STATE OF CALIFORNIA
dca
DEPARTMENT OF CONSUMER AFFAIRS

STATE AND CONSUMER SERVICES AGENCY • ARNOLD SCHWARZENEGGER, GOVERNOR

BOARD OF OCCUPATIONAL THERAPY
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PRACTICE COMMITTEE MEETING NOTICE & AGENDA

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

Tuesday, October 19, 2010

1:00 pm – Practice Committee Meeting

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

A. Call to order, roll call, establishment of a quorum

B. Introductions of Committee members

C. Review of Committee Member Roster

D. Review and discussion of Practice Committee's Roles and Responsibilities and consideration of recommending changes to the Board.

E. Consideration of board-approved legislative proposal to amend definition of Occupational Therapy, contained in Business and Professions Code Section 2570.2(k), and recommendation to the Board of possible changes.

F. Discussion of specialized occupational therapy skills acquired post entry-level (e.g., wound care, lymphedema treatment, assistive technology, etc.,) recognition of various certification organizations, and the Board's role in monitoring these areas.

G. Discussion and consideration of amending Section 4161, California Code of Regulations, Continuing Competency.

H. Discussion of Section 4184, California Code of Regulations, Delegation of Tasks to Aides and Section 2570.2(a), Business and Professions Code, regarding responsibility for documentation.

I. Discussion and consideration of prohibition of teaching continuing education courses when a practitioner's license is on probation.

J. Selection of 2011 meeting dates.

K. Public comment on items not on agenda.

L. 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 Tabatha Montoya 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.

AGENDA ITEM D

California Board of Occupational Therapy

PRACTICE COMMITTEE

Roles & Responsibilities

1. Review and provide recommendations to Board staff on *Applications for Advanced Practice Post-Professional Education* received from course providers;

2. Review and provide recommendations to Board staff on initial applications for licenses/certificates received from individuals who have not been engaged in the practice occupational therapy for five years;

3. Review and provide recommended responses to the Board on various practice issues/questions submitted by licensees and consumers;

4. Provide guidance on continuing competency audits, including reviewing and providing recommendations on audit responses, if necessary;

5. Review and provide recommendations to Board staff on applicants for the Expert Reviewer Program;

6. Review and provide recommendations to Board staff on revisions to various applications and forms used by the Board;

7. Review and provide recommendations to the Board on practice related proposed regulatory amendments.

8. Establish resource pool of Expert Reviewers to review and provide recommendations to Board staff on *Applications for Advanced Practice Approval* in hand therapy, physical agent modalities, and swallowing assessment, evaluation, or intervention.

AGENDA ITEM E

Amend Business & Professions Code Section 2570.2(k)

(k) "~~Practice of~~ ~~o~~Occupational therapy" means the therapeutic use of purposeful and meaningful goal-directed activities (occupations) which engage the individual's body and mind in meaningful, organized, and self-directed actions that maximize independence, prevent or minimize disability, and promote or maintain health, well being, and quality of life. Occupational therapy services encompass research, education of students, occupational therapy assessment, treatment, education of, and consultation with~~, individuals who have been referred for occupational therapy services subsequent to diagnosis of disease or disorder (or who are receiving occupational therapy services as part of an Individualized Education Plan (IEP) pursuant to the federal Individuals with Disabilities Education Act (IDEA)).~~ individuals, groups, programs, organizations, or communities.

(1) Occupational therapy assessment identifies performance abilities and limitations that are necessary for self-maintenance, learning, work, and other similar meaningful activities. Occupational therapy treatment is focused on developing, improving, or restoring functional daily living skills, compensating for and preventing dysfunction, or minimizing disability. Occupational therapy techniques that are used for treatment involve teaching activities of daily living (excluding speech-language skills); designing or fabricating selective temporary orthotic devices, and applying or training in the use of assistive technology or orthotic and prosthetic devices excluding gait training). Occupational therapy consultation provides expert advice to enhance function and quality of life. Consultation or treatment may involve modification of tasks or environments to allow an individual to achieve maximum independence. Services are provided individually~~,~~ or in groups.~~, or through social groups.~~

(2) The licensed occupational therapist or occupational therapy assistant may assume a variety of roles in their profession, including but not limited to, clinician, supervisor of occupational therapy students and volunteers, researcher, scholar, consultant, administrator, faculty, clinical instructor, continuing education instructor and educator of consumers/clients. The term "client" is used to name the entity that receives occupational therapy services. Clients may be categorized as:

a) individuals, including individuals who may be involved in supporting or caring for the client (i.e. caregiver, teacher, parent, employer, spouse);

b) individuals within the context of a group (e.g., a family, a class); or

c) individuals within the context of a population (e.g., an organization, a community).

