinicians who serve as the fieldwork educators and facilitate the experience along well-defined criteria (helping students see the role for OT through the eyes of an experienced OT or OTA, practicing OT observation skills and completing documentation samples, facilitating groups, defining the potential role for OT at the site, etc.). Several "desires" were expressed by the Board at this meeting that resonate with goals that we hold for our St. Catherine University OTA Program – providing equity of opportunity for all students, increasing diversity in the profession, addressing workforce needs, and maximizing participation in our profession.

I hope that I have addressed the Board's concerns. If you would like further clarification or if you have additional questions about what we are working on and how we are educating our students, please contact me.

Sincerely,
Diane Anderson, PhD, MPH, OTR/L
Associate Professor
OTA Program Director
St. Catherine University
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Introduction

At its **November 4–5, 2016,** meeting, the **AOTA Board of Directors** reviewed the many complex challenges facing the viability of the existing fieldwork and other experiential components of occupational therapy education programs for occupational therapists and occupational therapy assistants. The Board voted to establish an Ad Hoc Committee to explore current experiential requirements in occupational therapy education and alternative models that would best ensure future entry-level practitioners are prepared to meet occupational needs of society.

AOTA convened an **Ad Hoc Committee** for a 2-day, face-to-face meeting in Bethesda, MD, on **February 6–7, 2017.**

At its **February 17–18, 2017,** meeting, the **AOTA Board of Directors** reviewed the report of the Ad Hoc Committee. After considerable discussion and questions, the Board of Directors voted to take the following actions:

1. Moved to accept the Fieldwork (Experiential) Ad Hoc Committee's report to the AOTA Board of Directors as written.
2. Charged the AOTA President to write to the ACOTE Education Standards Review Committee (ESRC) endorsing the Ad Hoc Committee's recommendation to change the current Level I Fieldwork Standards to reflect the Ad Hoc Committee's recommendations for the "Initial Experiential Learning Requirement" in the 2017 Standards as outlined in the report.
3. Charged the AOTA Executive Director to develop a report for the AOTA Board of Directors' October 2017 meeting detailing the potential impact and costs of implementing the proposed model for experiential learning that includes a post-graduate residency for graduates of entry-level programs for occupational therapists. The report should include, but not be limited to,
    1. Costs and timeline for advocating to state regulatory agencies for a provisional license model;
    2. Residency program requirements, competencies, and development costs;
    3. Design, costs, and timeline for a feasibility and pilot study for the proposed model.

Note. There was a considerable discussion regarding the recommendation for a post-graduate residency requirement for occupational therapy assistant graduates. Ultimately, the AOTA Board of Directors voted not to pursue this recommendation at this time. Consensus was reached that the model for occupational therapists and occupational therapy assistants do not need to be the same due to the different levels of educational preparation and scopes of practice. The following report includes the full findings and recommendation of the Ad Hoc Committee. The recommendations that will not be pursued have been marked by ~~strikethrough~~ in the text of the report.

Fieldwork (Experiential Learning) Ad Hoc Committee Report and Recommendations to the AOTA Board of Directors

Executive Summary

At its November 2016 meeting, the AOTA Board of Directors reviewed the many complex challenges facing the viability of the existing fieldwork and other experiential components of occupational therapy education programs for occupational therapists and occupational therapy assistants. The Board voted to establish an Ad Hoc Committee to explore current experiential requirements in occupational therapy education and alternative models that would best ensure future entry-level practitioners are prepared to meet the occupational needs of society.

AOTA convened an **Ad Hoc Committee** for a 2-day, face-to-face meeting in Bethesda, MD, on February 6–7, 2017. The Committee was charged by the Board to *"Explore current experiential requirements in occupational therapy education and alternative models that would best ensure future entry-level practitioners are prepared to meet occupational needs of society."* The meeting addressed the following 4 primary objectives:

- **Objective 1:** Identify the strengths and weaknesses of the current experiential requirements (including fieldwork) for occupational therapy education.
- **Objective 2:** Identify the requirements of alternative models used in other health professions and, where applicable, the history of the development of these requirements.
- **Objective 3:** Understand the implications of changing the experiential requirements for occupational therapy education (e.g., impact, if any, on accreditation, certification, and licensure).
- **Objective 4:** Articulate a model for experiential requirements for occupational therapy education that ensures future entry-level practitioners are prepared to meet the current and future occupational needs of society.

