STATE AND CONSUMER SERVICES AGENCY • ARNOLD SCHWARZENEGGER, GOVERNOR

BOARD OF OCCUPATIONAL THERAPY
2005 Evergreen Street, Suite 2050, Sacramento, CA 95815
Tel: (916) 263-2294 Fax: (916) 263-2701
E-mail: cbot@dca.ca.gov Web: www.bot.ca.gov

Occupational Therapy Assistants in Leadership Roles Ad-Hoc Committee TELECONFERENCE MEETING NOTICE & AGENDA

Rancho Los Amigos National
Rehabilitation Center
CART Building Conference Room
7601 E. Imperial Highway
Downey, CA 90242

Telephone numbers provided for Directions only
(562) 401-6800

Sacramento City College
Allied Health Department
Mohr Hall, Room 12
3835 Freeport Boulevard
Sacramento, CA 95822

(916) 558-2271

Friday, February 26, 2010

4:30 pm – Ad-Hoc Committee Meeting

The public may provide comment on any issue before the committee at the time the matter is discussed.

A. Roll Call

B. Approval of the January 7, 2010, Committee meeting minutes.

C. Discussion and consideration of responses to survey sent out to various stakeholders concerning occupational therapy assistants (OTAs) serving in a variety of roles.

D. Discussion regarding OTAs in supervisory, ownership, and management roles.

E. Consideration and development of recommendation(s) to the Board regarding the roles and guidelines for OTAs in supervisory, ownership and management capacities.

F. Discussion regarding the roles of OTAs in emerging and non-traditional practice areas.

G. Consideration and development of recommendation(s) to the Board regarding the roles and guidelines for OTAs in emerging and non-traditional practice areas.

H. Public comment on items not on agenda.

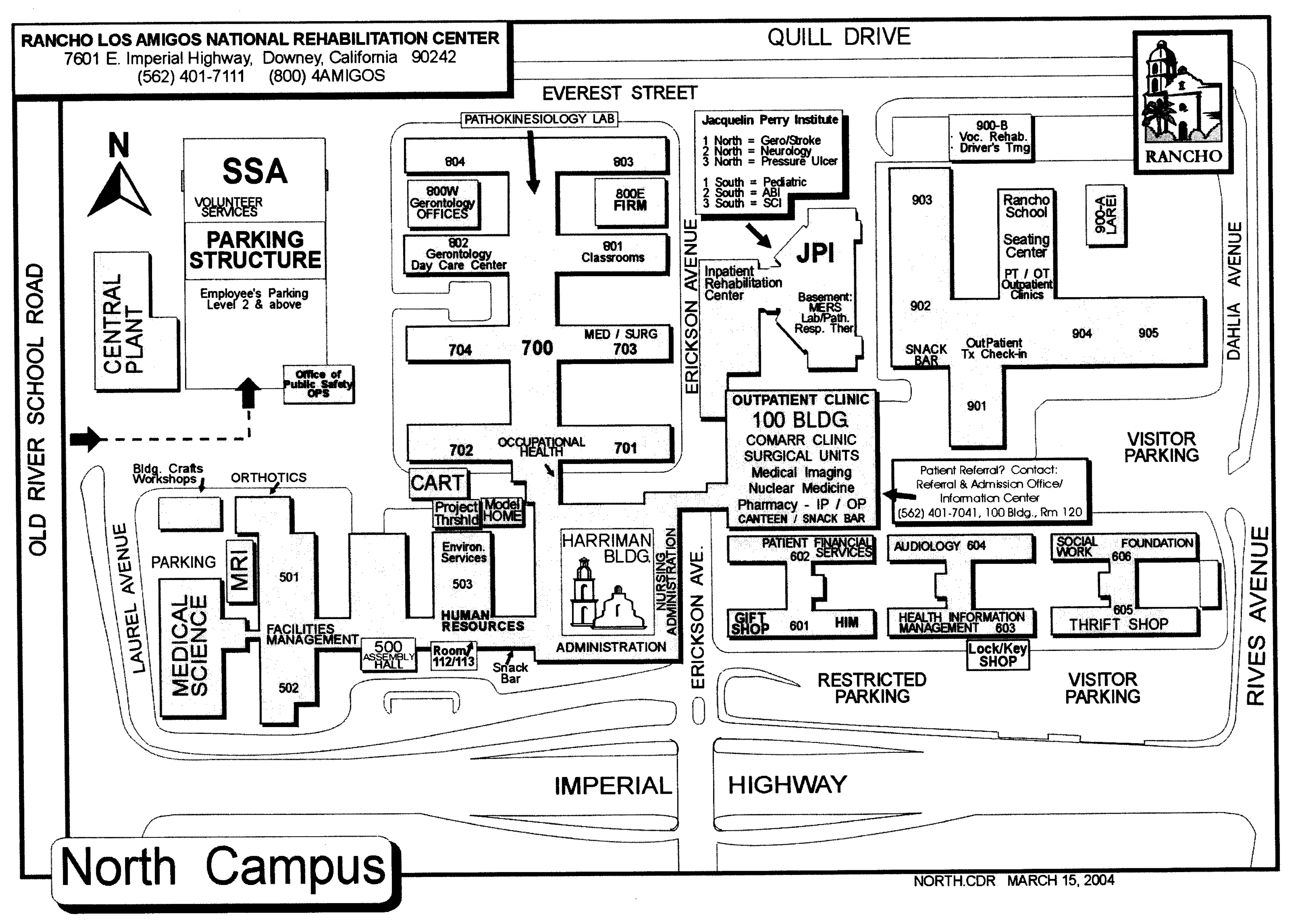
I. Adjournment

ALL TIMES ARE APPROXIMATE AND SUBJECT TO CHANGE
ACTION MAY BE TAKEN ON ANY ITEM ON THE AGENDA; ITEMS MAY BE TAKEN OUT OF ORDER

Questions regarding this agenda should be directed to Heather Martin, Executive Officer, at the Board's office in Sacramento. Meetings of the California Board of Occupational Therapy are open to the public except when specifically noticed otherwise in accordance with the Open Meeting Act. A quorum of the board may be present at the committee meeting.

Board members who are not members of the committee may observe but not participate or vote. Public comment is appropriate on any issue before the workshop at the time the issue is heard, but the chairperson may, at his or her discretion, apportion available time among those who wish to speak. The meeting is accessible to individuals with disabilities. A person who needs disability related accommodations or modifications in order to participate in the meeting shall make a request to Jeff Hanson at (916) 263-2294 or 2005 Evergreen Street, Suite 2050, Sacramento, California, 95815.

Providing at least five working days notice before the meeting will help ensure the availability of accommodations or modifications.



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802 Gerontology Day Care Center
801 Classrooms
704
700
MED / SURG 703
702
OCCUPATIONAL HEALTH
701
CART
Project Thrshld
Model HOME
Jacquelin Perry Institute
1 North = Gero/Stroke
2 North = Neurology
3 North = Pressure Ulcer
1 South = Pediatric
2 South = ABI
3 South = SCI
JPI
Inpatient Rehabilitation Center
Basement: MERS Lab/Path. Resp. Ther
ERICKSON AVENUE
OUTPATIENT CLINIC
100 BLDG
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ADMINISTRATION
LAUREL AVENUE
ERICKSON AVE.
PATIENT FINANCIAL SERVICES 602
GIFT SHOP
601
HIM
AUDIOLOGY 604
HEALTH INFORMATION MANAGEMENT 603
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FOUNDATION
606
605
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AGENDA ITEM B

JANUARY 7, 2010, MEETING MINUTES

The Minutes will be provided at the Meeting.

AGENDA ITEM C

SURVEY RESPONSES

1. Survey questions
2. Response to survey questions from other State Occupational Therapy Boards
3. Response to survey questions from the ListServe respondents of the Occupational Therapy Association of California.

Subject: Exploring issues involving OTAs in various roles/capacities
Importance: High

Dear Executive Officer/Executive Director/State Regulator =

The California Board of Occupational Therapy has established an OTA Leadership Ad Hoc committee to collect information regarding Occupational Therapy Assistants. This email is being sent on behalf of the Committee; we would appreciate you answering the questions below and providing any other information that you can share.

Questions:

1. How are OTAs used in supervisory role(s) in an administrative capacity? (i.e. director of rehab, case manager, clinical coordinator)

2. How, if at all, are OTAs used in a clinical supervisory role? (i.e. supervising OTRs)

3. As an OTA business owner, what are your roles and/or functions? What type of setting do you own or provide services?

4. How are OTAs used in management roles? In what type of setting?

5. Do the laws/regulations of your state address any of the above? If so, is the language in law, regulation or policy?

If possible, please respond by February 24th as the Committee will be meeting on February 26th. At the meeting any responses submitted will be added to the discussion. Please don't hesitate to call me at 916/263-1623 if you have any questions, or better yet, any suggestions! Thanks so much.

Thank you,
Heather Martin, Executive Officer
CA Board of Occupational Therapy
Office 916-263-2294
B'berry 916/416-9067
Fax 916-263-2701

Dear Executive Officer/Executive Director/State Regulator =

The California Board of Occupational Therapy has established an OTA Leadership Ad Hoc committee to collect information regarding Occupational Therapy Assistants. This email is being sent on behalf of the Committee; we would appreciate you answering the questions below and providing any other information that you can share.

Questions:

1. How are OTAs used in supervisory role(s) in an administrative capacity? (i.e. director of rehab, case manager, clinical coordinator)

Answer: This question is not within the scope of the OT practice act. OT-A's are only able to practice with a license under direct supervision of an Arkansas licensed OT.

2. How, if at all, are OTAs used in a clinical supervisory role? (i.e. supervising OTRs) No. The only exception would be is that they can oversee the activities of an OT Tech/Aide.

3. As an OTA business owner, what are your roles and/or functions? What type of setting do you own or provide services? This is a state agency. We regulate the profession of M.D.'s, D.O.'s, R.A's, P.A.'s, OT's, OT-A's, and Respiratory Therapists. This question isn't applicable.

4. How are OTAs used in management roles? In what type of setting? They are not used in management roles.

5. Do the laws/regulations of your state address any of the above? If so, is the language in law, regulation or policy? To best answer this question, I can only reiterate that OT-A's in our state, by law and regulation are able to practice with a license under the direct supervision of an AR licensed OT. They are closely monitored by their supervising occupational therapist and are required by law to inform in writing to this Board of who they are supervised by and where, and notify in writing any changes that occur. They can practice up to (30) days without a licensed OT in the event the OT leaves the facility. There currently is no limit ratio of OT's to OT-A's. However that regulation in in the works to limit the ratio's.

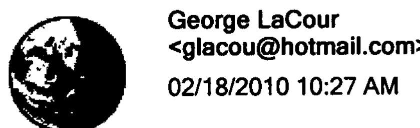
If I may be of further assistance, please let me know.

If possible, please respond by February 24th as the Committee will be meeting on February 26th. At the meeting any responses submitted will be added to the discussion. Please don't hesitate to call me at 916/263-1623 if you have any questions, or better yet, any suggestions! Thanks so much.

Thank you,

Heather Martin, Executive Officer
CA Board of Occupational Therapy
Office 916-263-2294

LA



George LaCour
<glacou@hotmail.com>
02/18/2010 10:27 AM

To <heather_martin@dca.ca.gov>
cc
bcc
Subject OTA Question from Louisiana OT Advisory Comm.

History: This message has been replied to.

Heather,

My I am one of the members of the OT advisory committee for the Louisiana State Board. In response to your questions our practice actice does not clearly define management positions for OTAs. It does clearly define:

1. OTRs supervise OTAs in a clinical setting
2. OTRs are repsonsible for the plan of care and only the OTR can change the plan of care.

I am an OTR and have been a manager as well since I started practicing years ago. OTAs mainly serve in a management capacity only in the nursing home setting where they are Case Managers or Clinical Coordinators. Their role is basically defined to make sure coverage is provided, handle all billing logistics, and other basic management tasks. In the hosptial and outpatient clinic settings OTAs are clinicians who supervise techs or students but that is about the full extent. This mostly reverts back to AOTA and their position on the roles and responsibilities of the OTR vs the COTA and who is in charge of patient care. Because a COTA works under the license of the OTR they do not supervise them. That is my perspective and I currently practice in an outpatient private practice. I was the director of inpatient and outpatient services in a hospital for 10 years and the qualifications for a manager position required it to be a therapist and not the assistant. Their added justification was based on who determined a clinician's competency and only an OTR could rate another OTR.

Hope this info helps.

George LaCour, OTR, CHT

Hotmail: Trusted email with Microsoft's powerful SPAM protection. Sign up now.

"Rosa, Jeff" <Jeff.Rosa@otptat.ohio.gov
>

02/22/2010 06:41 AM

To "Heather_Martin@dca.ca.gov" <Heather_Martin@dca.ca.gov>

cc

bcc

Subject RE: Exploring issues involving OTAs in various roles/capacities

History: This message has been replied to.

