

**PEDIATRIC CURRICULUM CONTENT FOR  
OCCUPATIONAL THERAPY ASSISTANTS**

**By**

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ABSTRACT

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With the onset of new standards for educational programs by the Accreditation Council for Occupational Therapy Education (ACOTE), colleges and universities are reviewing their curriculums for compliance. The standards guide curriculums as well as provide that occupational therapy education is consistent with meeting the practice needs and current treatment techniques of the occupational therapy practice across the nation. Educational curriculums vary distinctly in the curriculum design and what is covered in educational programs.

Educational programs recognize the variance of programs and seek additional guidance for a consistent educational base. Guidelines for professional level education in regards to pediatric curriculum content have been established. The Commission of Education for occupational therapy education has charged a task force to develop guidelines for pediatric curriculum content at the technical level of education.

The purpose of this study is to determine the current practice and base of knowledge for the delivery of pediatric occupational therapy services provided by an entry-level occupational therapy assistant. The data will be collected from pediatric faculty, occupational therapists and occupational therapy assistants on a national level. Guidelines for pediatric curriculum content for occupational therapy assistants will be developed upon completion of the data analysis. Pediatric practitioners and technical level program directors will review the proposed guidelines prior to submission to the Commission of Education for possible adoption.

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## CHAPTER I

### Introduction

With the onset of new standards for educational programs by the Accreditation Council for Occupational Therapy Education (ACOTE), colleges and universities are reviewing their curriculums. Changes in the curriculums are occurring to become compliant with these standards. The standards guide curriculums as well as provide that occupational therapy education is consistent with meeting the practice needs and current treatment techniques of the occupational therapy practice across the nation. Educational curriculums vary distinctly in the curriculum design and what is covered in educational programs.

The occupational therapy assistant programs in the past have a disadvantage of not having a consistent format for education of future occupational therapy assistants. This is mainly due to the lack of research and development of textbooks directed towards the occupational therapy assistant. Treatment techniques, books and documents in the past have been geared toward the occupational therapist and occupational therapy practice versus being directed towards the occupational therapy assistant. Currently, there are only six textbooks specifically written for occupational therapy assistant education, in which three of the texts have been published within the past four years. Thus technical level programs have relied upon using the standards (essentials prior to 1999), practice guidelines, role delineation documents, current treatment trends, state and national regulations to assist in developing curriculum. The standards (essentials) were the only means of assuring program consistency in a broad sense of interpretation.

Professional level programs sought to develop curriculum guidelines in various practice areas to assure curriculum consistency. In the 1980's, occupational therapy experts in the areas of sensory integration, hand development, child development, and

pediatric treatment developed guidelines for curriculum content and pediatrics (Dunn, et al, 1998). This document was approved by the American Occupational Therapy Association (AOTA) Commission on Education (COE) and subsequently circulated to professional and technical level occupational therapy educational programs. In 1997, COE sought to revise the guidelines. A survey of the revised guidelines was sent to professional and technical program directors, invited reviewers, the original authors, school special interest section members, members of the COE and national office staff. Upon completion of the data, the COE adopted revised Guidelines for Pediatric Curriculum Content for Occupational Therapy Programs (Giuffrida & Battaglia, 1998) directed for professional level education.

One of the issues also noted at the national level is assuring that curriculum contains academic areas so the OTs/OTAs are trained with some equality, but that role delineation is noted between the professional and technical levels. Shortly after the adoption of the *Guidelines for Pediatric Curriculum Content for Occupational Therapy Programs*, COE recognized the need for a parallel document for Occupational Therapy Assistant Programs. The Commission of Education (COE) noted that consistency of pediatric curriculum in the occupational therapy assistant programs would assure that education covers the essential practice needs noted in the occupational therapy field.

Consequently, the Wisconsin Department of Public Instruction (DPI) determined several years ago that there is a significant shortage of occupational therapists and occupational therapy assistants in certain regions of the state. The use of occupational therapy assistants is extremely low throughout the state in comparison to national average data collected for the practice analysis.