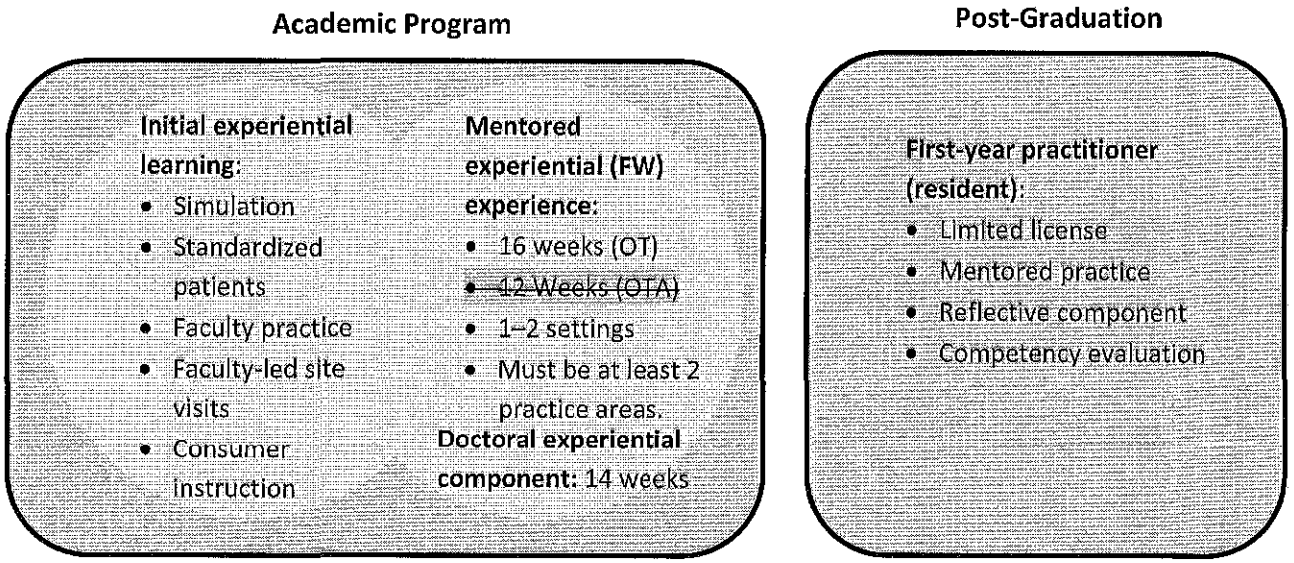
Recommendations

The committee is proposing a **NEW MODEL** of experiential education for occupational therapists and occupational therapy assistants that includes the following key elements:

- **Experiential Education Within the Academic Program:** Reduce the number of hours in mentored practice settings (Levels I and II fieldwork), and increase the amount of experiential instruction utilizing simulation, standardized patient encounters, and faculty-led practice experiences. The primary objective of experiential education within the academic program is to transition the student to practitioner, ensuring translation of knowledge, skills, and attitudes in the application of purposeful, occupation-based interventions.

- **First-Year Practitioner (Residency)**: Creation of a post-graduate first-year practitioner (resident) program within the practice community for occupational therapy ~~and occupational therapy assistant graduates~~. Graduates would have completed the certification exam and be practicing under a limited license until completion of the residency. The primary objective of the first-year practitioner (resident) program is to transition the graduate from resident to independent novice practitioner.

This reports details the deliberations of the Ad Hoc Committee and rationale for the recommendations.



Objective 1: Identify the strengths and challenges of the current experiential requirements (including fieldwork) for occupational therapy education.

Staff and content experts presented information to the committee members on the following:

- Overview of the current education requirements for experiential learning at OTA (Associate's/Bachelor's) and OT (Master's and Doctorate) programs;
- Trend data on occupational therapy education; and
- Higher education policy issues impacting occupational therapy education.

Key Findings

- Rapid growth has occurred in academic programs and in the numbers of OT and OTA students.
- There were 21,431 **Level II** fieldwork placements in 2015.
- A limited number of qualified faculty and practitioners are available to support experiential learning requirements.
- Health care delivery systems and models are changing.