Heather,
Here a responses that I received from 2 of my board members:

(1) I've been managed by an OTA before who was a director of rehab regionally. I think OTAs can be suited to management roles (much like OTs or PTs) provided their personalities and skills are commensurate with the position. Not all therapists make good managers, and the same is true for OTAs.
The manager I had who was an OTA still needed me to evaluate and manage/oversee the caseload for her, but she provided the rest of the managerial oversight (minutes, scheduling, hiring, firing, billing, etc.) on her own.
The only place it can sometimes get tricky, in my opinion, is if there is not good IDT and rehab team communication re: d/c planning and caseload management (from a LTC/SNF perspective here). The OT/OTA need to collaborate with d/c plans vs. the OTA making decisions independently during team meetings etc. However, I haven't ever had this be an issue where I've worked.
Overall, I think OTAs can be very successful as clinical and regional managers within a rehab/SNF/LTC setting provided they are able to effectively maintain a separation of their managing more administrative tasks independently, versus collaborating with the OT for clinical/caseload management.

(2) 1. How are OTAs used in supervisory role(s) in an administrative capacity? (i.e. director of rehab, case manager, clinical coordinator) From the administrative point of view I do know that at many contract companies, hire OTA's as rehab managers.

I believe the issue of OTA's as Rehab Mangers maybe something we need to discuss. Particularly if the Rehab Manger role over laps into providing clinical supervision for the OT.

2. How, if at all, are OTAs used in a clinical supervisory role? (i.e. supervising OTRs)

I have not heard of that happening in the Ohio area. I personally do not believe that an OTA should be providing clinical supervision for an OT. OTA's do not have the education or the licensure capabitlity to do so. It does not make sense.

3. As an OTA business owner, what are your roles and/or functions? What type of setting do you own or provide services? No Comment

4. How are OTAs used in management roles? In what type of setting? See my response to question #1.

5. Do the laws/regulations of your state address any of the above? If so, is the language in law, regulation or policy? We don't speak to it directly, but the OT and OTA roles are clearly spelled out. They do not include an OTA providing clinical supervison to an OT.

From: Heather_Martin@dca.ca.gov [mailto:Heather_Martin@dca.ca.gov]
Sent: Wednesday, February 17, 2010 7:00 PM
Subject: Exploring issues involving OTAs in various roles/capacities

"Felicia M Holgate" <felicia.m.holgate@state.or.us>

02/18/2010 07:54 AM

To <Heather_Martin@dca.ca.gov>

cc

bcc

Subject RE: Exploring issues involving OTAs in various roles/capacities OREGON

History: This message has been replied to.

1. How are OTAs used in supervisory role(s) in an administrative capacity? (i.e. director of rehab, case manager, clinical coordinator) All OT Assistants in Oregon must work under the direct supervision of a licensed OT and file a Statement of Supervision prior to working in Oregon. The Oregon OT Licensing Board does not have anything special about OT Assistants in administrative capacities. I do hear that sometimes OTAssistants are hired, for example, as rehab supervisor b/c their pay is lower and they get extra pay for that role, so it is less expensive for the facility to have the Assistant be the administrator... however, this can place an Assistant in an awkward role if they are being supervised under licensure law by someone they are administratively supervising. We have talked about the issue but have not anything in writing about this.

2. How, if at all, are OTAs used in a clinical supervisory role? (i.e. supervising OTRs) The Assistant is sometimes we are aware in the clinical supervisory role.

3. As an OTA business owner, what are your roles and/or functions? What type of setting do you own or provide services? The Oregon Board does not know of any OT Assistants in a business owner role though there might be.

4. How are OTAs used in management roles? In what type of setting? We believe there are some Assistants in the management role but do not track this.

5. Do the laws/regulations of your state address any of the above? If so, is the language in law, regulation or policy? No, we have not address this.

We would appreciate a summary of what you find. I attach our rules and Q and A regarding Assistants. Regards,

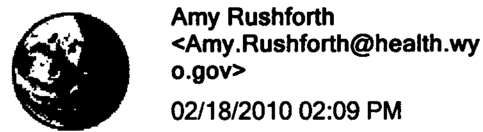
Felicia Holgate, Executive Director, Oregon Occupational Therapy Licensing Board 800 NE Oregon St. Suite 407 Portland, Oregon 97232 Tel: 971-673-0198 Fax: 971-673-0226 www.otlb.state.or.us

Click link for brief CUSTOMER SERVICE SURVEY:http://otlb.oregonsurveys.com

Mission Statement: To protect the public by supervising Occupational Therapy practice; to assure safe and ethical delivery of Occupational Therapy services.

From: Heather_Martin@dca.ca.gov [mailto:Heather_Martin@dca.ca.gov] **Sent:** Wednesday, February 17, 2010 4:00 PM
Subject: Exploring issues involving OTAs in various roles/capacities **Importance:** High

Dear Executive Officer/Executive Director/State Regulator -



Amy Rushforth
<Amy.Rushforth@health.wyo.gov>
02/18/2010 02:09 PM

To "'Heather_Martin@dca.ca.gov'" <Heather_Martin@dca.ca.gov>
cc
bcc
Subject COTA's

History: This message has been replied to.

Questions:

1. How are OTAs used in supervisory role(s) in an administrative capacity? (i.e. director of rehab, case manager, clinical coordinator) OTA's can be hired to be supervisors. If in a supervisory role they can supervise human resource issues, like continuing ed approval, vacation time approval, They do not however have the ability to be clinical supervisors of OTR's. If while in the supervisory position they continue to have patient or client care duties they are still required to be supervised by the OTR.

2. How, if at all, are OTAs used in a clinical supervisory role? Only of other COTA's or OTA students when appropriate.
(i.e. supervising OTRs)

3. As an OTA business owner, what are your roles and/or functions? Not sure- don't know any OTA's in private practice.
What type of setting do you own or provide services?

4. How are OTAs used in management roles? In what type of setting? Not aware of any.

5. Do the laws/regulations of your state address any of the above? If so, is the language in law, regulation or policy? Working on improving our laws to be more in line with the AOTA Model practice act. We are changing some of the wording to make the supervision of COTA's more clear.

Amy H. Rushforth, OTR/L
8204 State Hwy 789
Lander, Wyoming 82520
307)335-6741

"We walk a fine line accepting an individuals limitations yet pushing them toward an unknown potential" P. Salcedo

Constant Contact Survey Results

Survey Name: Role of OTAs
Response Status: Partial & Completed
Filter: None
Feb 22, 2010 7:46:09 PM

**1. How are OTAs used in supervisory role(s) in an administrative capacity? (i.e. director of rehab, case manager,
clinical coordinator) - Responses**

Answer

We do not employ any OTAs at our facility. We would hire them if we had applicants.

we do not use ota's at our acute hospital.
Overseeing Injury Prevention Program, with administrative role still being carried out by the Rehab. Manager, who is an OTR.

Not sure. I have worked with only one COTA in my 28 year career in pediatrics.
This note is to inform you that I am retired, and have no current and/or relevant information for you regarding the survey. Mary S. Leavitt OTR/L

We do not have any OTA's working in special education at this time

OTAs are not in an administrative capacity where I work.
they also have a credential in teaching or something else and an administrative credential. However, OTA's do supervise other OTA's and interns. Within the OT services "department" OT's are the case manager and in that role

We do not have any OTAs in the VA facility (Greater Los Angeles)that I work in.

I asssume you mean at a facility I might work at....and I am a private consultant, so I just have opinions.

The OTA's in my hospital setting are not in a supervisory/administrative role or capacity. We have two OTAs, working in our inpatient area, assisting with treatments and collaborating with OTRs.

We do not have COTAs in these roles.

1. I don't know of any OTAs in supervisory roles.

At my facility in none of these capacities.

They are not used in a supervisory or administrative capacity in my facility.

By level II OTR's. This is not a very common occurrence.

At my facility they are not currently holding any of these positions.

Not aware of any.

Director of Rehab
I have worked in hospitals most of my career and OTAs are clinical and does not hold any supervisory roles. I do remember an OTA holding a rehab manager position at a SNF that I was contracted to work at once.

In this private practice they are treating therapists.
and I shy away from reccommending employers higher them. Instead, I suggest employers budget to higher another OTR as it is better bang for their buck and they are held to a higher level of competency.

I have seen OTA's as Director of Rehab. in 2 SNF's
OTAs do not have the breadth of knowledge regarding OT practice that an OTR does so this limits good clinical and policy decision-making. 2) If an OTA is somehow administratively supervising an OTR who is directing clinical care that

This is not the case at our facility. They are team leaders and supervise COTA students.

They are not used in supervisory roles.

Facility Coordinater, assistant area manager, marketing

We don't have any where I work.

NA at my work area

not in our setting

They are not.
I have worked as a administrative manager in an OT practice setting, however I was in that position due to my knowledge and skills obtained from a business degree, not because of my education as an OTA.

I do not use COTA's in the setting I work in. I have worked with COTA's who have been case managers.

Not at our facility. We have one who participates in the OT management meetings to represent the COTA group.

There are no OTA's in my facility.

They aren't used in these capacities at my facility.

we do not utilize OTA in this capacity.
to the full continuum of care (including evaluation, planning of patient treatment, communication with physicians, etc.). This role should be reserved for OT/PT level, not assistant level.

OTAs not used in a supervisory role in our department.

I am not currently working with an OTA. In the past the OTA was the clinical coordinator along with doing direct treatment. As a team it was an absolutely wonderful collaboration.

none of the above in our clinic
In my experience they are a vital part of the health care team. In academia they are instructors and teach and develop classes, engage in professional development and scholarship.

I am a COTA and am the director of rehab

Not done where I work.
Administrative responsibilitites might include Logistics, keeping supplies ordered and neat□
Scheduling for inservices□

We do not currently employ COTAs

I'm not aware that OTAs are used in this way at all.
As an OTA, I have supervised OT Aides/students in a hospital setting. I have also done staff training in nursing homes and supervised/trained Nurses Aides.

none
In one of my previous jobs, an OTA was the Rehab Director. He worked with the other administrative staff and did scheduling, but did not have a direct supervisory role with the OTs, PTs and SLPs.

our clinic has COTAs as staff therapists and if we have a student OTA, they serve as clinical coordinator.

Not at all
the California Board of OT, since rehab directors supervise OTRs, and OTAs are not supposed to supervise OTRs clinically. OTAs argue that this is administrative supervision, and view this as an important advancement opportunity.

I have not worked with OTAs in supervisory roles.

Can't think of any OTAs used in above roles.

NA at where I work

One COTA directs activity of 3 RNA at long term acute hospital.

I think an OTA could be used in a supervisory role if their experience was greater than five years in rehabilitation.

Not used.

I do not know, I used to be able to supervise techs. with OT programs and now I am unable to.

No. Hands on treatment of clients under the supervision of the attending OT.
OTAs are not used in a supervisory or administrative capacity within our orgranization. An OT degree is required to perform supervisory and/or administrative functions.
Our facility did not have OTAs. I know what my personal thoughts are regarding OTAs in supervisory positions but have no experience with the subject.

The OTA is not used in a supervisory role.

I have observed COTAs to be successful in Rehab Supervisor and Facility Rehab Director positions, where they function in administrative roles rather than clinical supervisory roles. Clinical leadership can include providing clinical performance expectations, and clinical problem-solving. However, it becomes more challenging for COTAs to provide clinical supervision to OTRs due to limited assessment function, so that is best done by other licensed staff (OT or other disciplines) who are also involved in clinical assessment and care planning. In a Medicare setting, establishing RUG targets is also done with therapy staff who have done assessments, rather than solely by therapy director if director is an assistant (PTA or COTA)
I have been in the role of rehab manager for 4 years and recently moved to assistant DOR position. I have supervised staffs of 15+. Provide RUG management for facilities, staffing.□
Provide Restorative nursing training, facility inservices on falls, positioning, restraint reduction, body mechanics/transfer training, adaptive equiptment ect. I hire, fire, train, eval & manage wages. □

not in my setting, she does some info gathering, work @ acute hosp
They are not used in supervisory capacity currently in ADHC. However they would be better supervisors of an ADHC Occupational Therapy Maintenance Program than the RNs which are currently used.

We currently do not employ OTA's

OTA handle routine administrative tasks in a LTC setting, such as logging or notifying the therapist that there is an evaluation, keeping track of the organization's computer system.

In our facility we are not using them in any admistrative capastity. This is discouraged by our leadership unless the COTA has a masters in administration or health management.

OTAs have the same opportunities for administrative roles as OTRs. Both are lmiited by the nursing and PT centric culture in the medical model.

I have not had any experience with OTAs in supervisory/admin roles in the facilities I have worked.

Director of rehab, responsible for staffing/scheduling communicating medicare info from rehab team to facility and facility to rehab team. Monitoring staff productivity. Designating staff to complete tasks/responsibilities as requested by facility

Not used in supervisor role. Occasionally OTR will assign an OT/COTA student to the COTA to observe a treatment session. Our COTA appears to prefer only following the established treatment plan unless specifically requested to do something extra. She has taken on special projects though, like setting up a dressing closet in the ADL area. In admin, she also does clerical processing in updating treatment Rx's.

not used

2. How, if at all, are OTAs used in a clinical supervisory role? (i.e. supervising OTRs) - Responses

Answer

Above. NO OTAs

above

Never; our supervision guidelines do not permit this.

I don't think this is appropriate.