(l) "Hand therapy" is the art and science of rehabilitation of the hand, wrist, and forearm requiring comprehensive knowledge of the upper extremity and specialized skills in assessment and treatment to prevent dysfunction, restore function, or reverse the advancement of pathology. This definition is not intended to prevent an occupational therapist practicing hand therapy from providing other occupational therapy services authorized under this act in conjunction with hand therapy.

(m) "Physical agent modalities" means techniques that produce a response in soft tissue through the use of light, water, temperature, sound, or electricity. These techniques are used as adjunctive methods in conjunction with, or in immediate preparation for, occupational therapy services.

The American Occupational Therapy Association, Inc.

MEMORANDUM

TO: AOTA Board of Directors
Representative Assembly
Affiliated State Association Presidents
Commission on Practice
Commission on Continuing Competence and Professional Development
Special Interest Section Steering Committee
Accreditation Council for Occupational Therapy Education
Association of Student Delegates Steering Committee
Commission on Education
Ethics Commission
Education Program Directors
State Legislative Chairpersons
State Occupational Therapy Regulatory Boards
Paul Grace, President and CEO, NBCOT
AOTA Staff

FROM: Chuck Willmarth
Director, State Affairs and Reimbursement & Regulatory Policy

Marcy Buckner, JD
State Policy Analyst

DATE: September 23, 2010

SUBJECT: Feedback regarding the revised Definition of Occupational Therapy Practice for the AOTA Model Practice Act

AOTA has worked with state occupational therapy associations to enact state licensure laws for more than 30 years. Part of that support has included the development of reference documents such as the *AOTA Model Practice Act*, which includes a definition of occupational therapy practice.

The *Definition of Occupational Therapy Practice for the AOTA Model Practice Act* reflects the current scope of practice of occupational therapy and consistency with other AOTA documents. It is intended for use by state associations and state regulatory boards in updating state practice acts to reflect current practice and terminology. Once enacted into law, the definition legally defines the occupational therapy scope of practice in state statutes.

Revisions to the definition were last adopted by the RA in 2004. In June 2010, AOTA's State Affairs Group sought input from the Association's leadership, external stakeholders, and the membership in order to facilitate revisions to the definition. The input that was submitted was reviewed by AOTA staff, and has been compiled in to a revised version of the definition. We are now seeking comments on the revised version of the definition through this Zoomerang Survey: http://www.zoomerang.com/Survey/WEB22B6PWLFCCA.

The survey breaks the existing definition paired with the revised definition into six sections to provide feedback and then asks three general questions about the document. In the revised text, words with a strikethrough have been deleted and words with an underline have been added.

You may also submit proposed edits to the document using the "track changes" feature in WORD to stpd@aota.org. You may access the revised definition in WORD here: http://www.aota.org/DocumentVault/Surveys/Model-Def-Revision.aspx

Please complete the survey and/or submit feedback by October 29, 2010. Your input in this process will help define the occupational therapy scope of practice as the profession works to realize the Centennial Vision.

Draft Revisions to the Model Definition of Occupational Therapy Practice based on Stakeholder Input - September 2010
Please submit comments to stpd@aota.org by October 29, 2010.

Note: Text with a ~~strikethrough~~ has been deleted and text with an underline has been added. Sections A and B in the current version were switched in the revised version, so A is now B and B is now A.

Definition of Occupational Therapy Practice for the AOTA Model Practice Act

The practice of occupational therapy means the therapeutic use of everyday life activities (occupations) with individuals ~~or~~ groups, or populations ~~for the purpose of~~ to address participation and function in roles and situations in home, school, workplace, community, and other settings. Occupational therapy services are provided ~~for the purpose of promoting~~ for habilitation, rehabilitation, and promoting health and wellness ~~and~~ to those who have or are at risk for developing an illness, injury, disease, disorder, condition, impairment, disability, activity limitation, or participation restriction. Occupational therapy addresses the physical, cognitive, psychosocial, sensory, and other aspects of performance in a variety of contexts to support engagement in everyday life activities that affect physical and mental health, well-being, and quality of life.