Identified Strengths

- The faculty and practitioner community are committed to education and preparation of entry-level practitioners.
- The current fieldwork Level II enables students to be mentored by experienced practitioners in current practice.

Identified Challenges

- Number of qualified fieldwork sites:
    - A limited number of sites and practitioners are available to meet the growing needs of students.
    - A limited number of practitioners are qualified and prepared to be fieldwork educators.
    - Current fieldwork sites are located primarily in traditional medical and residential facilities (e.g., hospitals, long-term care facilities).
    - The current focus of fieldwork placements is on disease management.
- Cost/benefit of fieldwork:
    - Pressures exist to meet productivity and other practice demands.
    - Reimbursement policies do not allow for reimbursement of services delivered by students in all settings.
- Disconnect between education and practice:
    - Many faculty members are disconnected from current practice demands.
    - Many practitioners are not familiar with current education priorities (e.g., interprofessional education [IPE]).
    - Employers note that new graduates need extensive mentoring for first 6–9 months.

- Lack of outcomes on the current experiential learning model:
  - No evidence exists to demonstrate if the current 24/16-week model adequately prepares entry-level practitioners.
  - Entry-level expectations for practitioners can vary between academia versus employers.
- Not addressing the lack of diversity in the profession:
  - Few fieldwork placements occur in settings addressing the needs of underserved populations.
  - A lack of diversity exists in faculty and practitioners.

Objective 2: Identify the requirements of alternative models used in other health professions and, where applicable, the history of the development of these requirements.

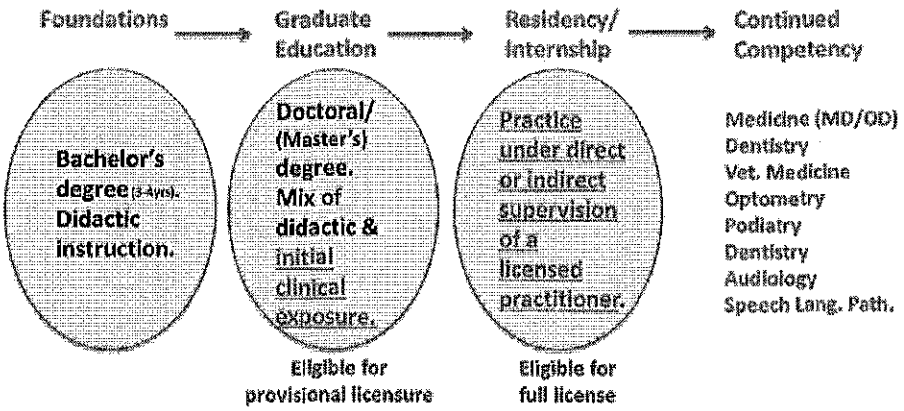
Staff and content experts presented information to the committee members on the following:

- History of experiential learning in other health professions and alternative models
- Current discussions in physical therapy and nursing
- Role of simulation and standardized patients.