Where I work the only ones I see OTAs supervising over are OTA students.
not related to clinical treatment. In other words the specific treatment plan would still be developed by the treating OTR but the OTA could be responsible for administrative activities such as schedules, developing forms, monitoring

We do not have any OTAs in the VA facility (Greater Los Angeles)that I work in.

I asssume you mean at a facility I might work at....and I am a private consultant, so I just have opinions.

OTA's used in a clinical supervisory role with Rehab Aides, Volunteers, OT & OTA students as appropriate.

I have never experienced or heard of this situation. (And, believe it would not be well received.)

I have not been in a setting where I knowingly have had this experience.

N/A

OTAs assist OTRs in the clinical supervision of OTR fieldwork students. That is the only clinical supervisory role in my facility.
I think that OTA's work alongside OTR's in order to support them in learning systems in place, the case load population, processes and protocols that are in place.

Not applicable

Can't think of any

N/A
Well, I was registry so the OTA did not do much, just reminded me on my documentation. She knew my skill set and respected my abilities, so she did not comment on my treatments or documentation.
They can supervise all level students in my clinic, as long as they have experience, and share the student with the director.

See above.
then it is appropriate to "administratively" supervise (e.g. provide work schedules, monitor productivity, facilitate meetings, coordinate communication, provide performance evaluations).

They should not be.

They are not at our facility

not

Experienced COTAs help to train new OTRs in tx techniques

What?!!?

How can OTA supervise OTR?

They never supervise OTs. Would only supervise OTA students.
As an OTA I have mentored OTRs in various settings, but never took on a supervisory position related to treatment. I have previously supervised other OTAs in conjuction with an OTR.

Not at our facility.

There are no OTA's in my facility.

They are not in supervisory roles at my facility.

Our OTA's all receive supervision from OTR's. They have supported the OTR with fieldwork for OTA (registry). Both OTAs had many years of experience and demonstrated competence at the job (although I only worked with them periodically). My opinion is that this role should be reserved for OT level (or, if OTA, there should be some

OTAs not used in a clinical supervisory role in our department.
There were no other OTA's to supervise. However when we were able to get students (not OTA nor OTR students) she was the supervisor.

Not at all
supervising students (OTA students) □
mentor to new OTR's and OTA's

Not done where I work.

They should supervise other OTAs, based on seniority and competence□
They should not supervise OTRs, but could provide orientation and on-site guidance to new OTRs

I doubt they should be.

As an OTA, I do a lot of collaborating with OTR's. The newly graduated OTR's appreciate the experience and knowledge I have gained in my 30 year career in OT.

none

At the clinic mentioned above, the OTA did some performance analysis of OTRs, PTs and SLPs, but kept the scope to whether the company directives were being followed and avoided professional issues.

They are not here.

N/A

See 1., above

Not sure

Not used

NA

not at all

I think an OTA can supervise an OTR if they are in that position. Otherwise they cannot supervise and OTR.

Not used.

I am able to supervise OT level I students only. Don't know what other COTA's are doing

Possibly as a team leader for specific activities, and supervision of others OTA's.

OTAs are not used in a supervisory role for clinical functions. If we used aides for treatment, which we do not due to the extensive supervision requirements for aides, then the OTA might have a supervisory role for the aides. This does not apply to our setting however.

OTAs are not used to supervise OTRs.

Not in my experience. In my work environment, management follows guidelines similar to those established by PT Board of CA re: PTA role with supervision.

I schedule, obtain Drs. orders, interceed with management to provide needed equipment, education, space in order to allow my therapists to treat with the fewest interruptions possible. I audit documentation for completeness and proof of skilled level of care. □
Lead department meetings to stay informed on the progress/problems of all residents on caseload to be able to report accurately at Medicare/Managed care meetings and also provide feedback on treatment goals, length of stay, and financial restrictions that apply. □
I fight for their raises & continuing ed, cover patient treatments when the load is too high. I encourage. □
I track outcomes and dollars. I strive to make sure that patients and staff alike are being treated with excellence.

not at all, but wise OTR will listen to input.

Not used.
This questions brings in to doubt the professional qualifications and importance of OTRs. If they can be supervised by OTAs, who require less professional training, then we have establised a strong case to elminate OTRs. I hope our State

No

It is not appropriate for OTAs to clinically supervise OTRs.

I have not had any experience with OTAs in a clinical supervisory role in the facilities I have worked.

Reviewing utilization of therapy minutes, staff productivity, chart audits,

Regs not interpreted that way.

not used

3. As an OTA business owner, what are your roles and/or functions? And, what type of setting do you own or provide services? - Responses

Answer

OTD and she is a consultant. She supervises our master's OT students. □
I supervise all teachers, aids, secretaries, and OTs on the premises. □

above

Unsure.

N/A
I am not an OTA but I have known OTA's who were business owners. Both were involved in providing programs in the community.

We do not have any OTAs in the VA facility (Greater Los Angeles)that I work in.

Does not apply to me.

Not applicable. Our OTAs are employees of the hospital setting we are working at.

N/A
When I was an independent contractor I have worked with OTAs who were also independent contractors but I was not their employer. I do not work as an independent contractor now.

N/A

Not applicable

I do not own a business.

Not applicable

na

N/A.
I am not an OTA business owner. I am an OTR/L (and have a Master's degree). I have employed OTA's and take OTA students. They are the same as my OTR's, with the exception of evaluations. We are a private practice pediatric based therapy organization.

I work in School Based Practice.

n/a

N/A

Pediatric school based practice

N/A

NA

Ped op rehab

N/A

NA

There are no OTA's in my facility.

I am not an OTA or a business owner

not applicable

N/A

I am not an OTA or OTA business owner.

NA

na

n/a

N/A

N/A

N/A

Hmmm. I'm not an OTA, I'm an OT, Licensed.
that are being made and how they will affect my ability to survive in my "retirement" years. Can I be a teacher and have a background in OT or do I have to leave my profession behind and start a new career? Could I still do Home Health

N/A

I am an OTR/L, not an OTA.

I am an OTR/L with my own clinic

N/A

I'm not an OTA business owner

Im not an OTA business owner.

NA

NA

I am not aware that an OTA can own a rehabilitation business.

doesn't apply

I am not a business owner
Clinical setting. Supervision of aides, evaluation of clients with development of treatment plan and follow up home program.

We are a statewide program administered through the local health departments for pediatric therapy. We use OTAs to provide treatment services under the direction of the OT. As the administrator I establish policies and procedures and assure treatment is being provided within the scope and mandates of the program. In Orange County we have 12 treatment units and use our OTAs to provide direct services at these sites.

I am not an OTA business owner

As a regional manager, my roles include regional operations responsibilities and clinical training to OT, PT and SLP staff within skilled nursing and assisted living environments.

I do not own a business.

I am an OTR , non business owner

N/A
been successful to date.□
□

Not applicable

Does not apply

NA. I am not an OTA business owner.

I am an OTR.

NA

Our COTA runs a photography business privately, outside of work hours, from her home.

I'm an OTR/L and lymphedema therapist.

4. How are OTAs used in management roles? In what type of setting? - Responses

Answer

Not used. We do not employ any OTAs.

above

Not sure

Unsure.

Where I work we do not have OTAs in management positions.

I don't know.

We do not have any OTAs in the VA facility (Greater Los Angeles)that I work in.

I asssume you mean at a facility I might work at....and I am a private consultant, so I just have opinions.
OTAs assist with miscellaneous management duties (i.e. scheduling of patient care, auditing medical charts and billing processes.

N/A

None at this facility

Not applicable

I have not experienced this type of a role, nor have I known an OTA who has been in a management role.

Not applicable

as a mentor to other OTAs, students, volunteers

Skilled Nursing Facilities

I have only experienced an OTA in a supervisory role at a SNF. In all my acute experience, they are clinical only.
If they have enough experience, they are treated the same way as an OTR. If they do not take that lead, they are not given that lead.

See answer to #1.

As mentioned above, I've only seen OTA's in Director of Rehab roles in SNF's. Personally, I think that it is not an appropriate practice in SNF's. The Director of Rehab. role in SNF's have to communicate clinical rationale and make clinical judgements during IDT meetings that should require clinical reasoning skills from the OTR/RPT/SLP levels.

NA

0

Refer to question 1.

DOn't know

There are no OTA's in my facility.

They are not used in management roles - acute care hospital.

not applicable in this setting

See #2

We practice in a SNF setting- OTAs not used in management roles.

Management as Supervisor of the clinic.

managing other OTAs, volunteers and /or rehab aides.

n/a

I am director of rehab in a SNF

I am unfamiliar with any OTA in a supervisorial role in any organizations I am associated with.

I don't know that they are.
Older OTA's have had previous careers or jobs in management. Again, experience and knowledge are definitely a determining factors to be considered.

none

in our clinic, the more experienced COTAs mentor and supervise the newer COTAs, and report back to me. We are a pediatric private practice, school-home-clinic based

Not at all

See 1 above

Don't know any

NA
OTA's can be in management roles if they also fulfill the requirements of any specific facility, i.e. have a Master's if required.

not used

Don't know but would be nice to find out.

?

OTAs are not used in management roles within our setting.

we have no OTAs used in management.

Answered above in #1

Mine are currently used in the Skilled setting. Previously I have had my own contract service.

NA

Not used.
I have seen OTA who usually have an additional professional degree working in management roles in healthcare- such as case coordinator, marketing, equipment rep.

Not used

Management roles in any setting, are appropriate for the OTA. Some possible tasks: staffing, scheduling, hiring, firing, collaboration with other managers, budgeting, etc

At the facility I work we have an OTA in a "lead" role, but with no special title or compensation. She is part of the OT Management Meetings and is the OTA voice on departmental issues that arise. She is also part of the Education Committee that decides on department wide education topics. She organizes seperate OTA education sessions and generally keeps the deparment informed regarding the latest OTA issues.

Director of Rehab SNF's□
OTA Program Director (OTA educational programs)□
Casemanagers

Only 2 COTAs with over 50 OT/PTs, and few management roles; neither COTA is in management. In this setting, county government, a county management class [of a year's duration, 3 - 4 dys mo x 12 months, and costing over $3000.00, not including the need to use your own vacation time to cover days taken away from your duties] is preferred when applying for a management position. It is not specific to therapy and is open to all county departments. The conditions make it difficult for everyone.

not used

5. Would you be willing to be contacted if there are questions about your responses? If yes, enter your email - Responses

Answer

Yes. I am partnering with a Family Source, Work Source, and Work Force Center in this new daycare facility. THe manager of the Family Source center is committed to training OTAs, PTAs, SLPAs, and other health related pre-professionals. She is engaging in talks with several community colleges in our area now to that end.

no

darlene.bickett@sharp.com

No.

sure

Yes. Bettyj0204@yahoo.com

vadams@lbschools.net

rosalyn.petty@va.gov

evertm@san.rr.com

N/A

yes lflorey4040@aol.com

Yes you may contact me. Email would be the best mode of communication. darlenecookcota@yahoo.com

rroberts_xx@yahoo.com

No.

Yes.

Yes, hulatiki@hotmail.com

ljjubilado@aol.com

secty@otaconline.org

yes

maryzim1@live.com

trinayogore@yahoo.com

Sure, peggyowens@pacificautism.org

yes

no

jmhcjh@sierratel.com

yes

Sure--Stephanie@kidswork.biz□
I'm an OTR and do not employ OTAs. I wish I could hire other OTRs, so then I could hire an OTA. But I work in a small private practice.

Yes. marion.higgins@verizon.net

ovforever2@yahoo.com

sure-- werthgale@cox.net□
and dgale@usa.edu

No

No, thanks

Sure.

BirtheOTR@msn.com

Ok, but I am now retired and in my previous job as the OT with an assertive community treatment program, we only had one OT and did not employ OTAs

no, concerned for my job, sorry

kandjlatner@hotmail.com

leinarsson@ochca.com

yes

Yes. keils2@yahoo.com

Sure, Karanbrownkaran@yahoo.com

NA

Yes. ksmith@aging.ca.gov

bnakasuji@therapywest.org

mhawkin9@dph.ca.gov

sure melissa.szamet@peoplefirstrehab.com

no

cbrown@dph.sbcounty.gov

no

AGENDA ITEM D

DISCUSSION REGARDING OTAS IN SUPERVISORY, OWNERSHIP, AND MANAGEMENT ROLES.

1. "Managerial Competencies for the Occupational Therapy Practitioner, Part I," from AOTA's Special Interest Section Quarterly
2. "Managerial Competencies for the Occupational Therapy Practitioner, Part II," from AOTA's Special Interest Section Quarterly

Special Interest Section Quarterly

Administration & Management

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Managerial Competencies for the Occupational Therapy Practitioner, Part I

■ Salvador Bondoc, OTD, OTR/L, CHT, Christine Kroll, MS, OTR/L, and Nathan Herz, OTD, MBA, OTR/L

The development and maintenance of practice competencies are inherent professional duties of every occupational therapy practitioner, regardless of years of experience and level of expertise. Aside from being a regulatory requirement of most states and certification bodies, being and remaining competent are ethical obligations (American Occupational Therapy Association [AOTA], 2005, Principle 4). Although much is known about competencies required to practice occupational therapy, a limited amount of attention is given to management and leadership competencies for practitioners to succeed in management roles. From a broad perspective, the occupational therapy profession recognizes many primary roles in management, administration, and leadership from supervisor of a few staff members to administrator of large divisions, organizations, or provider networks. However, no study exists that specifically focuses on managerial competencies of occupational therapy practitioners whose primary role is as a manager or an administrator.