The practice of occupational therapy includes:

A. Evaluation of factors affecting activities of daily living (ADL), instrumental activities of daily living (IADL), education, work, play, rest and sleep, leisure, and social participation, including:
   1. Client factors, including body functions (such as neuromuscular, sensory and pain, visual, mental, perceptual, cognitive) and body structures (such as cardiovascular, digestive, nervous, integumentary, genitourinary systems), values, beliefs, and spirituality.
   2. Habits, routines, roles, rituals, and behavior patterns.
   3. Cultural, physical, environmental, social, and ~~spiritual~~ virtual contexts and activity demands that affect performance.
   4. Performance skills, including motor and praxis, ~~process~~, sensory-perceptual, emotional regulation, cognitive, and communication~~/interaction~~ and social skills.

B. Methods or ~~strategies~~ approaches selected to direct the process of interventions such as:
   1. Establishment, remediation, retention, or restoration of a skill or ability that has not yet developed ~~or~~ is impaired, or is in decline.
   2. Compensation, modification, or adaptation of activity or environment to enhance performance.
   3. ~~Maintenance~~ Retention and enhancement of ~~capabilities~~ skills or abilities without which performance in everyday life activities would decline.
   4. ~~Health promotion~~ Promotion of health and wellness, including the use of self-management strategies, to enable or enhance performance in everyday life activities.
   5. Prevention of barriers to performance and participation, including disability prevention.

C. Interventions and procedures to promote or enhance safety and performance in activities of daily living (ADL), instrumental activities of daily living (IADL), education, work, play, rest and sleep, leisure, and social participation, including:
   1. Therapeutic use of occupations, exercises, and activities.
   2. Training in self-care, self-management, health management and maintenance, home management, and community/work reintegration.
   3. Development, remediation, or compensation of physical, mental, cognitive, neuromuscular, sensory functions and behavioral skills.
   4. Therapeutic use of self, including one's personality, insights, perceptions, and judgments, as part of the therapeutic process.
   5. Education and training of individuals, including family members, caregivers, groups, and others.
   6. Care coordination, case management, and transition services.
   7. Consultative services to groups, programs, organizations, or communities.

8. Modification of environments (home, work, school, or community) and adaptation of processes, including the application of ergonomic principles.
9. Assessment, design, fabrication, application, fitting, and training in seating and positioning, assistive technology, adaptive devices, and orthotic devices, and training in the use of prosthetic devices.
10. Assessment, recommendation, and training in techniques to enhance functional mobility, including ~~wheelchair~~ management of wheelchairs and other mobility devices.
11. Low vision rehabilitation.

~~11.~~ 12. Driver rehabilitation and community mobility.

~~12.~~ 13. Management of feeding, eating, and swallowing to enable eating and feeding performance.

~~13.~~ 14. Application of physical agent modalities, and use of a range of specific therapeutic procedures (such as wound care management; techniques to enhance sensory, perceptual, and cognitive processing; manual therapy techniques) to enhance performance skills.

Adopted by the Representative Assembly 5/21/04 (Agenda A11, Charge 60)

AOTF The American Occupational Therapy Foundation

AOTA® The American Occupational Therapy Association, Inc.

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OCCUPATIONAL THERAPY RESEARCH AGENDA

The Occupational Therapy (OT) Research Agenda identifies the major research goals and priorities for occupational therapy research. The goals and priorities span five categories: Assessment/measurement, **Intervention Research**, Basic Research, **Translational Research**, and **Health Services Research**. A sixth related category, Research Training, addresses capacity building to accomplish the research goals and priorities.

Three of the five research categories—**Intervention Research, Translational Research, and Health Services Research**—are recognized as being of paramount importance for the next decade because it is imperative that the efficacy and effectiveness of occupational therapy interventions be ascertained; that the optimal dose, frequency, duration, and location of occupational therapy interventions be determined; and that the salient elements (or active ingredients) of occupational therapy interventions be identified. The study of occupational engagement and participation, problems in engagement and participation, and interventions to restore, prevent or compensate for problems in engagement and participation is complex and requires the collaboration of scholars from various disciplines, thus placing occupational therapy research in an interdisciplinary context.