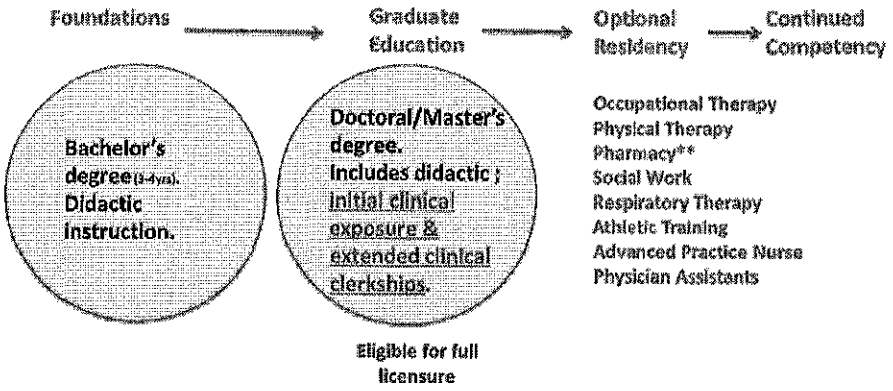
Key Findings

- Graduate models of health care education

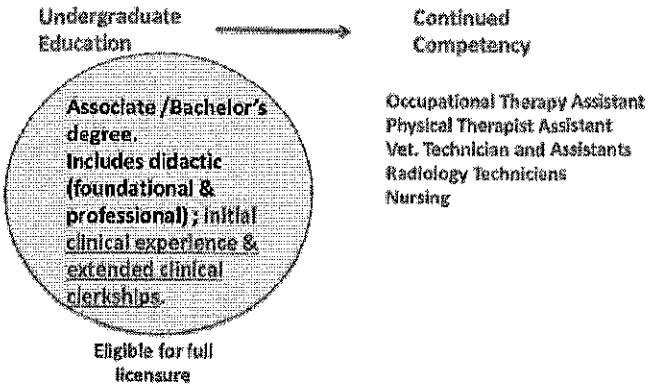
Model A



Model B



- Undergraduate model of health care education



- Simulation:
  - The simulation delivery models are consistent with learning theories used in the OT program curriculum designs.
  - There is a growing role for simulation and standardized patient experiences in the experiential learning model.
  - Outcome data indicates no statistical difference in outcomes for students in several health professions when simulation was used to replace clinical hours.
- Other models:
  - Faculty-led clinical experiences (nursing)
  - Faculty practices
  - Consumer instruction.

What can we learn from other professions that could address our biggest challenges faced by the profession in meeting the experiential requirements for occupational therapy entry-level education?

- Progressive experiential learning:

    - Support for the concept that each stage of the experiential learning model should build on the competencies developed in the previous stage.
- Simulation:
    - Evidence clearly supports the use simulation and standardized patients in the development of foundational practice competencies (currently Level I fieldwork).
- Faculty-led experiential learning activities:
    - Ideally, these activities are included as part of the development of foundational practice competencies (currently known as Level I fieldwork).
    - Opportunities are created for faculty to spend more time in and obtain exposure to the current practice environment.
    - Opportunities are created for practitioners to interact with faculty and learn about current educational trends (e.g., evidence-based practice, knowledge translation, IPE).
    - There would be a decreased demand on fieldwork sites to develop activities.
- Post-graduate residency (first-year practitioner):
    - This model has been successful in several of other professions (e.g., audiology, medicine, optometry, podiatry).
    - Pressure is reduced on both academic and practice environments for fieldwork placements.
- Training needs:
    - More web-based learning opportunities for fieldwork educators are needed.

Objective 3: Understand the implications of changing the experiential requirements for occupational therapy education (e.g., impact, if any, on accreditation, certification, and licensure).

Staff and content experts presented information to the committee members on the following:

- Implications for accreditation
- Implications for certification
- Implications for licensure
- Implications for the practice community (fieldwork sites)
- Implications for the education community
- OTA vs. OT.

Key Findings

- Accreditation:
    - Any alternative model mandated across all educational programs would require changes in the ACOTE standards.
- Certification:
    - No impact on the NBCOT certification exam is foreseen with any alternative model.
- Licensure:

- Significant potential impacts could occur depending on each state's practice act; many states require only graduation from an ACOTE-accredited school and NBCOT certification, but some also stipulate experiential requirements.
- A post-graduate/certification requirement would require a "provisional license," which would mean potentially revising many of the states' practice acts.

- Practice community:
  - Changes in the experiential requirements would impact the demands on the practice community. The exact impact is dependent on the model finally adopted by the profession. For example, a post-graduate residency would require practices to develop "resident" positions.
  - A post-professional requirement (residency) would require enough placements being available and developing additional opportunities for placements.
- Education community:
  - A post-professional requirement may require changes in credit load, just when many professions are trying to decrease costs through decreasing credit load.
  - The question remains whether a residency program requires an education program to limit the number of students.
- OTA vs. OT:
  - Consensus was reached that the model for both OTs and OTAs do not need to be the same due to the different levels of educational preparation and scopes of practice.