As members of the Administration & Management Special Interest Section (AMSIS) Standing Committee, we took it upon ourselves to examine and explore what seems to be uncharted territory within occupational therapy. We conducted a survey of AOTA members through the SIS Listservs to target a cross-section of practitioners who participate in both clinical and management duties. Because many AOTA members belong to more than one SIS, the exact number of members exposed to the survey request is not definite. A total of 97 practitioners responded within the month that the survey was electronically available. Respondent demographics are discussed in detail later in this article.

Managerial Competencies Defined

When considering the ideas behind management competency, we must understand the actual meaning of competency. Many different definitions of *competency* are used in the various trade literature, with the meaning depending on the context in which the word is used. In the December 2002 issue of the *AMSIS Quarterly*, Burkhardt, Braveman, and Gentile (2002) delineated the terms *competent, competency, competence, competencies*, and *continuing competence*. Dictionary.com (2008) defines *competency* as "the necessary abilities to be qualified to achieve a certain goal or complete a project." Spencer and Spencer (1993) believed that managerial competencies comprise a set of criteria that relate to what is considered as effective or superior performance in one's job situations. In addition, managerial competencies may include personal attributes that may be innate (BNET Business Dictionary, 2008) or specific to the individual (Albanese, 1989). Based on these definitions, we view managerial competencies as a set of knowledge, skills, and personal attributes that enable a person to effectively perform and even excel at managerial tasks and duties according to standards. This definition is supported by literature (Lucia & Lepsinger, 1999).

The idea that one can transcend standards of performance suggests that knowledge, skills, and attributes related to being a manager can be improved through training or experience. As with all areas of expertise, one may meet the minimum requirements for the task or may choose to develop skills to exceed expectations. As occupational therapy practitioners, any area of specialization can improve or be further developed as we progress in our careers; management and administration are no exception. However, standards for effective performance should be specific to a given organization's context. What is considered exceptional performance in one may be average for another; what may be critically essential for one organization may be secondary for another.

Survey Procedure and Outcomes

The first and second authors created an electronic survey on Surveymonkey.com and posted the link on the AOTA SIS Listservs for 4 weeks. The electronic posting sought practitioners who are in management and administrative positions regardless of their practice area. The survey instrument consisted of two parts. Part I asked for respondents' demographic information, including age, gender, title, years of practice, and years of experience as a manager. Part II specifically asked respondents to relate how they became managers; what they perceived as essential skills, knowledge, and attributes of an effective and competent manager; what the challenges are to being a manager; and their recommendations and suggestions to promote managerial competence among occupational therapy practitioners. The instrument used a combination of multiple-choice, rank, and open-ended formats. Although this survey does

not fully represent the population of occupational therapy practitioners, it provides qualitative information on management competencies. As AOTA moves toward the celebration of its centennial year in 2017, this information may help to support practitioners as managers and administrators and the impact that their leadership may have on our future.

Ninety-seven AOTA members responded to the survey, but only 60 completed Part II. Respondents ranged in age from 28 to 61 years and in years of experience in their position from 3 to 36 years. A small, but significant number of respondents assumed managerial positions early in their occupational therapy career. The majority practiced in skilled nursing or geriatric long-term facilities (28.87%) and acute or inpatient rehabilitation hospitals (28.87%). Although small in number, men comprised 11.46% of the sample, which is slightly above the gender distribution within the AOTA membership. Many respondents had obtained a master's degree (47.92%), with a variation in their orientation (e.g., public health, public administration, advanced occupational therapy practice, health administration, business administration, leadership). Of interest, a small percentage (2.08%) of respondents had an associate's degree. Anecdotally and by personal experience, the authors are finding more occupational therapy assistants assuming supervisory, managerial, or administrative positions in their organizations. Although occupational therapy assistants may not clinically supervise occupational therapists, the skills of a manager or administrator are distinct from their clinical role and skills. Many occupational therapy assistants come to their clinical role after many other jobs outside of health care and other degrees that assist in the management role. The details and nuances of what their role entails within their organization are captured in only a small way by this survey.

At least 5% of the respondents supervise multiple areas within an organization or a network of facilities across and within large organizations. This small group of respondents tends to hold high-ranking positions, such as director of operations, vice president, and area or regional manager, and may directly or indirectly supervise between 50 and 500 employees. Consequently, these respondents oversee employees from various professional backgrounds, not just occupational therapy and rehabilitation professions. In fact, our survey found that more than 60% of our respondents supervise employees from multiple professions: occupational therapists and occupational therapy assistants, physical therapists and physical therapist assistants, athletic trainers, recreational therapists, speech–language pathologists, case managers, and administrative support staff. Figure 1 depicts the distribution of respondents by the composition of personnel they manage.

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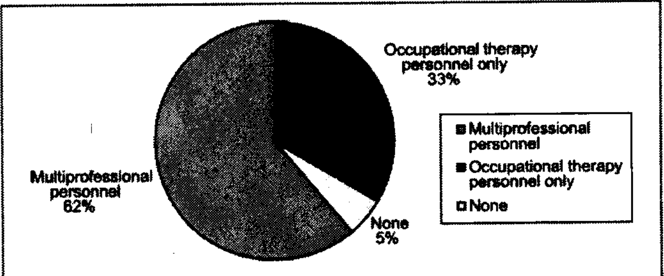

Figure 1. Distribution by composition of supervised personnel.

Becoming a Manager

In developing the survey questions, we wanted to find out how respondents came to be in a management role during their career and obtained their anecdotal stories and perceptions in response to, "How did you become a manager?" Sixty practitioners responded to this question, and their responses were clustered based on the following themes: (a) formal education or continuing professional education; (b) self-initiative to build one's skills or contribute to the organization; (c) having the desire for or interest in a management role; (d) seeking opportunities; (e) falling into a management role by "accident"; and (f) having prior experience in management. (Note that because the survey was placed only on AOTA SIS Listservs, the responses are limited to persons who are AOTA members and actively seeking additional professional networking through their participation on the listservs.)

Formal or Continuing Education

Eight respondents reported seeking out management as part of or the entire job role through additional education, believing that obtaining an advanced degree in business, management, or leadership assists or directly correlates with obtaining a managerial role. One respondent believed that having board certification in geriatrics, using best practice in patient care, and having a passion for geriatric care assisted her in obtaining a management role. In these instances, recognized advanced degrees and professional designation of specialty were viewed as valuable.

Initiative to Build Skills or Contribute to the Organization

Self-initiative in the form of volunteering to take on additional job responsibilities or to find a way to improve the workplace without being asked is seen as a path to obtaining a management role. One respondent stated, "I was assertive and pointed out ways we could better our department, participated in QI projects, and demonstrated good organizational and management skills." This person noted (anonymously) that he or she had been director of occupational therapy and then was promoted to the interdisciplinary manager role. Some respondents actively sought to promote themselves into positions that did not even exist. For example, one noted, "I presented a proposal to my clinic administrator to develop department manager positions to facilitate company growth, productivity, and overall efficiency. I was then offered the position based on my proposal." Another stated,

> I obtained the position by continuing to look for needs that the company had in terms of development or management and worked to fill those needs. I personally sought out education on communication and management skills development and learned from mentors.

These respondents indicated a desire to improve the workplace by seeking to improve performance and operations and received managerial roles as a result.

Interest in a Management Role

Some respondents sought a management role through the interview process in that a position as a manager came open, and they

interviewed for the job. Some respondents interviewed internally with a site or company for which they already worked, whereas others interviewed with a company as an external candidate. One respondent stated,

> I actually marketed and convinced this skilled nursing/geriatric rehab facility that hiring me as a full-time salaried position would be in their best interest.... I was successful, and shortly after being hired, I helped them advertise and hire in-house PT and SLP as well.

As a result of the desire to have a management role, these respondents found advancement through a direct job change.

Seeking Opportunities or Falling Into Management by "Accident"

In other situations, respondents reported working their way into the manager role in a facility sometimes by desire and sometimes by default. One shared the following:

> I assumed more responsibilities gradually over time staying at the same institution. I believe my OT ability to analyze the situation and the components that are contributing helped me be successful, as well as staying patient and employee centered.

Prior Experience in Management

Several respondents believed that their past experiences in business or work-related supervision were beneficial in searching for and being successful in management roles. One stated: "I was supervisor in the past. I worked my way up the ranks. It was the school of hard knocks." For another, it was "[past] experience and ability to articulate a future direction for the department."

Backgrounds in business management, mentoring of less-experienced therapists, and proven leadership skills within occupational therapy and with other disciplines outside of therapy were all listed as valuable experiences. Management roles often are earned and seen as a reward for hard work and loyalty, but there are practitioners who do not feel competent in this role after taking it on. Being a hard-working, skilled therapist does not necessarily make one a good manager or leader. The skills required for this level of responsibility have not been the focus of occupational therapy training; therefore, the competent therapist may not be a competent manager without additional training or experience.

The survey respondents listed many characteristics that are important for achieving a management role and being successful. Personal characteristics related to work ethic, such as "hard-working," "attention to detail," and "willingness to take on responsibility." Knowledge in the work area for reimbursement and clinical skill and being a lifelong learner were included, as were learned skills related to organization, problem solving, patience, ability to negotiate, ability to deal with different personalities, ability to build consensus, confidence, and objectivity.

Essential Knowledge, Skills, and Personal Attributes

Part II of the survey asked respondents what they considered to be essential knowledge, skills, and attributes of managerial competencies. According to Lucia and Lepsinger (1999), a cluster of knowledge, skills, and attitudes correlates with job performance. In our survey, several distinct themes emerged.

Essential Knowledge

Essential knowledge can be construed as the base knowledge needed to perform managerial functions and may include an understanding of concepts and issues internal and external to one's work context. Most of the respondents identified the following items as knowledge that is essential to having managerial competencies:

- Advanced or specialized clinical knowledge related to the service or practice area, for example, pathophysiology of conditions or treatment protocols (18%)
- Knowledge of regulatory and reimbursement issues, including documentation (64%)
- Budgeting or an understanding of profit–loss theory (20%)
- Understanding of institutional or organizational procedures, policies, mission, philosophies and culture, for example, human resource policies, supervisory practices, and performance improvement (31%)
- Knowledge of general principles of effective supervision and personnel management (13%)

Other items suggested fell within typical management functions, such as strategic planning, outcomes management, and forecasting and maintaining awareness of health care trends.

Essential Skills

Many respondents stated that having interpersonal communication skills (30%), organizational skills (33%), time management skills (17%), and problem-solving skills (15%) are essential to management competency. Further, they identified as essential the ability to foster timely decision making (5%), build teams (5%), listen (5%), motivate (5%), and advocate for the staff (7%). Some indicated that having general management skills (20%) and clinical skills (20%) is key. Other skills that in our opinion are important but were notably missing are computer skills and marketing. The pressures of the current work environment for many health care providers leave little room for anything that does not solve immediate problems. Many key managerial tasks, such as team building and motivating staff, often are relegated to the "back burner" in lieu of other, more pressing issues.

Essential Attributes

Essential attributes refer to personal characteristics, values, and attitudes that may facilitate success when assuming the role of a manager. Certain attributes may be inherent to the individual but, nevertheless, are capable of changing over time. Respondents identified the following attributes as essential components of managerial competency: flexibility (30%), honesty and being ethical (23%), optimism and a positive attitude (22%), fairness (17%), empathy (13%), ability to project that employees are valued (13%), and industriousness and a strong work ethic (12%). Other attributes cited were the ability to motivate others, project self-confidence, and show compassion.

Initial Recommendations

Though delineated in this survey, we believe that all of the domains—knowledge, skills, and attributes—are interrelated and constitute collective criteria for managerial competencies. Because the data provided in Part II of the survey are qualitative in nature, we are limited in making statistical correlations among the domains. However, on careful examination, we propose that the competency items generated by the themes are a good starting point to evaluate one's own competencies as a manager.

Antonacopoulou and Fitzgerald (1996) established that a relationship exists among perceived performance, anticipated future performance, and expected performance. Because there is a great variation in some contextual variables, such as practice setting and size of the organization (number of staff), the manager should consider his or her own contexts and environments of practice in the self-examination process.

The personal assessment of how one becomes a manager and the identification of competencies related to being a manager provide insight into not only what managers value, but also what they perceive as necessary knowledge, skills, and attributes to be successful as a manager. As we explore managerial competencies, these insights should give us some additional information related to the desire to manage, the knowledge required, and the skills one can learn to be competent in a managerial work role. ■

Editor's note: A follow-up article will focus on barriers and facilitators to becoming an effective and successful manager and a discussion of implications for the occupational therapy profession.