This emphasis on **intervention/prevention**, **translational**, and **health services** research is consistent with the American Occupational Therapy Association's Centennial Vision of occupational therapy as "a powerful, widely recognized, science-driven, and evidence-based profession." It is also consistent with the National Institutes of Health (NIH) Roadmap, the Initial National Priorities for Comparative Effectiveness Research put forth by the Institute of Medicine of the National Academies (June, 2009), the Testimony of the Disability and Rehabilitation Coalition before the Interagency Committee on Disability Research (August 13, 2008), the Effective Health Care Program of the Agency for Healthcare Research and Quality (AHRQ) (2008), and the comments by Senator Baucus (D-Mont) on Introduction of The Comparative Effectiveness Research Act of 2008 (August 1, 2008). Simply stated, our clients (patients) want the most effective interventions for their performance problems and occupational therapy practitioners want to provide them with these interventions. However, for practitioners to provide the most effective interventions, occupational therapy interventions must be defined, described, and tested, so that practitioners know what is effective for which clients. **Treatment effectiveness** takes into account considerations such as: what mixture (e.g., interesting task + progressive grading of cognitive components of task + modeling) of

occupational therapy is needed to promote positive change (can be delivered in a reproducible manner—is manualized); how strong must the intervention be to promote positive change (dose), how often must clients (patients) participate in the intervention to promote positive change (frequency); how long must the intervention be delivered to promote change (duration), and where (location) is the best place (hospital, school, home, workplace, community) for the intervention to occur. Likewise, **prevention** activities extend the role and function of occupational therapy into community activities aimed to promote occupational engagement and participation of the total population and to prevent secondary conditions among those already living with disabling conditions. Prevention research generally addresses a particularly vulnerable, but as yet unaffected, segment of the population with an emphasis on promoting occupation and preventing secondary conditions. This area, also, is in its infancy in occupational therapy and requires efficacy and effectiveness studies, but may require a more population-based approach to methodology.

The intent of placing a priority on **intervention**, **translational**, and **health services** research is to stimulate research on occupational therapy interventions. In examining occupational therapy interventions priority is given to interventions that are client-centered, occupation-based, theory-driven, and manualized. Recognizing that the science of occupational therapy practice is in its infancy, the priority is broadly defined to include preliminary work leading to efficacy (research under tightly controlled conditions) or effectiveness (research under real-world conditions) trials, that is, it includes "proof of concept" studies of interventions (including quantitative, qualitative, and mixed methodologies); pilot, feasibility studies of interventions; and, single-subject intervention studies.

Research Categories	Major Research Goals	Research Priorities
Assessment/ Measurement	▪ Develop screening instruments to determine functional ability across the lifespan, with acceptable sensitivity and specificity. ▪ Develop outcome instruments sufficiently responsive to measuring change in daily life activities, including activity and participation. ▪ Develop and evaluate strategies for identifying and/or measuring the health impact of environments on activity engagement and participation in daily life. ▪ Develop and evaluate strategies for identifying and/or measuring the influence of activity engagement in daily life on health.	▪ Screening instruments to identify performance deficits in persons of all ages with chronic disorders and disability. ▪ Instruments for simultaneously evaluating person–occupation–environment (context).

Research Categories	Major Research Goals	Research Priorities
Intervention—Preventive, Restorative, Compensatory: To promote function/wellness in people of all ages—those without disabilities, those with (or at-risk for) disabilities, and/or chronic health problems.	▪ Devise a taxonomy of occupational therapy/rehabilitative interventions (so that the content of occupational therapy can be uniformly described). ▪ Evaluate the *efficacy* of occupational therapy interventions (in controlled conditions). ▪ Create novel, theory based interventions for promoting activity/participation/occupation and improving quality of life. ▪ Determine a means of evaluating the outcomes of occupational therapy interventions and prevention strategies in an interdisciplinary and translational context.	▪ Application of interventions that: 1) Are client-centered (i.e., personalized). 2) Manipulate an occupational therapy modality/method (i.e., use as the method of change): a) Occupation (i.e., activity/participation based) b) Cognitive, sensory, motor, and/or affective functions (i.e., impairment-oriented) c) The environment (i.e., lived-in, virtual; technology, including splints) 3) Are theory driven (e.g., motor learning theory, self-efficacy theory). 4) Are manualized (i.e., structured, and hence replicable). 5) Involve a priority population: defined as a subpopulation of concern both to society and to the field of occupational therapy and its interventions (see Addendum).