DPI conducted several surveys as well as task forces to study and investigate why this shortage is occurring. One of the areas identified is the lack of understanding of the profession by administration and the lack of fieldwork sites for training of the students.



The task force identified that administrators generally do not support fieldwork for students in the occupational therapy field even though the support of student teachers is widely accepted. One area of concern was that administration in the public schools did not know what occupational therapy education included in the areas of pediatric and school based practice. They also did not know what treatment skills the occupational therapy assistants could provide compared to that of the occupational therapists.

*The National Occupational Therapy Practice Analysis: Findings and Implications for Competence*, (Dunn & Cada, 1998) note that school systems are the second highest employer of occupational therapy assistants although this is not the case in Wisconsin. The practice analysis data (Dunn & Cada, 1998) also indicates that experienced occupational therapy assistants work in the schools systems. This data may indicate that the educational programs are not properly preparing students to enter the pediatric realm of practice upon graduation from technical programs. Since there isn't a specific textbook directed towards the education of the neither occupational therapy assistant nor guidelines besides the essentials and standards from ACOTE, pediatric course material is varied and not consistently presented across the nation.

#### Statement of the Problem

A review of the literature shows that educational programs may not be properly preparing students to enter a delivery system which requires strong critical thinking skills, adaptability and consultative skills as a new practitioner (Dudgeon & Greenberg, 1998). Studies have also shown that OTAs must be able to demonstrate the competent ability to intervene in classroom systems.

### Purpose of the Study

The purpose of this study is two folds. One, to determine the national pediatric curriculum guidelines for Occupational Therapy Assistant (OTA) educational programs. Two, to identify current pediatric practices, competency skills for treatment and need for critical thinking skills for the entry-level pediatric OTA.

### Objectives

Objectives of the research for the development of the guidelines for pediatric curriculum content for occupational therapy assistants are as follows:

1. To identify treatment skills, competencies and educational needs of occupational therapy assistants for school based and pediatric practice.
2. To identify current trends of practice for the occupational therapy assistant in pediatric practice arena.
3. To determine guidelines that would provide consistency of the provision of pediatric education across the nation in preparing students for school-based, entry-level, pediatric practice.

### Limitations

The study is limited to occupational therapy assistant pediatric faculty, practicing occupational therapists and occupational therapy assistants with pediatric experience who have provided fieldwork experiences for occupational therapy assistant students. Program directors select the practitioners to complete the survey, limiting the subject base. Program directors may choose not to participate or send the survey to practitioners

limiting the response rate. Pediatric occupational therapist or certified occupational therapy assistants may not participate in the provision of fieldwork experience for occupational therapy assistant students, which limited the distribution of the surveys. The geographical base is limited to the states/jurisdictions that have Occupational Therapy Assistant Programs, which includes Puerto Rico.

## CHAPTER II

### Literature Review

The purpose of the literature review was to analyze current literature relating to the need of guidelines to support educational programs curriculum. The review of literature focuses upon the national association's responsibility to members and the public, competency of the occupational therapy practitioner, and educational program's responsibilities for the education of future practitioners.

#### Standards of the American Occupational Therapy Association

The American Occupational Therapy Association (AOTA) has a responsibility to provide information to its members and the public to promote a health care system that is of high quality, accessible and affordable (Moyers, 1999). The *Guide to Occupational Therapy Practice* (Moyers, 1999) outlines the scope and process of occupational therapy. This guide along with the *Standards of Occupational Therapy Assistant Education* (AOTA, 1999), *Standards of Occupational Therapy Education* (AOTA, 1999), *The National Occupational Therapy Practice Analysis: Findings and Implication for Competence* (Dunn, 1998), *Standards of Practice for Occupational Therapy* (AOTA, 1998) and *Practice Guidelines Series* (AOTA) will shape future practitioners for current practice as well as for the predicted futuristic health care system.