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Salvador Bondoc, *OTD, OTR/L, CHT, is Assistant Professor of Occupational Therapy, Quinnipiac University, 275 Mt. Carmel Avenue EC-OCC, Hamden, Connecticut 06518; Salvador.bondoc@quinnipiac.edu.*

Christine Kroll, *MS, OTR/L, is Director of Clinical Operations, Healthcare Therapy Services, Inc., Indianapolis, Indiana.*

Nathan Herz, *OTD, MBA, OTR/L, is Assistant Professor of Occupational Therapy, Medical College of Georgia, Department of Occupational Therapy, Augusta, Georgia.*

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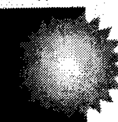

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Managerial Competencies for the Occupational Therapy Practitioner, Part II

■ Christine Kroll, MS, OTR/L, Salvador Bondoc, OTD, OTR/L, CHT, and Nathan Herz, OTD, MBA, OTR/L

In the September issue of the *Administration & Management Special Interest Section (AMSIS) Quarterly*, Part I of this article focused on a survey completed by the first two authors to explore the expectations and parameters of managerial competencies for occupational therapy practitioners (Bondoc, Kroll, & Herz, 2008). We surveyed American Occupational Therapy Association (AOTA) members through the SIS Listservs to target a cross-section of practitioners who participate in both clinical and management duties. Because many AOTA members belong to more than one SIS, the exact number of members exposed to the survey request is not definite. Ninety-seven practitioners responded within the month that the survey was electronically available.

The survey instrument consisted of two parts. Part one asked for respondents' demographic information, including age, gender, title, years of practice, and years of experience as a manager (see Table 1). Part II specifically asked respondents to relate how they became managers; what they perceived as essential skills, knowledge, and attributes of an effective and competent manager; what the challenges are to being a manager; and their recommendations and suggestions to promote managerial competence among occupational therapy practitioners. The instrument used a combination of multiple-choice, rank, and open-ended formats.

Managerial competencies were defined "as a set of knowledge, skills, and personal attributes that enables a person to effectively perform and even excel at managerial tasks and duties" (Bondoc et al., 2008, p. 1). As such, we explored the specific knowledge, important skills, and personal attributes that the respondents identified as assisting them in assuming and being successful in an administration, management, or leadership role.

What Is Most Important to a Manager?

Using a scale from 1 to 10 with 10 being the most important, respondents ranked six focus areas that we identified as important in management and administration. These focus areas are recognized by the profession and are often cited by managers and administrators as relevant in their role. They are: (a) the implementation of the *Occupational Therapy Practice Framework: Domain and Process* (AOTA, 2002), (b) evidence-based practice, (c) quality measures and indicators, (d) documentation, (e) continuing competency, and (f) diversity issues. Sixty of the 97 respondents completed this portion on the survey. A score of 8 to 10 is considered high, and a score of 6 or less is considered low.

The occupational therapy profession has focused on implementing the *Occupational Therapy Practice Framework* (OTPF) for several years. Practitioners often have found it difficult to put energies toward understanding and implementing a change in practice philosophies and processes. Part of the difficulty may come from a "fear of the unknown" or a lack of understanding of OTPF concepts. Additionally, many managers question what benefit they may derive from OTPF implementation. Others may see a value in OTPF implementation. However, support for changes in environment, documentation, and even caseload management may be necessary and can be difficult without support from upper management. As occupational therapy managers, 33 (55%) respondents ranked implementing the Framework as high importance, and 27 (45%) ranked it as low.

Evidence-based practice is another issue that has been strongly emphasized throughout the health professions in recent years. Because of the rise in health care costs, efforts have focused on health care practices in areas where the results are supported by evidence from research, assessments, and documented outcomes. Many clinicians have protocols that guide intervention, and insurance companies want to know why they choose to treat the way they do and whether the expected outcome is commensurate to the treatment cost. Forty-five (75%) respondents ranked evidence-based practice as high, and 15 (25%) rated it as low.

Many institutions focus on measuring the outcome of our interventions. As well, measuring outcomes is mandated by the government for skilled nursing facilities through the quality indicators and measures generated from the Minimum Data Set used in assessment and the development of a patient care plan. Hospitals, inpatient rehabilitation units, and private practices with the Physician Quality Reporting Initiative also measure or report specific outcomes in order to meet payment requirements. Fifty-three (88%) respondents ranked quality measures and quality indicators as a high priority, and 7 (12%) ranked it as low.

Table 1. Survey Respondent Demographics (*N* = 97)

Variable	Number
Age	
Mean in years (range)	44.73 (28–61)
Standard deviation	8.57
Gender	
Male	11 (11.46%)
Female	86 (88.54%)
Highest degree attained	
Associate's degree (e.g., AAS, AS)	2 (2.08%)
Bachelor's degree	39 (40.63%)
Master's degree (e.g., MOT, MBA, MPH)	46 (47.92%)
Doctoral degree (e.g., OTD, EdD, PhD)	9 (9.38%)
Total years of experience with an occupational therapy title	
Mean in years (range)	20.01 (3–36)
Standard deviation	8.70
Years of managerial experience	
Mean in years (range)	10.5 (1–30)
Standard deviation	7.07
Practice setting	
Acute care/inpatient rehabilitation	28 (28.87%)
Higher education	4 (4.12%)
Home health	2 (2.06%)
Mental health institutions/agencies	4 (4.12%)
Multiservice or multiple facilities	5 (5.15%)
Outpatient clinic or comprehensive outpatient facility	12 (12.37%)
Private practice/clinic	6 (6.19%)
School-based system	7 (7.22%)
Skilled nursing or geriatric long-term facility	28 (28.87%)
No response	1 (1.03%)
Staff size	
Mean number of employees (range)	45 (0–1,000)
Quartile 1	5
Quartile 2/median	15
Quartile 3	34

Documenting our services has become critical, given the scrutiny of medical records for both reimbursement and legal concerns. Documentation for payment and for a defensible intervention plan has become so important that most companies provide training in this area, and many continuing education seminars are offered on the subject. Fifty-three (88%) respondents ranked documentation as a high priority, and 7 (12%) ranked it as low.

Continuing competence is an ethical and professional concern and our utmost responsibility as professionals to ensure that we and our employees are up-to-date in our field of practice (AOTA, 2005). We live in a litigious society, and employing professionals who are not competent puts clients or one's business at risk, not only leading to less business, but also putting a mark on one's reputation as a provider. Further, managers and clinicians are equally responsible in ensuring that clients benefit from our business while avoiding harm (Occupational Therapy Code of Ethics Principles 1 and 2). Forty-nine (82%) respondents ranked continuing competence as a high priority, and 11 (18%) ranked it as low.

Dealing with issues of diversity is relevant to all areas of practice and affects all business and health care entities. According to AOTA's Centennial Vision, the profession wants to be perceived as being able to meet the needs of a diverse and growing population (AOTA, 2007). Wikipedia.org (n.d.) defines *diversity in business* as "the business tactic [that] encourages diversity to better serve a heterogeneous customer base." In a world of growing diversity, we must be able to work with others who have differing backgrounds, beliefs, and abilities. As occupational therapy practitioners, we are taught that our clients should not be judged and that any personal judgments should not affect the care we provide. This practice is true not only for the client–therapist relationship but also for professional ones. Thirty-seven (62%) respondents ranked diversity issues as a high priority, and 23 (38%) ranked it as low.

Although some of these issues may not occur daily, keeping up-to-date, maintaining an eye on the occupational therapy profession, protecting reimbursement, promoting competent practice, and handling issues of diversity are considered important to the occupational therapy practitioner in a management role. One then could ascertain that these areas would benefit from additional training and education for the administrator or manager to attain and maintain competence in his or her role.

Factors That Facilitate Assuming a Management Role

In this open-ended part of the survey, respondents were asked what they perceived as assisting them in becoming a manager or administrator. Many answers were similar, and several themes emerged. For instance, communication skills was a prominent response. Statements about the importance of being "direct," having "open communication with the interdisciplinary team and patients/families," "developing effective communication strategies," and "listening to employees" were made, as well as the importance of soliciting feedback and being open-minded. Communication skills are taught in terms of client–therapist rapport but may not be a focus outside of the practitioner role; as such, it is an important area for professional development as a leader in any type of situation, professional or otherwise. Without good communication skills, no one will care how well a practitioner performs the individual tasks of his or her job (Low & Kalafut, 2002).

Skills not specific to occupational therapy may be learned to promote the type of job role one wants or to help one be successful within a managerial role. The respondents stated that learning to be a leader was very important. Comments such as "constant learning about management/teams," "working and learning with managers from other areas of the organization," and "continuing education/learn to be a leader" reflect the belief that leadership can be learned and trained. Other respondents believe that one either is a natural leader or not; that is, some persons seem to emerge as leaders naturally. However, according to respondents, becoming an effective leader takes learning; experience; and, if one is lucky, a great mentor to work under. The facilitator here was the identification of weak areas in functioning as a manager, administrator, or leader and how to address the deficit.

Respondents found networking within one's profession and business, being organized, knowing how to delegate, and continuing to keep clinical skills sharp as important in becoming a manager or leader. Several made specific recommendations regarding weekly monitoring of key Web sites, both professional and governmental, and participation in state and national occupational therapy associations. Having accurate information is valuable.

Respondents recommended being flexible, continuing to learn, and growing both professionally and personally as important to

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assuming a management or leadership role. Evidently, management is not for the faint of heart, according to comments such as "keep a thick skin," "don't get discouraged," "work really hard," "learn from your mistakes," and "learn to take constructive criticism." Taking on a management role sometimes requires risk taking: "Just do it; jump in; take a risk" and "go outside of norms/comfort zones in attempting to meet needs."

The responses to our survey suggest that becoming and functioning as an occupational therapy manager is facilitated by learning and growing as a leader, both personally and professionally. Communication skills, developing good mentors, staying abreast of current professional information, and learning to be a good supervisor are all important. Taking care of oneself while going through this process is equally important and necessary to one's own sense of balance.

Barriers and Challenges

The survey asked respondents what they thought are barriers or challenges to becoming an occupational therapy manager or what they deal with as a manager. As with facilitating factors to becoming a manager, several themes emerged. A resounding response was "time," whether it be time to treat, time away from treatment to do administrative or other work, time constraints or limitations, time to follow through on priorities, or time management skills. Time is a critical element, and occupational therapy managers are feeling the pressure of completing multiple tasks in a short amount of time.

Another perceived barrier is a conflict between serving in a practitioner role and being a manager. Many respondents indicated that they were not full-time managers and had treatment responsibilities. Comments indicate that the balance between treating and managing appears not to be harmonious, for example: "practicing as a therapist while maintaining director position," "in our clinic, I also have a full-time caseload, it makes it difficult to be an effective leader," and "overload with caseload and administrative work."

Some respondents mentioned a lack of role models or access to mentors as a barrier. Going along with this concern is a lack of education or training. One respondent mentioned, "My undergraduate degree did not prepare me enough for a leadership role—a lot of 'on the job training.'" Another stated that a "restricted work environment where there is no support for growth" was a barrier. This barrier is not surprising because one of the key facilitators to assuming or being successful in a management role (as stated previously) is finding a mentor.

Respondents saw personal perception—that is, a person's own way of needing to "have it your way," or "fixated on 'being right'"—as personal challenges. Other related challenges mentioned were "needing everyone to like you," "taking things personally," and "rigidity." These barriers likely represent a problem shared by others. As mentioned in the discussion on facilitators to assuming a management role, being open-minded and learning about management and leadership are key. One respondent's comment sums it up: "Seeing a leadership role as a 'supervisor' instead of a 'leader' is a barrier, [but] not an insurmountable one, once one identifies the challenge."

As a part of the barriers/challenges mentioned, other barriers and challenges include staffing, burnout, staff members who are not fully engaged, personality conflicts and gossip, negative attitudes, and a difficult work culture. These comments go back to the diversity issues and communication skills mentioned previously as high priority issues.

One respondent stated that "the tyranny of urgent" is a challenge, meaning a "crisis superseding ... staff development [and] team development." Another respondent indicated the challenge of "getting caught up in the 'day-to-day' tasks and not stepping back to think/plan strategically." Another stated that "micro-managing" staff is a challenge and a trap that new managers, and sometimes those with more experience, sometimes fall into to ensure that work is done correctly. Micro-management may be born out of a manager's fear of failure (e.g., not meeting deadlines or meeting productivity targets), but staff may perceive it as a lack of faith in their abilities. A vicious cycle is created when managers allocate too much time in overseeing minute processes and creating urgency on seemingly unimportant matters, which then leads to more pressure on employees to produce more than what is manageable, causing decline in morale and subsequent loss in productivity. Further, not everything gets done because the manager cannot be everywhere at once.

What Will Promote Managerial Competencies?

The survey asked respondents what they would recommend in terms of promoting managerial competencies: What would make things better? From a personal development standpoint, the suggestions were to "obtain a mentor" and to network with other managers from the same and other professions and businesses. Other advice is to be organized, mentor one's own staff, reinforce the use of evidence-based practice, and promote autonomy. Additionally, "learn the system that you work in, be flexible but make your suggestions. Understand when the answer is 'no' but investigate other avenues." One respondent suggested that we "utilize our task analysis skills and use of activities to develop effective management programs." Remembering to "include employees in the problem-solving process and hold them accountable" was another suggestion. Finally, "have bigger expectations for yourself."