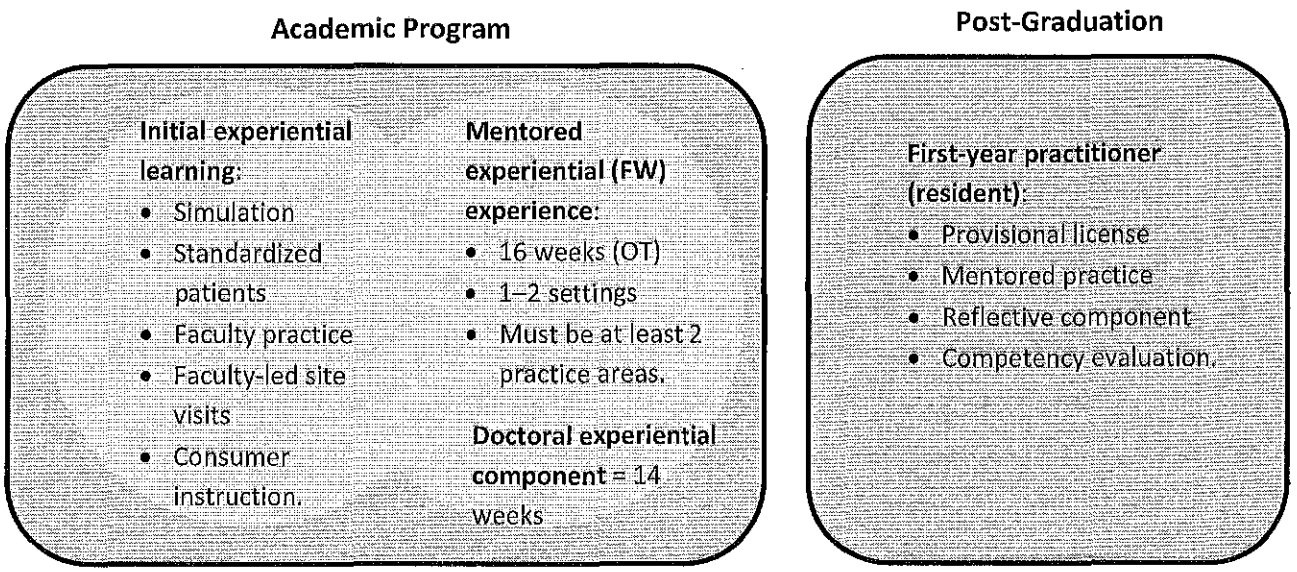
Objective 4: Articulate a model for experiential requirements for occupational therapy education that ensures future entry-level practitioners are prepared to meet the current and future occupational needs of society.

Ad hoc committee members divided into small groups to work on the following 2 questions:

- What would be the key elements in a new model for experiential learning in entry-level education for OTs? OTAs?

Recommendations

- Move to a model of experiential learning for **OCCUPATIONAL THERAPISTS** that includes a post-graduate residency:



Experiential education within the academic program: Transition the student to practitioner, ensuring translation of knowledge, skills, and attitudes in the application of purposeful, occupation-based interventions. The graduate will demonstrate competency in

- Evaluation and formulation and implementation of the therapeutic intervention plan to facilitate occupational performance and participation that is culturally relevant; reflective of current occupational therapy practice; based on available evidence; and based on theoretical perspectives, models of practice, and frames of reference
- Safety in direct care encounters
- Documentation demonstrating the distinct value of OT
- Ethical and professional behaviors
- Therapeutic use of self
- Communication of OT's role with clients and stakeholders
- Self-reflection of professional skills and development.

First-year practitioner: Transition the graduate from resident to independent novice practitioner. The practitioner will demonstrate basic competencies to fulfill the following roles in a rapidly changing and dynamic nature of contemporary health and human services delivery systems:

- Direct care provider
- Consultant
- Educator
- Leader/manager
- Researcher/scientist
- Advocate for the profession and the consumer.

- Move to a model of experiential learning for **OCCUPATIONAL THERAPY ASSISTANTS.** ~~that includes a post-graduate residency~~

Academic Program

Post-Graduation

Initial experiential learning:
- Simulation
- Standardized patients
- Faculty practice
- Faculty -led site visits
- Consumer instruction.

Mentored experiential (FW) experience:
- ~~12-weeks~~
- 1–2 settings
- Must be at least 2 practice areas.