AOTA has three commissions that promotes standards, bylaws, codes, guidelines, procedures, etc. to assure that the delivery of occupational therapy services is meeting current technological, ethical and evolving needs of the practice. The Commission of Education (COE) promotes and maintains the quality of standards of the educational programs. COE with the Accreditation Council of Occupational Therapy Education (ACOTE) collaboratively assures within their realm that new graduates have the clinical

reasoning skills, educational/knowledge background, professional behaviors, ethical base and technical skills for occupational therapy practice. The new Standards of Education which replace the *Essentials and Guidelines for an Accredited Educational Programs for the Occupational Therapist/Occupational Therapy Assistant* (AOTA, 1999 a, & b) will require educational programs to be in compliance with the standards by July 2000. The Standards reflect the need for changes in the educational system for increased competency levels of new graduates to meet the demands of employers and changes noted in the field of practice.

The practice analysis (Dunn & Cada, 1998) provides educational programs with current data of the changes noted in the field of occupational therapy. This document may serve as a guideline for curriculum changes along with the Standards of Education. The practice analysis (Dunn & Cada, 1998) also outlines the areas of testing for the revised National Certification Exam for the occupational therapist and occupational therapy assistant. The exam, revised in February of 2000, reflects the changes in practice arena.

#### Charge from the Commission of Education

The Commission of Education recognizes that educational programs desire detailed guidelines in regards to the areas of practice more than the Essentials and Standards of Education provides. Due to the variance of curriculum throughout the nation, educational programs question if students are receiving consistent education to prepare them for practice. In 1980s, *Guidelines for Curriculum Content in Pediatrics* (Dunn, et.al, 1988) were written and distributed to developing programs as well as occupational therapy and occupational therapy assistant educational programs. In 1989, COE appointed an ad hoc committee to assess pediatric academic content and subsequent fieldwork education (Wendt, et. al, 1989). Changes in the field of pediatric practice

resulted in a revision of the Guidelines for Pediatric Curriculum Content for Occupational Therapy (Giuffrida & Battaglia, 1998) were adopted by the Representative Assembly in 1998. COE recognized the need of a companion guideline to reflect the practice of occupational therapy assistants within the field of pediatric practice. Subsequently a charge was put forth to WISCOUNCIL to develop a companion guideline for occupational therapy assistant programs.

#### Past Data Collection for Pediatric Curriculums

COE adopted the original guidelines for pediatric curriculum in 1988. This document was based upon the findings of the 1988 Survey of Pediatric Practice, which was a random sample of 250 therapists working with infants, preschool, school aged children and adolescents (Dunn, et. al, 1988). In the decade that followed the survey, service delivery in pediatric occupational therapy has changed dramatically. Review of specific articles indicates that the skills and information occupational therapists are required for pediatric practice requires changes in the educational preparation of occupational therapists (Bundy, 1997; Case-Smith, 1994; Powell, 1994; Royce & Furbush, 1996). This concern in regards to the content requirements for generic entry-level pediatric practice, caused the chair of the Commission of Education, Caroline Brayley, Ph.D., OTR/L to request that the original guidelines be reviewed (Giuffrida & Battaglia, 1997). An extensive literature review was conducted during the review process focussing on contemporary pediatric practice as well as academic preparation.

In 1989, one year after the guidelines were written, Bundy and Lawlor presented results of national survey regarding occupational therapy services in the public school sector. This survey focused upon seven services in which therapists ranked their

significance. Results of the survey indicated that therapist's ability to work as a team member, be assertive in regards to treatment and communication needed improvement in providing services (Bundy, Lawlor, Keilhofner, & Knecht, 1989).