Respondents also made recommendations related to additional management-specific continuing educational programming from AOTA and state associations. Some would like to see basic competencies created and then continuing education units applied to support the competencies. The creation of an advanced practice certification specifically for managers also was suggested. Several respondents mentioned additional programming at the AOTA Annual Conference & Expo in this area of expertise.

Further support for the occupational therapist as a leader, manager, or administrator was a common theme among the respondents' comments. One said, "I manage all therapies; I often reference APTA [American Physical Therapy Association] and ASHA [American Speech–Language–Hearing Association] for information. I have noticed that APTA has a multitude of leadership references and research, which I have found helpful. I'm glad to see research like this going on in AOTA!" Another stated, "Get out there! There could be many more OT practitioners in management. AOTA could provide a short self-paced course: perhaps that is what this survey will support."

Conclusion

The survey reported in this article helped the AMSIS Standing Committee to determine what our members believe are management priorities, what helps one become and succeed as a manager, what challenges managers face, and what we can do to move forward. Although the sample size was small, it represented a select group of individuals who are connected to AOTA and active in the profession. The comments and insights tell of their struggles and triumphs and give ideas to make us better leaders. Additional references are listed that discuss management competencies in relation to changes in health care systems and specific competencies for the middle manager in occupational therapy to assist further search for information on this topic. Our profession supports occupational therapy practitioners as managers and leaders, hence the development of the AMSIS. Could we do more? Absolutely! There is always more work to be done and

more goals to achieve. We thank all who responded to our survey for sharing their knowledge and experience. ■

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Christine Kroll, *MS, OTR/L, is Director of Operations, Healthcare Therapy Services, Inc., Indianapolis, Indiana.*

Salvador Bondoc, *OTD, OTR/L, CHT, is Assistant Professor of Occupational Therapy, Quinnipiac University, 275 Mt. Carmel Avenue EC-OCC, Hamden, Connecticut 06518; Salvador.bondoc@quinnipiac.edu.*

Nathan Herz, *OTD, MBA, OTR/L, is Assistant Professor of Occupational Therapy, Medical College of Georgia, Department of Occupational Therapy, Augusta, Georgia.*

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DISCUSSION REGARDING THE ROLES OF OTAs IN EMERGING AND NON-TRADITIONAL PRACTICE AREAS.

1. "Professional Responsibilities in Meeting Societal Needs in Alternative Practice Markets," from AOTA's Special Interest Section Quarterly
2. "OTAs as Entrepreneurs," from AOTA's Special Interest Section Quarterly

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Professional Responsibilities in Meeting Societal Needs in Alternative Practice Markets

■ Christine Kroll, MS, OTR, Monica Robinson, MS, OTR/L, Tara Glennon, EdD, OTR/L, BCP, FAOTA, and Salvador Bondoc, OTD, OTR/L, CHT

Nine years from now, we will celebrate our profession's centennial. From its humble humanistic beginnings in Clifton Springs, New York, we have a profession that began with six founders in 1917 to one with more than 100,000 active occupational therapy practitioners in 2004 (U.S. Department of Labor Bureau of Labor Statistics, 2007). Despite the profession's growth, we continue to aspire for more—a realization of our potential to become "a powerful, widely recognized, science-driven, and evidence-based profession with a globally connected and diverse workforce meeting society's occupational needs" (American Occupational Therapy Association [AOTA], 2006, p. 1).

To realize the vision of our profession, AOTA has put forth a strategic plan that includes "building the capacity to fulfill the profession's potential and mission... [by] ensuring an adequate and diverse workforce for multiple roles" (AOTA, 2006, p. 2) and demonstrating and articulating our value to individuals, organizations, and communities... [by] meeting societal needs for health and well-being" (p. 3). To date, many in our profession have delved into practice areas or assumed roles that are considered alternative to the traditional, and we may view this as an indicator of our profession's continued growth and expansion. Although encouraging, we must proceed with caution when taking the proverbial path less traveled and consider the ethical, legal, and pragmatic implications.

As the health care and wellness areas of practice evolve to meet the changing demands of society, occupational therapy practitioners are in an exceptional position to assume alternative roles and enter "emerging markets." How then should occupational therapists and occupational therapy assistants present themselves in areas that are not identified as purely occupational therapy, what many have termed as *emerging markets?* Two possibilities exist of how one might provide services within these alternative market areas: (a) functioning as an occupational therapy practitioner and billing for such services (whether through traditional channels or not) and (b) using one's previously attained occupational therapy skills and applying them within a new professional role.

Looking back, practice within the community may seem new, but it is where the profession has always been. In a way, by entering emerging markets we are rediscovering our roots. We are confident that we can meet the challenge that our Centennial Vision has put forth. However, present-day hurdles must be overcome to assure that the practitioner is meeting professional and legal obligations.

This article seeks to open a dialogue on the complex issue of emerging markets and initiate an exchange of information and resources as the profession identifies where and how it fits within nontraditional practice arenas. This article is not intended as legal advice.

Presenting Yourself to Prospective Clients

Conceptualizing how you present yourself to your prospective client will depend on the types of services you intend to offer. If you intend to offer your services as "occupational therapy" and bill your services as such, then you as a provider are subject to licensure laws, and the *occupational therapy* services you provide are subject to the regulations of the profession where your practice is conducted. On the other hand, how do we present ourselves when we enter a nontraditional or emerging market that may fall outside of our state licensure laws and regulations?

Through the decades, our profession has made strides to be recognized and respected by the broader society. Thanks to the efforts of our leaders, government programs such as Medicare, Medicaid, workers' compensation, and the Individuals with Disabilities Education Act (IDEA; Public Law 101-476) have paid for our services in practice domains we now consider to be traditional. Given the public's recognition of our profession's achievements and contributions to communities, it would seem natural to always want to present ourselves as skilled professionals with specialized knowledge and training in occupational therapy. Although the public recognizes occupational therapy practitioners in traditional areas, how are we viewed and how do we prefer to be viewed in nontraditional areas? Is it possible to present ourselves as professionals with training as occupational therapists and occupational therapy assistants within nontraditional or emerging markets?

To answer these questions, we begin by investigating state regulations and scope of practice, because each state is different. We also must determine regulatory implications of practicing in nontraditional areas. Finally, we must ask: What legal and ethical standards are we held to? What, if any, precedents have been set? Understand that regulatory bodies and professional associations

have a shared obligation to protect the public in ensuring that (a) the services an occupational therapy practitioner renders follow set standards and that (b) the services classified as occupational therapy are rendered by competent and qualified occupational therapy practitioners. As such, these entities should be consulted first.

Working Outside the Field of Occupational Therapy

Many occupational therapy practitioners who are not working within the field of occupational therapy highlight, promote, and advocate their professional skills when applying for alternative jobs. Although they may have gone on to obtain additional certifications in their new field of practice, they still strongly emphasize their background in problem solving and parallels to the occupational therapy process of analysis and implementation as core components to achievement in their new career. It is important to note that no one owns or controls your right to claim your education or earned degree; it is the legal use of your credentials within context that is being discussed.

In the process of working in an alternative arena, the practitioner must consider the reality: He or she is part of a regulated profession and is stepping outside of the traditional boundaries into areas where he or she is not the sole provider of the *same* professional services; therefore, the services rendered are not defined as occupational therapy in such a way as to exclude others. Thus, you are not providing or billing for occupational therapy services. For example, health and wellness is a growing practice area that is increasingly popular for occupational therapy practitioners; however, we are joining numerous other regulated and nonregulated professionals who work for private monies in that industry. Do we present ourselves as occupational therapy practitioners to show how we can add to this growing industry, or do we avoid any misconceptions related to our particular state regulation and simply pursue this area of practice just as another professional would in this industry? If we elect the former, we must assert what distinguishes our service as occupational therapy; that is, the focus of our service is in the enhancement of occupational performance through the systematic use of the occupational therapy process.

In general, we respect those who have received additional training and skills. The public as a whole is interested in what qualifies a person to provide a service for which they are going to pay money and for which they depend on the outcome. The value of being able to present yourself as a regulated professional is both personal and professional. Admittedly, environments or settings may exist in which being an occupational therapy practitioner is more beneficial or necessary than others. In these instances, however, other questions arise; for example: What legal or regulatory research should you consider first? As an occupational therapy practitioner, you are responsible for keeping up to date on the regulations and laws that guide your practice. All 50 states and 3 jurisdictions regulate occupational therapists (i.e., in various forms such as licensure, certification, or trademark), whereas 47 states and 3 jurisdictions regulate occupational therapy assistants (National Board for Certification in Occupational Therapy [NBCOT], 2007). Being familiar with your state regulations, especially scope of practice, goes a long way in understanding what constitutes "occupational therapy" and what you may or may not do as an occupational therapy practitioner.

State regulations include information about how occupational therapy is defined, what requirements must be met to claim practitioner credentials, and a host of other issues. The regulations in each state or jurisdiction vary greatly, meaning that if you are planning on moving to a new state or jurisdiction, you should do some investigation first by contacting or visiting the Web site of that state's occupational therapy board. NBCOT maintains a contact list of state regulatory boards on its Web site (www.nbcot.org/webarticles/anmviewer.asp?a=100&z=22). Membership in your state occupational therapy association is another way to familiarize yourself and gain information about the state's practices as well as to network with other therapists in your area or areas of practice.

As a matter of professional obligation, occupational therapy practitioners must review their state regulations regularly for changes that could affect their practice. In addition, federal rules may change or be reauthorized that could have a sweeping effect on one's practice, such as Medicare rules and IDEA, to name a few. Further, state- or region-specific implementation of federal rules may add to or change practice. For example, certain Medicare regulations are based on provider agreements where various rules add regulations to practice. However, a private practitioner who is not billing insurance (i.e., private pay) may not be bound to such an agreement with Medicare but would still be bound by the state regulations.

Barbara L. Kornblau, JD, OT/L, FAOTA, DAAPM, ABDA, CCM, CDMS (personal communication, September 26, 2007), AOTA Past President, articulated that each state's regulations and laws may include many components that any occupational therapy practitioner should thoroughly understand, including referral requirements or direct access, evaluations requirements and record keeping, scope of practice, supervision, ethical or professional provisions, and how the client is defined.

- *Referral requirements.* An occupational therapist needs an order to initiate treatment and to continue treatment. Usually, regulations list a physician as needing to give a referral for treatment. Other disciplines, such as nurse practitioners and optometrists, also may give a referral. Some settings or types of treatment may be specifically excluded from the referral requirement, or you may have no requirement at all for a referral. If you work in a primarily medical model setting, you may need to have a referral from a physician in order to be reimbursed, so attending to the insurance systems within which you work is important.
- *Direct access.* Clients may be able to access your services directly without being seen by a physician or having a prescription to do so. Direct access is popular and sought after by some professions because it broadens the public's access to their services. A potential client does not need the extra step of obtaining a referral from a physician. One disadvantage, however, is that most insurance providers, including Medicare, still require a physician's prescription before ancillary services, such as occupational therapy, are provided. Additionally, liability is higher, and in a medical model, it may not be desired or practical. In non–medical model settings, a physician order may not seem appropriate. Non–medical model service, such as wellness or

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school system intervention, could be excluded, or not, from a referral requirement.

- *Evaluation requirements and record keeping.* Some state regulations are very specific with regard to what must be documented in an evaluation and require that an evaluation take place before any intervention. Record keeping may be specified as well. Because some states are explicit and others are not, never assume that what you were taught or have experienced in one state or setting applies to all states and settings.
- *Scope of practice.* How the services you provide are defined is determined by the scope of practice. How broad or narrow your services are might have been determined through several factors, including the precedent of how other professions were defined and the type of political circumstance that existed at that time. AOTA collaborates with state associations in monitoring threats to practice, such as other professions' encroachment of scope of practice, and subsequently taking action to thwart such threats.
- *Supervision requirements.* Supervision requirements for occupational therapy personnel, including occupational therapy assistants, aides, and student clinicians (i.e., fieldwork students), may be specified within your state regulations. The degree of detail is variable and may provide a great deal of guidance and limitations or very little. Again, in an insurance-driven system you will need to attend to your payment sources to see their specific supervision requirements. When two or more regulations apply, the more restrictive rule supersedes others.
- *Ethical or professional provisions.* Most professional regulations at the state level include a set of ethical and professional standards. These standards often are overlooked and, therefore, should be reviewed. Some states adopt the AOTA *Occupational Therapy Code of Ethics (2005)* and may have some language regarding professional conduct. Some states mandate specific tests (e.g., health care regulations, medical errors, jurisprudence) that a practitioner must complete before attaining initial licensure or renewal.
- *How the client is defined.* Most state regulations include definitions that apply to documents. Review the definitions, specifically the terms *client, patient,* and *occupational therapy.* These definitions could make a difference in how the regulations apply in different settings. As occupational therapy practitioners, we are moving in the direction of meeting societal needs; we may have clients who are more closely defined as populations or environments. Therefore, if in the state regulations, an occupational therapy "client" or "patient" refers only to an individual person receiving occupational therapy services, then performing services geared toward a population may be outside of the scope of occupational therapy as defined by that state.

Other regulations that you may check concern consulting, where you are not treating a "client" but providing professional advice, and teaching, such as conducting seminars. These roles may be further defined by the state and may be found on the state board's Web site. When "best practice" is not articulated, the law may look to a recognized authority for what is considered standard and customary practice. Thus, professional guidelines and position statements from AOTA also might apply.