~~**First-year practitioner (resident):**~~
- ~~Provisional license~~
- ~~Mentored practice~~
- ~~Reflective component.~~

~~**Experiential education within the academic program:**~~ ~~Transition the student to practitioner, ensuring translation of knowledge, skills, and attitudes in the application of purposeful, occupation-based interventions. The graduate will demonstrate competency in~~
- ~~Under the supervision of and in cooperation with the occupational therapist, implementation of the therapeutic intervention plan to facilitate occupational performance and participation that is culturally relevant, reflective of current occupational therapy practice, based on available evidence, and based on theoretical perspectives, models of practice, and frames of reference~~
- ~~Safety in direct care encounters~~
- ~~Documentation demonstrating the distinct value of OT~~
- ~~Ethical and professional behaviors~~
- ~~Therapeutic use of self~~
- ~~Communicate OT's role with clients and stakeholders~~
- ~~Self-reflection of professional skills and development.~~

~~**First-year practitioner** Transition the graduate from resident to novice practitioner. The practitioner will demonstrate basic competencies to fulfill the following roles in a rapidly changing and dynamic nature of contemporary health and human services delivery systems:~~
- ~~Direct care provider~~
- ~~Educator~~
- ~~Advocate for the profession and the consumer.~~

Ad hoc committee members divided into small groups to work on the following questions:

- Who would be the key stakeholders in a new model for experiential learning?
- What are the implications for each stakeholder?
- What are the potential timelines?

Findings

- **Stakeholders and implications:**
  - Students:
    - Ensures ALL graduates receive mentoring in the first year of practice
    - Empowers graduates to be a generalist and develops pathways to specialist
    - Is there an impact on tuition? Is the starting salary potentially less?
  - AOTA:
    - Guidelines for first-year practitioner (residency) program
    - Recognition program
    - System for developing and matching graduates to first-year practitioner (residency) program
    - Regulatory/reimbursement/policy implications: Lobbying state legislatures.
  - ACOTE:
    - Support change to entry-level standards.
  - State associations:
    - Guidelines for limited practice statutes
    - Resources for regulation change.
  - State regulatory agencies:
    - Support the model through limited license provisions.
  - NBCOT:
    - Possible changes to foreign graduate review process.
  - Academic programs:
    - Training faculty on simulation
    - Decrease in fieldwork tuition
    - Potential increase in faculty hours currently devoted to fieldwork
    - Greater involvement of faculty in practice environments.
  - Providers:
    - Change in staffing patterns
    - Possible title, salary, and electronic medical records changes
    - Implications for increased quality through improved link between academic programs and school environments.
  - Payers
    - Implications of a limited practice license for CMS, school systems, etc.

- **Timelines:**
  - Short term:

- Recommend removal of current Level I fieldwork requirements from the proposed 2017 ACOTE standards (implementation date July 1, 2019), and substitute the recommended "Initial Experiential Learning Requirements" with examples of how these may occur (e.g., simulation, faculty practice).
- Implement a pilot program for 8 OT programs ~~8 OTA programs~~ under the **proposed model** starting in academic year 2018–2019. Data will be utilized to support the new model. Pilot programs will reflect diversity in geographical location, host institutional mission, and degree level.

- Long term:
  - Recommend changes in the experiential requirements in the 2023 ACOTE standards (implementation date July 1, 2025) to reflect the proposed model.
  - Implementation of the **proposed model** across all programs in academic year 2025–2026.

Ad Hoc Committee Participants:

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CAOT & ACOTUP Position Statement: Professional responsibility in fieldwork education in occupational therapy (2012)

It is the position of the Canadian Association of Occupational Therapists (CAOT) and Association of Canadian Occupational Therapy University Programs (ACOTUP) that all occupational therapists have the professional responsibility to engage and support entry level occupational therapy fieldwork education where possible.

Recommendations for occupational therapists:

1. Occupational Therapists practicing in Canada contribute to fieldwork education of entry level occupational therapy students (for example: supervising, co-supervising, support/cover for occupational therapist who is supervising by redistributing caseload).
2. Occupational therapists offer at least one fieldwork placement a year, as appropriate.
3. Occupational therapists explore innovative methods to support entry level student education.

Commitments from occupational therapy organizations:

CAOT recognizes completion of fieldwork is an integral component of occupational therapy education. CAOT accreditation standards require completion of 1000 hours of fieldwork. CAOT therefore encourages occupational therapists to support fieldwork through supervision of occupational therapy students in fieldwork placements.

ACOTUP will provide occupational therapists with continuing education opportunities to acquire, maintain and refine requisite knowledge and skills to fulfill their role as fieldwork educators.