Changes in federal laws and regulations changed the provision of services to children with disabilities. The Individual with Disabilities Education Act (IDEA), 1990 [Public Law 101-476], IDEA Amendments, 1991 [Public Law 102-119] and the changes in Public Law 015-17, the amending of IDEA (1997) has had a significant impact of the services provided to children in public schools as well as OT services for early intervention. Pediatric OT services not only are provided in the public schools but in hospitals, home settings as well as community settings. With the expansion of services, a stronger knowledge base for pediatric therapists is required.

In a survey conducted by Crowe and Kanny indicated that rural pediatric therapists of Northwestern United States feel unprepared upon entering the field. Powell (1994) completed a study involving therapists from Michigan. The intent of this study was to identify specific knowledge areas that therapists need to begin practice in the schools. The study investigated the tasks of the therapists, assessment areas, treatment areas, neurophysiological approaches and frequency of other services not frequently provided. The study asked respondents to list content areas specifically related to school-based occupational therapy (Powell, 1994). Entry-level practice for the occupational therapist was the focus of this section of the study.

Research in the past 15 years have indicated the needs for specific instruction of content to graduate occupational therapist prepared for entry-level practice in the field of pediatrics. A search of literature did not demonstrate results in specific surveys related to

the education of the occupational therapy assistant in the field of pediatrics. A report was submitted to COE titled *COE Ad Hoc Committee to Study Pediatric Education and Fieldwork at the Technical Level* (1990) in 1990. The study discusses the need to set guidelines for OTA pediatric curriculum and establishing technical competencies. The report was submitted but COE took no formal action in response to the survey.

### Training of Occupational Therapy Assistants

The Essentials and Guidelines for an Accredited Educational Program for the Occupational Therapy Assistant (AOTA, 1991b) and Standards for Occupational Therapy Assistant Education (AOTA, 1999b) are generically stated so programs can be unique in curriculum design and establishing programs. Although this philosophy promotes individuality for programs' curriculum design, course work relating to theory and the practice of consultation, training is not uniform in teaching standards (Dudgeon & Greenberg, 1998). In today's competitive environment, employers have increased performance standards of new graduates. They expect inexperienced practitioners to produce at a competent level and the competence to be taught prior to entering the work force.

In 1990, practitioners and leaders in occupational therapy education recognized that there is a disparity between occupational therapy education and practice (Wittman, 1990). Educational programs, professional and technical levels, focused upon theory, cognitive based education, research, roles and disease process. Practitioners and potential employers value entry-level therapists and assistants to be able to handle clinical situations involving patient care, treatment modalities, productivity, clinical reasoning skills as well as being adaptable and flexible in professional manners (Wittman, 1990). Educational programs were challenged by occupational practitioners to provide an education that not only encompassed the scope of occupational therapy practice but also



prepared the student for realism of the field. An increase of competency in the areas of technical skills, clinical reasoning skills, dealing with reimbursement issues as well as wider base of knowledge faced educational programs. Students require strong practical, ethical and professional management skills to work in the field. These issues brought forth in 1990 continue to focus in upon the curriculum in 2000.

The field of practice has significantly changed over the past decade. In the recently published *National Occupational Therapy Practice Analysis* school systems are the second highest employer of occupational therapy assistants (Dunn & Cada, 1998). Employment of occupational therapy assistants (OTA) within a school system was practically unheard of 15 years ago. This data emphasizes the need for enhanced training of the OTA to provide appropriate services in school-based practice, which functions significantly different than that of the medical model.

School-based practice encompasses various theories, assessment tools, treatment and roles depending upon the needs of the school district, rural versus urban and experience of the practitioner (Powell, 1994). It was noted at that time, educational programs training practitioners were to focus on the functions, tasks and roles of the OT/OTA as well as the team within the school district. Since the mid-1990s, educational programs focused upon perceptual-motor training, neurophysiological approaches, sensory integration techniques/philosophy, and neurodevelopmental treatment. Skills in activities of daily living, wheelchair positioning, handwriting skills, evaluations, documentation and play and leisure skills were enhanced in the educational programs to meet the needs of the school-based and pediatric treatment.