Research Categories	Major Research Goals	Research Priorities
Translational Research	▪ Evaluate the *effectiveness* of occupational therapy interventions (under conditions of usual care). ▪ Examine the implications of novel developments in sciences related to occupational therapy (e.g., medical/biopsychosocial/occupational/environmental) for the science and practice of occupational therapy. ▪ Examine change processes, whereby new ideas are diffused and adopted in theory and practices.	▪ Examine the effects of stem cell transplantation, neural implants and other novel and developing medical therapies on functional recovery (e.g., when is the best time to intervene to promote recovery of body structures/functions, activity, or participation). ▪ Apply the methods of computational modeling to predict functional recovery (e.g., mathematical modeling of how hand function will improve following hand surgery and rehabilitation services).

(Cont. from pg. 3)

Research Categories	Major Research Goals	Research Priorities
Basic Research: 1) The experience of disability and/or chronic health problems for individuals and their families across the life span. 2) Examination of body structures and functions supporting performance in daily life.	▪ Examine relationships among impairment (body structures and functions), activity (activity limitations), and participation (participation restrictions). ▪ Delineate how productive occupation promotes lifelong health and reduces the risk of chronic disease and disability and maintain quality of life in people of all ages. ▪ Identify determinants of healthy lifestyles. ▪ Examine the response of individuals and their families to changes in functional independence. ▪ Examine intrinsic mechanisms (e.g., genetic, physiological, psychological [sensory-perceptual-motor, cognitive]) and how they support performance in daily life. ▪ Examine extrinsic mechanisms (e.g., technology, social support, culture, social policies) and how they support performance in daily life.	▪ Examine brain-behavior relationships in daily life activities.

(Cont. from pg. 4)

Research Categories	Major Research Goals	Research Priorities
Health Services Research	▪ Evaluate performance outcomes for diagnostic groups based on type of occupational therapy intervention, site of service delivery, professional training, and/or team composition. ▪ Evaluate performance outcomes for racial/ethnic groups based on type of occupational therapy intervention, site of service delivery, professional training, and/or team composition. ▪ Design and implement community-based participatory research to "increase the relevance, acceptability, and usefulness of evidence-based scientific findings in improving" occupational therapy (rehabilitation).	▪ Develop and implement a database for use in outcomes research and quality improvement studies. ▪ Identify quality indicators for evaluating occupational therapy services and outcomes. ▪ Design and implement studies comparing the effectiveness of different treatment options, including different occupational therapy approaches and different rehabilitation approaches. ▪ Examine the effects of evidence-based evaluation and intervention guidelines on occupational therapy practice. ▪ Identify where practice lags behind practice guidelines to provide evidence of need for quality indicators. ▪ Identify, develop, and evaluate occupational therapy's role in community preparedness.

Research Categories	Major Research Goals	Research Priorities
Research Training	▪ Increase occupational therapy's research capacity. ▪ Socialize occupational therapy educators to preparing occupational therapy scientists. ▪ Expand occupational therapy's knowledge and skills in using population-based research for the purpose of prevention and promotion of occupation.	▪ Prepare Program Directors in research universities to support early career (< 5 years post doctoral degree) occupational therapist scientists. ▪ Prepare doctoral students to conduct intervention research. ▪ Financially support intervention research of early career (< 5 years post doctoral degree) occupational therapist scientists and doctoral students.

Addendum: Priority Populations; including individuals desiring to enhance their occupational function and health, and those who live with:

1. Developmental disorders (e.g., autism spectrum disorders, cerebral palsy, intellectual disabilities)
2. Physical impairments (e.g., stroke, obesity, cancer, spinal cord injuries, hand injuries, work injuries)
3. Cognitive impairments (e.g., dementia, traumatic brain injury, stroke)
4. Mental disorders (e.g., depression, posttraumatic stress disorder, persistent mental illness)
5. Chronic health conditions (e.g., arthritis, diabetes)
6. People with preventable secondary conditions (e.g., diabetic neuropathy, decubitus ulcers, social isolation, sedentary lifestyle)

AGENDA ITEM F

Skills acquired post entry-level:

- Wound care
- Lymphedema treatment
- Spinal cord injury
- Traumatic brain injury
- Assistive technology
- O&P amputees
- Driver rehabilitation
- Others…

AGENDA ITEM G

CALIFORNIA BOARD OF OCCUPATIONAL THERAPY

PROPOSED AMENDED REGULATORY LANGUAGE
Title 16, Division 39, California Code of Regulations

Proposed amendments are shown by strikeout for deleted text and underlined for new text.