Ms. Kornblau reiterated that if you are using your credentials as an occupational therapy practitioner, then you are *probably* bound to the laws that regulate occupational therapy, although individuals who are not occupational therapists would not be bound by such laws because they are not practitioners. An example might be an occupational therapy practitioner who is working as an aquatic exercise instructor. Assuming that in most states aquatic exercise instruction could be done by an unlicensed person, if the occupational therapy practitioner presents himself or herself as a licensed professional providing occupational therapy services, then he or she is bound to the laws that regulate occupational therapy, whereas others who teach aquatic exercises but are unlicensed would not be bound by such laws.

Issues Related to Occupational Therapy Assistants

If you are an occupational therapy assistant and choose to use your title in rendering services in an emerging area, then you are held to the laws that apply. One such law is the requirement that occupational therapy assistants must receive supervision from an occupational therapist while rendering occupational therapy services. Conversely, if you are not presenting yourself as an occupational therapy assistant, then those laws may not apply. Anecdotally, some occupational therapy assistants have developed an employer or business relationship with an occupational therapist to fill the requirements of clinical supervision whenever applicable. One major pragmatic and ethical consideration in such a partnership is that business and clinical relationships must be delineated because they are mutually exclusive. Entering into a business partnership does not automatically equate to a supervisor–supervisee relationship. The occupational therapy assistant still must comply with the requirements for clinical supervision as defined by the state.

The Role of Occupational Therapy in Policy Making

Regulations may have been in place for some time and could affect how occupational therapists may practice. In a way, these regulations have assisted the growth of the profession by recognizing the value of occupational therapy and paying for its services. However, policies may also restrict the scope and the manner in which occupational therapy is practiced. If we find that we cannot be occupational therapists in practice due to regulations, then we should consider how the regulations could be changed through advocacy. Moving forward, we must "integrate policy into practice" (B. Kornblau, personal communication, September 26, 2007).

How can occupational therapy professionals make changes so that we can function as practitioners in environments that have not historically paid for, supported, or been outlined as occupational therapy? The key is policy. AOTA provides us with a vision of a "powerful profession" recognized and easily accessed by the public. However, our future may essentially be bigger than what our regulations allow right now, so we have to work to change policy to reflect our ability to "collaborate for success"; have the "power to influence"; and "articulate our value to individuals, organizations, and communities" (AOTA, 2006). Occupational therapy practitioners may influence policy by being active in their state associations and AOTA, which actively monitor and lobby for not only the legislation and regulations that protect and favorably affect how occupational therapy is practiced, but also the populations that may potentially benefit from our services.

Conclusion

Although we now call them alternative or emerging practice areas, the Centennial Vision conceptualizes that these services will, in fact, be commonplace and part of occupational therapy practice. As such, occupational therapy practitioners must be ready to meet societal needs in a manner consistent with our professional and ethical responsibilities. To do so, each practitioner must reflect on the types of services he or she wishes to provide, how to provide them in a manner consistent with the profession's ethos and core values, AOTA's Vision, requirements of credentialing bodies, and legal boundaries set by our state regulations. ■

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Christine Kroll, *MS, OTR, is Director of Clinical Operations, Healthcare Therapy Services, 5214 S. East Street, Building D, Suite 1, Indianapolis, Indiana 46227; ckroll@hts1.com. She also is Chairperson, AMSIS, and Past President, Indiana Occupational Therapy Association.*

Monica Robinson, *MS, OTR/L, is Rehab Systems Consultant, HCR Manor Care, Toledo, Ohio. She also is Professional Development Coordinator, AMSIS, overseeing communication and reimbursement.*

Tara Glennon, *EdD, OTR/L, BCP, FAOTA, is Professor of Occupational Therapy, Quinnipiac University, Hamden, Connecticut, and Owner, Center for Pediatric Therapy, Connecticut. She also is Private Practice Subsection Coordinator, AMSIS.*

Salvador Bondoc, *OTD, OTR/L, CHT, is Assistant Professor of Occupational Therapy, Quinnipiac University, Hamden, Connecticut. He also is* AMSIS Quarterly *Editor.*

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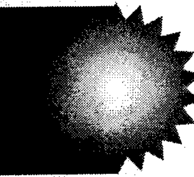

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OTAs as Entrepreneurs

■ Salvador Bondoc, OTD, OTR/L, CHT

We are delighted to present three visionary occupational therapy assistants (OTAs) who are entrepreneurs and administrators/managers of organizations that provide occupational therapy services. We share their personal accomplishments as examples of what OTAs are capable of achieving as professionals and, most importantly, what OTAs can contribute for the advancement of our profession. Three exceptional individuals—Caroline Alterio, COTA; Rosemarie Armour, COTA; and Theresa "Terry" Olivas de La O, COTA—were interviewed through e-mailed questionnaires. The interviews proceed as follows.

Briefly describe your business/organization and your professional background as it relates to your business/organization.

Caroline Alterio: I currently co-own a private outpatient occupational therapy practice with my husband Christopher who is a registered occupational therapist (OTR). We have two locations for ABC Therapeutics, Occupational Therapy, PLLC: a pediatric outpatient clinic located in Clarence, NY, and an outpatient orthopedic hand clinic located in Lockport, NY. We also have many contracts throughout the western New York area in early intervention, preschool, and school-based occupational therapy. I have been in practice for about 17 years. My primary practice area has been in outpatient orthopedic hand injuries and cumulative trauma injuries. I have had the unique opportunity to have worked alongside an orthopedic hand surgeon for the past 11 years and the privilege of observing many surgical procedures directly in the operating room.

Rosemary Armour: I am owner of Vision Rehabilitative Services (VRS). VRS is a specialized occupational therapy company with expertise in pediatric vision therapy, adult vision rehabilitation post-brain injury and stroke, and low vision intervention for adults with degenerative eye disease. In addition, we offer a comprehensive return-to-driving program for adults with disabilities that consists of both in-clinic and on-the-road assessments. I employ four part-time occupational therapists.

I received an associate of science degree in occupational therapy from Indiana University in 1989. I attended college after I was married and had three children, began my career in a hospital inpatient unit, and developed a passion for working with the brain injury population. I then worked for several years with a wonderful neuropsychologist, Dr. Lance Trexler, at the Center for Neuropsychological Rehab (CNR), an outpatient brain injury clinic. CNR was a place for great professional development.

While I was working at CNR, my daughter was diagnosed with convergence insufficiency by our optometrist Dr. Greg Ossip (also my brother-in-law), and the treatment consisted of several vision therapy sessions. This was a new field for me. I was intrigued! As I observed my daughter's sessions, I realized that many of the patients I have worked with had the same symptoms that my daughter was having: double vision, poor tracking, and headaches after a visual task. I asked Dr. Ossip whether he did vision therapy with patients with brain injury. He stated that he had just returned from a conference given by the Neuro-Optometric Rehabilitation Association and that if I was interested in adding that component to his practice, he would help me with the training. I worked for Ossip Optometry for 7 years, became manager of the vision therapy program, and hired an additional occupational therapist to the staff. Four years ago, we decided that it was time for me to go out on my own, so I wrote up a business plan, took out a small loan, and opened Vision Rehabilitative Services in March 2001.

Terry de La O: I am the co-owner and Chief Executive Officer of Therapy Designs, a for-profit organization that was a dream of my business partner, who is an OTR, and mine several years ago. Vera Rubio Arzaga, MS, OTR/L, and I celebrated our company's inception on January 3, 2006. We founded the company to provide consulting services to community-based organizations that serve children in foster care, emancipated youth, and survivors of domestic violence.

When we founded Therapy Designs, we had intended to file for nonprofit status in order to seek grants and become a viable agency for the Hispanic community and those in most need of our services. However, a for-profit model seemed to work better for this venture because we wanted to market occupational therapy and the uniqueness of both our backgrounds. We believed that if we did not do this, we would not succeed with our project, a one-of-a-kind conference for Latino young men and their fathers. The conference has been one of my visions for more than 5 years. It was designed with Latino cultural and family values in mind and aimed toward empowerment and "learning how to work towards achieving a successful future" for young Latinos (www.familysuccessbydesign.org). I organized the first conference in 2004. A year later, Vera and I decided as two Latinas to make our combined visions happen.

On March 3, 2006, we filed for a separate nonprofit organization, Family Success By Design, Inc., in California, of which I am Executive Director. Its mission, as a "multicultural focused organization [is

to]...address the needs of families and individuals in health, education, and occupation, in order to promote productive lives" (www.familysuccessbydesign.org). The process for filing our 501(c)(3), took many hours, but our teamwork and enthusiasm for our vision made us eager to complete the task. That was critical to both Vera and I, as without our occupational therapy background and passion for what we do, I do not believe that we would have been as successful in our work together. You must thoroughly research and devise a business plan with the right vision and mission to carry out your dream.

My relationship with Vera in both of our companies is one of collaboration and equal partnership, rather than one of boss–subordinate or supervisor–supervisee. When we practice direct occupational therapy services, we collaborate. I am in charge of all the other day-to-day operations of the two companies.

How did you become interested in becoming an entrepreneur? How did you become a manager in your organization? What factors facilitated that?

Alterio: My husband and I decided to go into private practice about 6 years ago; however, he has done contract work in various capacities since 1989. We believed that becoming private practitioners would provide us greater opportunities for career development, growth, and financial gain. I do not directly supervise or have clinical responsibilities for our employees, but I am quite knowledgeable with regard to the billing aspect of our business, including filling out the contracts for health maintenance organizations (HMOs) and private insurance companies. Additionally, I am responsible for getting initial authorizations for all workers' compensation cases and keeping up on the reimbursement structures of all payer entities, such as Medicare, Medicaid, and private HMOs.

Armour: I was raised in a family that encouraged entrepreneurship and helping others. My mother is a registered nurse, and my stepfather is an attorney who had several small businesses. I think my blend of a small business and a patient-centered practice was inevitable. The ability to provide services with a model that I developed is very rewarding. I believe that many of the skills we learn in our occupational therapy education help with management and business development, such as activity analysis, problem solving, and building therapeutic relationships. I use these skills daily.

De La O: When I was 11 years old, I knew I wanted to be an occupational therapist. When I became a COTA, I did more than what was expected from me. I knew that one day I would own my company because I wanted to do more for the children and families I served. I have always been a self-starter in all that I do. What I considered as my strengths in leadership were perceived negatively as a threat by others (notably some OTRs working in traditional settings). I have always been recognized as a team player and a strong client advocate; however, not all share my vision and my view of the bigger picture.

Over my 27 years as an OTA, I have learned to turn negative reactions toward me into positive actions—to make change, be the change. I received this advice: "If you want to make change, Terry and you want to make change within the profession for other OTAs and those you serve, then you must get involved in your associations, address policies being voted on, and get involved in the world outside of OT." Without those leaders' innovative visions and my family's personal sacrifices, I would still be struggling. Although not all leaders and practitioners in the profession see the future with OTAs involved, it is my hope that the course of history will change. I know it can; I am an example of the change.

I believe that my state and national association involvement at every level has helped me to be a strong leader. I learned from my involvement that visionaries are many times perceived negatively by those who do not see the big picture. It is wonderful but sad that only in the past 4 years have I been able to demonstrate that my work was valuable and on the cutting edge. I owe this opportunity to two exceptional OTRs who now sit on our nonprofit Board as officers, my parents, and my 12-year-old daughter who is my world.

For many years, I have received encouragements to have my own business from colleagues within and outside of the occupational therapy profession. They saw in me that when I set my ideas in place, I could make things happen. I learned that I should not question my dreams and ideas even when critics do.

How much of an influence does your occupational therapy background have on your being an entrepreneur and manager/administrator?

Alterio: I believe that my educational background at the associate's level did not have much influence on my decision to go into private practice. The educational course work and requirements also did not prepare me for what is necessary to be a private practitioner. I believe that I have gained much of my knowledge through continuing education, support and joint efforts of working alongside my husband, and keeping up to date on the changes of the reimbursement requirements set forth for proper coding and billing.

Armour: It is a little different scenario with an OTA as the "boss" with OTRs, but in our case, everyone works very well together. I consider myself the person that allows us to do the type of work we passionately want to do. I am very lucky that I work with four very talented professional women. A small business owner once told me that the key to a successful business is to surround yourself with the "cream of the crop" employees, and they will always make you look good! He was so right. I cannot leave out a young gentleman that I recently hired part-time to do the billing. For the first few years, I thought I had to do this myself (partly because I was too cheap), but hiring another person to do billing has taken away loads of stress from me. That is advice I would give anyone starting his or her own business: Hire people to help with the areas you are not trained in. I had some very costly and stressful mistakes that could have been avoided if I had an office assistant who was trained in billing procedures.

De La O: My background as an OTA has everything to do with my being an entrepreneur, administrator, political advocate, media marketer, businesswoman, client advocate, and practitioner. I make decisions with my occupational therapy frame of mind: I think day in and day out, how can I bring occupational therapy to the forefront not only to those our companies serve, but also to those in the world who need us?

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What barriers or advantages have you encountered related to being an OTA/business owner in the health care arena?