Background

The CAOT Profile of Practice of Occupational Therapists in Canada (2012) identifies supporting fieldwork education as one of the key competencies within the occupational therapist's role of practice manager. It is imperative for the future of the occupational therapy profession that

occupational therapists embrace the role of preceptor and commit to fieldwork education for student occupational therapists.

Occupational therapy placements provide an ideal opportunity for students to learn skills and apply theories in practice, but also for professionals to use some the many enablement skills, one of which is 'to educate' (Townsend & Polatajko, 2007). Fieldwork placements provide structured learning experiences which allow students to develop professional behaviour, professional identity and competence to practice in the future (Mason & Bull, 2006). Likewise, educating, coaching and mentoring are key enabling skills which make occupational therapists competent role models and supervisors for students (CAOT, 1997; 2002).

Nevertheless, there are also some challenges within the profession to offering fieldwork placements. For example, as academic enrolments increase, greater demands are placed on practitioners and fieldwork placements for students have become more limited in number and more difficult to secure (Thomas et al., 2007). Lack of physical space, workload pressures, lack of time and staffing issues (e.g. turnovers, part-time and precarious employment) are additional barriers to therapists offering student placements (Thomas et al., 2007). With these barriers, the benefits in offering fieldwork placements are often overlooked. For example, in a 2007 study conducted by Thomas et al., supervisors identified enhancement of clinical reasoning and time management skills, as well as increasing the diversity in the workplace and promoting the exposure of their services to the university and community as benefits to hosting fieldwork placement students. In this study, occupational therapists also noted that offering fieldwork placements made graduate recruitment more efficient as student capabilities and work characteristics can be assessed during fieldwork (Thomas et al., 2007). These benefits counter the perceptions of decreased productivity when offering placements decreases the time and cost needed to train new hires and improves employee retention rates (Thomas et al., 2007). It is hoped that by understanding the benefits of offering fieldwork placements occupational therapists will assume this responsibility with the outcome being increased preceptor value and meaning. In addition, identifying the difficulties in obtaining placements will assist in the process of recommendations and solutions to this issue.

Professional Responsibility

According to the CAOT Code of Ethics, it is the "member's responsibility to the profession and the professional organization to do everything within their means to provide for growth and development of occupational therapy" (CAOT, 1996, p. 2). This can include developing programs for clients or developing educational programs for occupational therapy fieldwork students (CAOT, 1997; 2002). In addition to the professional responsibility, educating future occupational therapists and offering fieldwork experiences clearly contribute to the growth and development of the occupational therapy profession. This will ensure that the next generation of occupational therapists is prepared upon graduation and ensures that the profession of occupational therapy will continue to prosper (Thomas et al., 2007).

Placement models

It is important to understand the purpose of fieldwork and how essential it is in occupational therapy education. To continue the promotion and development of the profession, it is the duty of current occupational therapists to take on the role of fieldwork educator in leading and shaping the future of this profession (Jung & Tryssenaar, 1998). Occupational therapists agree to adhere to their code of ethics including the professional responsibility to provide support for students through appropriate practice education opportunities.

Various fieldwork models have been well documented in the literature (Hummel, Higgs & Mulholland, 2010; Baldry Currans, 2003; DeClute & Ladyshewsky, 1993). For example, the traditional apprenticeship model of one (1) therapist: one (1) student, and newer models including two (2) therapists: one (1) student, two (2) students: one (1) therapist or 'group' and 'role' emerging models It is recognized that these models all provide a deeper understanding of students' transition from classroom to practice setting (Bonello, 2001). The ability to offer a variety of methods of teaching to fit with everyone's' preferences or context will broaden the student experience and provide flexibility to the occupational therapists providing student education.

Glossary of Terms

Fieldwork Education: Refers to the practical integration and application of knowledge, skills and attitudes learned at university, to professional Occupational Therapy practice in the real world (Canadian Guidelines for Fieldwork Education in Occupational Therapy (CGFEOT), 2011)

Fieldwork Placement: Refers to the course component of the placement which is usually undertaken in a facility external to the University. Placements are facilitated with the provision of professional support, supervision, guidance, feedback and evaluation by an Occupational Therapist (CGFEOT, 2011)

Fieldwork Educator: A qualified Occupational Therapist or Occupational Therapy Educator with at least one year's experience (World Federation of Occupational Therapists, 2002)

Occupational therapy: The art and science of enabling engagement in everyday living through occupation; enables people to perform the occupations that foster health and well-being; enable a just and inclusive society so that all people may participate to their potential in the daily occupations in life (Townsend & Polatajko, 2007).