School-based occupational therapy practice has changed dramatically over the past five years. Practice ten to fifteen years ago focused on individual treatment techniques in which the student was removed from the classroom. Treatment was provided in a separate room/space away from the student's peers. Presently treatment of

the student is provided in an inclusion environment i.e. in the classroom or learning environment. Thus, practitioners require strong management skills and group process techniques to provide treatment within that environment.

This change has also occurred within the service realm of the Birth to Three programs within the State of Wisconsin. In the past, practitioners provided OT services within a clinic in which the infant/child traveled to. Current legislation mandates that services be provided within the family structure, in other words, services are home based. Practitioners working in this environment require time management skills and family relations skills besides the developmental/treatment knowledge base required of the profession for services of the birth to three population.

The practice analysis data indicates that experienced therapists and OTAs work in the school systems (Dunn & Cada, 1998). This may indicate that the educational programs are not properly preparing students to enter a delivery system which requires strong critical thinking skills, adaptability and consultative skills as a new practitioner (Dudgeon & Greenberg, 1998). Therapists and OTAs must be able to demonstrate the competent ability to intervene in classroom systems and team collaboration within the educational delivery system (Youngstrom, 1998). The foundation of these skills should begin within the formal training of occupational therapy assistants prior to entering the field. Education of OTAs for this practice arena requires not only a foundation in academic preparation but also a strong correlation between academia and fieldwork. Practical application of the treatment techniques in fieldwork will prepare the student to provide the level of services required upon entry-level employment.

#### Competency of Entry-Level Occupational Therapy Assistant Practitioners

It is the responsibility of any health care professional to assure competency in the delivery of services. This level of competency meets the responsibilities to the public it

serves, be it clients/patients, employers, insurance companies and the profession. The expectation placed on entry-level practitioners has changed dramatically over the past two decades. Employers no longer allow employees to gradually work into positions allowing time to adjust to the new environment. Entry-level practitioners must demonstrate competent levels of service on the day they enter the field. Although entry-level practitioners will develop increased levels of competence during the first year of practice, they need to demonstrate strong entry-level skills to compete in today's employment situations.

The entry-level skills that an occupational therapy assistant must have upon graduation from an accredited program not only involves academic knowledge base but an understanding of knowledge, clinical skills, interpersonal skills, problem solving, clinical judgement and technical skills (Norman, 1985). Researchers have argued that competence must also be demonstrated within the cognitive, psychomotor and affective domains (Youngstrom, 1998). Values and personal attitudes weight just as heavily as knowledge and technical skills when dealing in health care situations.

Practice and competence levels are strongly linked to one another. Due to the rapid changes in technology and scientific knowledge base, practitioners must have internal motivation to expand their knowledge base, technical skills and personal performance. Level I and II Fieldwork experiences allow the student to develop competencies beyond the classroom setting. These experiences are valuable in developing the student's clinical reasoning skills, problem-solving abilities, patient interaction and applying the knowledge they acquired in the academic setting.

Reed (1999) discusses that the development of clinical reasoning skills involves recognizing changes needed to improve behavioral skills. Improvement of behavioral skills enhances professional behaviors such as time management, rapport building, teamwork, communication skills, etc. These professional behaviors also strengthen the role the occupational therapy assistant student assumes in the profession. Fieldwork experience allows the student to acquire confidence, responsibility and competence in skills related to the fieldwork setting as well as experience in the supervision of personnel.

The roles of the occupational therapist and occupational therapy assistant is outlined in the documents *Occupational Therapy Roles* (AOTA, 1993) and *Entry-Level Role Delineation for Registered Occupational Therapists (OTRs) and Certified Occupational Therapy Assistants (COTAs)* (AOTA, 1990). These documents clearly identify that the responsibility for occupational therapy services lies within the realms of the occupational therapist, thus the occupational therapy assistant is professionally supervised by the occupational therapist. The occupational therapist and occupational therapy assistant are responsible for providing services within their levels of competence. They share mutual responsibility for clarifying competencies and responsibilities within the setting they are working (AOTA, 1987). The occupational therapy assistant must demonstrate a level of competency in the skills required for that setting. In collaboration with the occupational therapist, the supervision level and level of service competency of the occupational therapy assistant is established within the setting. Although the documents clearly indicate the roles and supervision levels of the OTR and COTA, the

level of competency within a particular setting may alter the level of supervision and provision of services.