Article 7. Continuing Competency Requirements

§ 4161. Continuing Competency.

(a) Effective January 1, 2006, each occupational therapy practitioner renewing a license or certificate under Section 2570.10 of the Code shall submit evidence of meeting continuing competency requirements by having completed twenty-four (24) professional development units (PDUs) during the preceding renewal period, ~~twelve (12) PDUs for each twelve month period,~~ acquired through participation in professional development activities.

(1) One (1) hour of participation in a professional development activity qualifies for one PDU;

(2) One (1) academic credit equals 10 PDUs;

(3) One (1) Continuing Education Unit (CEU) equals 10 PDUs.

(b) Topics and subject matter shall be pertinent to the practice of OT. Courses predominantly focused on business issues, marketing, or exploring opportunities for personal growth are not eligible for credit. Course material must have a relevance or direct application to a consumer of OT services. Except as provided in subdivision (c), p~~P~~rofessional development activities acceptable to the board include ~~but are not limited to,~~ programs or activities sponsored by the American Occupational Therapy Association (AOTA) or the Occupational Therapy Association of California; post-professional coursework completed through any approved or accredited educational institution, ~~that is not part of a course of study leading to an academic degree~~; or otherwise meets all of the following criteria:

(1) The program or activity contributes directly to professional knowledge, skill, and ability;

~~(2) The program or activity relates directly to the practice of occupational therapy;~~ and

~~(3)~~ (2) The program or activity must be objectively measurable in terms of the hours involved.

(c) PDUs may also be obtained through any or a combination of the following:

(1) Involvement in structured special interest or study groups with a minimum of three (3) participants. Three (3) hours of participation equals one (1) PDU, with a maximum of six (6) PDUs credited per renewal period.

(2) Structured mentoring with an individual skilled in a particular area. For each 20 hours of being mentored, the practitioner will receive three (3) PDUs, with a maximum of six (6) PDUs credited per renewal period.

(3) Structured mentoring of a colleague to improve his/her skills. Twenty (20) hours of mentoring equals three (3) PDUs, with a maximum of six (6) PDUs credited per renewal period.

(4) Supervising the fieldwork of Level II occupational therapist and occupational therapy assistant students. For each 60 hours of supervision, the practitioner will receive .5 PDU, with a maximum of eight (8) PDUs credited per renewal period.

(5) Publication of an article in a non-peer reviewed publication. Each article equals five (5) PDUs, with a maximum of ten (10) PDUs credited per renewal period.
(6) Publication of an article in a peer-reviewed professional publication. Each article equals10 PDUs, with a maximum of ten (10) PDUs credited per renewal period .
(7) Publication of chapter(s) in occupational therapy or related professional textbook. Each chapter equals 10 PDUs, with a maximum of ten (10) PDUs credited per renewal period.
(8) Making professional presentations at workshops, seminars and conferences. For each hour presenting, the practitioner will receive two (2) PDUs, with a maximum of six (6) PDUs credited per renewal period.
(9) Attending a meeting of the California Board of Occupational Therapy. Each meeting attended equals two (2) PDUs, with a maximum of six (6) PDUs ~~earned~~ credited per renewal period.
(10) Attending board outreach activities. Each presentation attended equals two (2) PDUs, with a maximum of four (4) PDUs ~~earned~~ credited per renewal period.

(d) Partial credit will not be given for the professional development activities listed in subsection (c) and a maximum of XX (*to be determined*) PDUs may be credited for the activities listed in subsection (c).

(e) This section shall not apply to the first license or certificate renewal following issuance of the initial license or certificate.