Alterio: To be honest, I have not really encountered roadblocks as an OTA in private practice. I believe that I have only grown into a better and more well-rounded practitioner in all aspects of the profession. I have become knowledgeable with respect to legislative issues that affect practice in the state of New York and changes in reimbursement, especially Medicare and Medicaid programs. Some may think that being an OTA is a barrier because most insurance companies require a baccalaureate degree to negotiate a contract for service and require the OTR to have oversight of the OTA during service delivery. This again has not affected me directly as I have had the privilege of having direct and continuous supervision from my husband and co-owner.

Armour: Creating VRS continues to be a very rewarding experience. Are there days that I wonder why I am doing this? Would it be easier to work for someone else for more money, more benefits (such as health care!), and less anxiety and worry? Usually, I have my answer that day—a reminder from a coworker/employee about how much she loves working for the company, hearing patients say that their physician wanted them to come to VRS because we are the best, or having a patient or parent state that he or she is so glad to have found us. I know that I have made the right decision, and I am excited to think of new ways to make VRS an even better company.

De La O: Our business is not traditional health care. We are a community-based mental health practice focused on wellness and prevention. We are doing ground-breaking occupational therapy. My vision is that our unique "Animo: Latino Young Men's Conference," which we do as a lone agency locally, will go nationwide within 2 years. (*Animo* is a Latin term that refers to having purpose or intention.)

My personal struggles as an OTA to be seen as a viable member of the profession for so many years have taught me to keep moving forward and to keep my actions positive in thought and implementation. To forge ahead and to use my frustration and anger with those OTRs who remain narrow-minded in their views of a COTA has given me great strength. It is critical that we encourage collaboration between the OTR and COTA in all areas of practice and research. Based on my experience, I do not believe that the profession gives the OTA enough value and emphasis in educating the public and future practitioners.

As a business owner, what liaisons or strategic partnerships did you feel were important to your success?

Alterio: One of the most critical factors in the ongoing success of our business is the strategic partnership between my husband and me. We have a mutual commitment to the success of our business. With the ever-changing delivery of health care, we are both dedicated to pursuing continuing competency in practice and management and keeping abreast with legislation and reimbursement policies. Positive relationships in our community with key stakeholders such as physicians, school principals, teachers, and parents also are very important in the advancement of our success.

Armour: Time is better spent on patient care, building liaisons with the local outpatient rehabilitation staff, physicians, and case managers. These liaisons have been a key factor in our growth and success. Because of our company's small size, we are able to give timely and personal customer service.

De La O: Networking beyond our comfort zones with non–occupational therapy forums and being ready to take part in strong alliances in the political arena were key to our success. Our important accomplishments include participating directly in U.S. Representative Grace Napolitano's Mental Health Forum in partnership with other community agencies and being invited by Governor Schwarzenegger's task force to advocate for persons with disabilities. Media relationship was very important with our marketing efforts, especially with our focus on the uniqueness of occupational therapy practice. I also provided assistance to my state association and to the American Occupational Therapy Association whenever there was a call to action. All of these created visibility and credibility.

What advice would you give to other occupational therapy practitioners, in general, and to OTAs, in particular, who may be interested in becoming an entrepreneur and manager/administrator?

Alterio: I believe that being a member of both your national and state association is important because they provide many foundational opportunities and resources that are vital in the private practice arena. If someone is interested in becoming a private practitioner in his or her state, it is helpful to research the laws of business corporations and the laws that govern the practice of occupational therapy. You also will need to look into malpractice and liability insurance.

Armour: If someone is considering opening his or her own practice, I would suggest the following:

1. Have a strong desire to learn because you will need to learn something new almost every day.
2. Have a detailed business plan and have many different people review the plan—someone from health care, a financial advisor, and a small business owner.
3. Surround yourself with the best. Remember that your reputation depends on it!
4. Have more capital than you think you are going to need.
5. Make sure that your business not only feeds the body, but also the soul. You have to have a passion for your business to succeed.

De La O: I would suggest the following:

1. Never give up on your dreams about why you became a COTA. Never believe that your work or you being an OTA is second-rate.
2. Always advocate on your patients' behalf. Remember, we are there to serve their needs, not ours.
3. Be ready for the sacrifices with your family; friends; and, at times, your own lifestyle while starting your own business. If you have children, always keep time for them. I thank my parents for being there every day for me in making my dreams a reality.
4. Have a financial planner to work with you. Having a Certified Public Accountant who knows nonprofits sit on your board also is beneficial.
5. Be sure to have a backup plan with your business financially. If possible, have a side job and manage both well so neither suffers.
6. Be sure you have people around you who believe in you and your work every day. Make every effort to stay positive.
7. Have a business partner who you can count on when moments become overwhelming and with whom you can share both growth and success.

Conclusion

Learning how to manage, administrate, or run a business enterprise may go beyond what entry-level occupational therapy education provides. However, these skills may be acquired through additional

education, self-reflection, and blending of performance and process skills that we possess as OTs or OTAs. Either may indeed change roles from that of a practitioner to that of a manager, administrator, or entrepreneur. However, adoption of any one of these roles should never compromise our direct care duties as either an OT or an OTA but, rather, foster greater OT–OTA collaboration. ■

Salvador Bondoc, *OTD, OTR/L, CHT, is Editor of the Administration & Management Special Interest Section Quarterly.*

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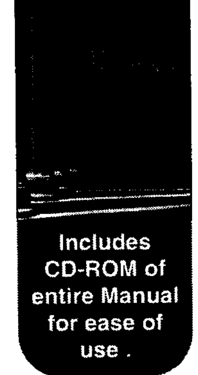

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Miscellaneous Materials

1. Los Angeles county job descriptions.
2. Business & Professions Code references to "corporations."

MTP Occupational Therapy Job Descriptions

- **Certified Occupational Therapy Assistant**

  Provides occupational therapy services to assist patients with physical disabilities attain or regain physical functioning, and conducts structured assessments and screenings.

- **Occupational Therapist I**

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- **Occupational Therapist II**

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- **Occupational Therapy Supervisor I**

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- **Occupational Therapy Instructor**

  Develops, organizes and conducts formal and informal occupational therapy education courses as well as and field work experience programs for students. Trains occupational therapy staff and allied health personnel. Conducts training and evaluates its effectiveness in achieving educational objectives.

- **Occupational Therapy Supervisor II**

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1050. – Chiropractic Corporations
A chiropractic corporation is a corporation which is registered with the State Board of Chiropractic Examiners with reference to corporations rendering professional services as chiropractors and has a currently effective certificate of registration from the board pursuant to the Professional Corporation Act, as contained in Part 4 (commencing with Section 13400) of Division 3 of Title 1 of the Corporations Code, and this article. Subject to all applicable statutes, rules and regulations, such chiropractic corporation is entitled to practice chiropractic. With respect to a chiropractic corporation, the governmental agency referred to in the Professional Corporation Act is the State Board of Chiropractic Examiners with reference to corporations rendering professional services as chiropractors. As used in this article, the "board" refers to the State Board of Chiropractic Examiners.

1800. - Dental Corporations
A dental corporation is a corporation that is authorized to render professional services, as defined in Sections 13401 and 13401.5 of the Corporations Code, if that corporation, its shareholders, officers, directors, and employees rendering professional services who are dentists, physicians and surgeons, dental assistants, registered dental assistants, registered dental assistants in extended functions, registered dental hygienists, registered dental hygienists in extended functions, or registered dental hygienists in alternative practice are in compliance with the Moscone-Knox Professional Corporation Act (Part 4 (commencing with Section 13400) of Division 3 of Title 1 of the Corporations Code), this article, and other statutes, rules, and regulations applicable to a dental corporation and the conduct of its affairs. Subject to all applicable statutes, rules, and regulations, a dental corporation is entitled to practice dentistry. With respect to a dental corporation, the governmental agency referred to in the Moscone-Knox Professional Corporation Act is the Dental Board of California.

2400. - Medical Corporations
Corporations and other artificial legal entities shall have no professional rights, privileges, or powers. However, the Division of Licensing may in its discretion, after such investigation and review of such documentary evidence as it may require, and under regulations adopted by it, grant approval of the employment of licensees on a salary basis by licensed charitable institutions, foundations, or clinics, if no charge for professional services rendered patients is made by any such institution, foundation, or clinic.

2536. – Speech-Language-Audiology Corporations
A speech-language pathology corporation or an audiology corporation is a corporation which is authorized to render professional services, as defined in Section 13401 of the Corporations Code, so long as that corporation and its shareholders, officers, directors, and employees rendering professional services who are speech-language pathologists or audiologists are in compliance with the Moscone-Knox Professional Corporation Act, this article, and all other statutes and regulations now or hereafter enacted or adopted pertaining to the corporation and the conduct of its affairs.

With respect to a speech-language pathology corporation or an audiology corporation, the governmental agency referred to in the Moscone-Knox Professional Corporation Act is the Speech-Language Pathology and Audiology Board.

3160. – Optometric Corporations
An optometric corporation is a corporation that is authorized to render professional services, as described in Sections 13401 and 13401.5 of the Corporations Code, if that corporation and its shareholders, officers, directors, and employees rendering professional services who are physicians and surgeons, psychologists, registered nurses, optometrists, or podiatrists are in compliance with the Moscone-Knox Professional Corporation Act as contained in Part 4 (commencing with Section 13400) of Division 3 of Title 1 of the Corporations Code, the provisions of this article, and all other statutes and regulations now or hereafter enacted or adopted pertaining to the corporation and the conduct of its affairs. With respect to an optometric corporation, the governmental agency referred to in the Moscone-Knox Professional Corporation Act is the State Board of Optometry.

3670. – Naturopathic Corporations
A naturopathic corporation is a corporation that is authorized to render professional services, as defined in Section 13401 of the Corporations Code, if the corporation and its shareholders, officers, directors, and employees rendering professional services who are naturopathic doctors are in compliance with the Moscone-Knox Professional Corporation Act (Part 4 (commencing with Section 13400) of Division 3 of Title 1 of the Corporations Code), this chapter, and all other statutes and regulations now or hereafter enacted or adopted pertaining to that corporation and the conduct of its affairs. With respect to a naturopathic corporation, the governmental agency referred to in the Moscone-Knox Professional Corporation Act is the committee.

4987.5. – Marriage and Family Therapy Corporations
A marriage and family therapy corporation is a corporation that is authorized to render professional services, as defined in Section 13401 of the Corporations Code, so long as that corporation and its shareholders, officers, directors, and employees rendering professional services who are marriage and family therapists, physicians and surgeons, psychologists, licensed clinical social workers, registered nurses, chiropractors, or acupuncturists are in compliance with the Moscone-Knox Professional Corporation Act (Part 4 (commencing with Section 13400) of Division 3 of Title 1 of the Corporations Code), this article, and any other statute or regulation pertaining to that corporation and the conduct of its affairs. With respect to a marriage and family therapy corporation, the governmental agency referred to in the Moscone-Knox Professional Corporation Act is the Board of Behavioral Sciences.

5150. – Accountancy Corporations
An accountancy corporation is a corporation which is registered with the California Board of Accountancy and has a currently effective certificate of registration from the board pursuant to the Moscone-Knox Professional Corporation Act, as contained in Part 4 (commencing with Section 13400) of Division 3 of Title 1 of the Corporations Code, and this article. Subject to all applicable statutes, rules and regulations, an accountancy corporation is entitled to practice accountancy. With respect to an accountancy corporation, the governmental agency referred to in the Moscone-Knox Professional Corporation Act is the California Board of Accountancy.

NON-HEALING ARTS CORPORATIONS

5610. – Architectural Corporations
A professional architectural corporation is a corporation which is authorized to render professional services, as defined in Section 13401 of the Corporations Code, so long as that corporation and its shareholders, officers, directors, and employees rendering professional services who are licensed architects, are in compliance with the Moscone-Knox Professional Corporation Act (Part 4 (commencing with Section 13400) of Division 3 of Title 1 of the Corporations Code), this article, and all other statutes and regulations pertaining to the corporation and the conduct of its affairs. With respect to an architectural corporation, the governmental agency referred to in the Moscone-Knox Professional Corporation Act is the California Architects Board.

6160. – Law Corporations
A law corporation is a corporation which is registered with the State Bar of California and has a currently effective certificate of registration from the State Bar pursuant to the Professional Corporation Act, as contained in Part 4 (commencing with Section 13400) of Division 3 of Title 1 of the Corporations Code, and this article. Subject to all applicable statutes, rules and regulations, such law corporation is entitled to practice law. With respect to a law corporation the governmental agency referred to in the Professional Corporation Act is the State Bar.

8040. – Shorthand Reporting Corporations
A shorthand reporting corporation is a corporation which is authorized to render professional services, as defined in Section 13401 of the Corporations Code, as long as that corporation and all of its shareholders, officers, directors, and employees rendering professional services who are certified shorthand reporters are in compliance with the Moscone-Knox Professional Corporation Act, this article, and all other statutes and regulations now or hereafter enacted or adopted pertaining to that corporation and the conduct of its officers. With respect to a shorthand reporting corporation, the governmental agency referred to in the Moscone-Knox Professional Corporation Act is the Court Reporters Board of California.