Role Emerging: Student placements in settings where there is no established occupational therapy service (Bossers, 1997)

References

Association of Canadian Occupational Therapy University Programs. (2011). Canadian Guidelines for fieldwork education in occupational therapy. Toronto, ON: Author.

Baldry Currens, J. (2003a). The 2:1 clinical placement model: Review. Physiotherapy, 89(9), 540-554.

Bonello, M. (2001). Fieldwork within the Context of Higher Education: a Literature Review. British Journal of Occupational Therapy, 64, 93-99.

Bossers, A., Cook, J, Polatajko, H., Laine, R. (1997). Understanding the role emerging placement. Canadian Journal of Occupational Therapy, 64, 70-81.

British Association of Occupational Therapists and College of Occupational Therapists. (2005). Code of ethics and professional conduct. Retrieved February 4, 2011 from http://www.cot.org.uk/

Canadian Association of Occupational Therapists. (2012) Profile of Occupational Therapy Practice in Canada. (3rd . Ed.). Ottawa, ON: CAOT Publications ACE
Canadian Association of Occupational Therapists. (1997; 2002). Enabling occupation: An occupational therapy perspective (1st. Ed.). Ottawa, ON: CAOT Publications ACE.
Canadian Association of Occupational Therapists. (2007). CAOT Code of ethics. Retrieved Februrary 3, 2011 fromhttp://www.caot.ca/default.asp?pageid=35.

College of Occupational Therapists of British Columbia. (2006). Code of Ethics. Retrieved February 4, 2011 from http://www.cotbc.org/Quality-Practice/Standards-of-Practice/Code-of-Ethics.aspx.

Cooper, R., & Raine, R. (2009). Role-emerging placements are an essential risk for the development of the occupational therapy profession: the debate. British Journal of Occupational Therapy, 72(9), 416-418.
DeClute, J & Ladyshewsky, R. (1993). Enhancing Clinical Competence Using a Collaborative Clinical Education Model. Physical Therapy, 73, 683-689.

Hummell, J., Higgs, J. & Mulholland, S. (2010). Models of fieldwork education in L. McAllister,. M. Paterson, J. Higgs, & C. Bithell (Eds.), Innovations in allied health fieldwork education: A critical appraisal, 97- 110. Rotterdam: Sense Publishers.

Jung, B., & Trussenaar, J. (1998). Supervising students: Exploring the experience through reflective journals. Occupational Therapy International, 5(1), 34-47.

Mason, L. R., & Bull, B. J. (2006). Practice placement education in mental health: the educator's experience. British Journal of Occupational Therapy, 69(1), 22-30.

Occupational Therapy: Clinical Educators. (2010). Retrieved February 2, 2011 from McGill University School of Physical and Occupational Therapy site http://www.mcgill.ca/spot/clinicaleducation/ot/

Thomas, Y., Dickson, D., Broadbridge, J., Hopper, L., Hawkins, R., Edwards, A., & McBryde, C. (2007). Benefits and challenges of supervising occupational therapy fieldwork students: Supervisors` perspectives. Australian Occupational Therapy Journal, 54(1), 2-12.

Townsend, E.A. & Polatajko, H.J. (2007). Enabling Occupation II: Advancing an Occupational Therapy Vision for Health, Well-being & Justice through Occupation. Ottawa, ON: CAOT Publications ACE.

World Federation of Occupational Therapists. (2002). Revised Minimum standards for the education of occupational therapists. WFOT Publications: Author.

Resources

Fieldwork models:
http://umanitoba.ca/faculties/medicine/units/medrehab/ot/fwk_models.html

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Position statements are on political, ethical and social issues that impact on client welfare, the profession of occupational therapy or CAOT. If they are to be distributed past two years of the publication date, please contact the Director of Professional Practice Tel. (613) 523-2268 or E-mail: practice@caot.ca.