(f) Of the total number of PDUs required for each renewal period, a minimum of one half of the units must be directly related to the delivery of occupational therapy services, which ~~(1) The delivery of occupational therapy services~~ may include: models, theories or frameworks that relate to client/patient care in preventing or minimizing impairment, enabling function within the person/environment or community context. Other activities may include, but are not limited to, occupation based theory assessment/interview techniques, intervention strategies, and community/environment as related to one's practice.

(g) Applicants who have not been actively engaged in the practice of occupational therapy within the past five years completing continuing competency pursuant to section 2570.14(a) of the Code to qualify for licensure/certification shall submit evidence of meeting the continuing competency requirements by having completed, during the two year period immediately preceding the date the application was received, forty (40) PDUs that meet the requirements of subsection (b). The forty PDUs shall include:

(1) Thirty-seven (37) PDUs directly related to the delivery of occupational therapy services, which may include the scope of practice for occupational therapy practitioners or the occupational therapy practice framework;
~~(2) One (1) PDU related to occupational therapy scope of practice;~~
~~(3) One (1) PDU related to occupational therapy framework;~~
~~(4)~~ (2) ~~One (1)~~ Three (3) PDUs related to ethical standards of practice ~~for an occupational therapist~~ in occupational therapy.

Note: Authority cited: Sections 2570.10 and 2570.20, Business and Professions Code.
Reference: Section 2570.10, Business and Professions Code.

AGENDA ITEM H

DISCUSSION REGARDING RESPONSIBILITY FOR DOCUMENTATION:

BPC Section 2570.2(a)

".....The OT or OT Assistant is responsible for documenting the client's record concerning the delegated client-related tasks performed by the aide."

CCR Section 4184 - Delegation of Tasks to Aides

(a) The primary function of an aide in an occupational therapy setting is to perform routine tasks related to occupational therapy services. Non-client related tasks may be delegated to an aide when the supervising occupational therapy practitioner has determined that the person has been appropriately trained and has supportive documentation for the performance of the services.
(b) Client related tasks that may be delegated to an aide include specifically selected routine aspects of an intervention session. In addition to the requirements of Code section 2570.2, subdivisions (a) and (b), the following factors must be present when an occupational therapist delegates a selected aspect of an intervention to an aide:
(1) The outcome anticipated for the aspects of the intervention session being delegated is predictable.
(2) The situation of the client and the environment is stable and will not require that judgment or adaptations be made by the aide.
(3) The client has demonstrated previous performance ability in executing the task.
(4) The aide has demonstrated competence in the task, routine and process.
(c) The supervising occupational therapist shall **not** delegate to an aide the following tasks:
(1) Performance of occupational therapy evaluative procedures;
(2) Initiation, planning, adjustment, or modification of treatment procedures.
(3) Acting on behalf of the occupational therapist in any matter related to occupational therapy treatment that requires decision making.
(d) All documented client related services shall be reviewed and cosigned by the supervising occupational therapist.

Possible questions to consider:

- Who is responsible for documenting? The OT or OT Assistant (as stated in the law) or the Aide who then gets it co-signed by the OT (as stated in the regs)?

- IF the Aide can document with a co-signature, then who co-signs? Only the supervising OT? Or could both/either the OT and the OTA co-sign?

AGENDA ITEM I

From Board of Behavioral Sciences' (BBS) regulations:

§1887.10. COURSE INSTRUCTOR QUALIFICATIONS

(a) A provider shall ensure that an instructor teaching a course has at least two of the following minimum qualifications:

(1) a license, registration, or certificate in an area related to the subject matter of the course. The license, registration, or certificate shall be current, valid, and free from restrictions due to disciplinary action by this board or any other health care regulatory agency;

(2) a master's or higher degree from an educational institution in an area related to the subject matter of the course;

(3) training, certification, or experience in teaching subject matter related to the subject matter of the course; or

(4) at least two years' experience in an area related to the subject matter of the course.

(b) During the period of time that any instructor has a healing arts license that is restricted pursuant to a disciplinary action in California or in any other state or territory, that instructor shall notify all approved continuing education providers for whom he or she provides instruction of such discipline before instruction begins or immediately upon notice of the decision, whichever occurs first.

A condition for Probation from BBS' Disciplinary Guidelines:

Instruction of Coursework Qualifying for Continuing Education Respondent shall not be an instructor of any coursework for continuing education credit required by any license issued by the Board.