Numerous states have written guidelines for the supervision level and required competencies of occupational therapy personnel within the public school setting. Birth to three programs and pediatric programs within hospital settings follow state and federal guidelines in regards to the provision of services and supervision as well as the guidelines set by AOTA. A wide variance in the interpretation of the regulations and supervision of occupational therapy assistants may be noted from state to state. Notably, occupational therapist supervision and comfort level of working with an occupational therapy assistant may dramatically vary from individual to individual therapist. The occupational therapist may not be clearly realized the occupational therapy assistant's entry-level competence.

The myth that occupational therapists are more competent than occupational therapy assistant is just a myth. The occupational therapist and occupational therapy assistant are equally competent on the basis to perform the duties associated with their individual positions and roles designated to them (Youngstrom, 1998). The two levels of the profession need to clearly understand their roles, academic and fieldwork preparation in order to provide appropriate services to the public in which they serve.

The review of literature indicates that in establishing guidelines for pediatric curriculum across the nation, educational institutions would have a basis in which they could compare and contrast their present curriculum. This first step in establishing guidelines should serve to provide a base in establishing stronger competency levels for OTA practitioners. School Systems, Birth to Three programs and community-based programs may hire new practitioners if they have a document that provides the base of

training the OTA has had. These guidelines may assist in the education of potential employers to the type of services an OTA may provide for their system as well as the supervision level required.

## CHAPTER III

### Methodology

#### Subjects

The survey was sent to program directors of nationally accredited OTA programs and OTA programs with developing program status in January of 2000. The request was made for the program directors to distribute the survey to a local pediatric registered occupational therapist (OTR), pediatric certified occupational therapy assistant (COTA), and a pediatric faculty member for a total of three surveys from each program's geographical areas. The request for practitioners to complete the survey would demonstrate current practice trends and needs for entry-level occupational therapy assistants.

Surveys were sent to 185 programs. A total of 177 surveys were returned with a 95% response rate only 13% of the programs returning all three surveys. Programs in the nation were represented with at least one returned survey at a return rate of 55%. Programs were represented from 79% of the states that have OTA programs. Puerto Rico was not represented. Of the 177 surveys, 78 were from academicians (44%), 42 from occupational therapists (24%) and 57 from occupational therapy assistants (32%). Practitioners (occupational therapist and occupational therapy assistants) completed a total of 56% of the surveys.

#### Instrumentation

A survey was developed in June of 1998 paralleling sections and content from the *Guidelines for Pediatric Curriculum Content for Occupational Therapy Program*. This survey was piloted in the State of Wisconsin obtaining input from occupational therapy

programs, occupational therapy assistant programs and committee members (Appendix A). Twelve questionnaires were sent with a return rate of 67%. The data collected from the pilot study assisted in formulating a final survey tool (Appendix B).

The design of the questions on the survey is similar to the content areas of the *Guidelines for Pediatric Curriculum Content for Occupational Therapy Programs* but were condensed and simplified for ease of comprehension. Three basic areas are emphasized: academic preparation, opportunities for Level I Fieldwork and development of competency during Level II Fieldwork. The needs evaluated in these three areas focus upon eight areas of content:

1. Typical and Atypical Development
2. Family Issues
3. Pediatric Diagnoses and their Impact on Occupational Performance
4. Occupational Performance Assessment and Intervention Process: Approaches
5. Occupational Performance Assessment and Intervention Process: Evaluation
6. Occupational Performance Assessment and Intervention Process: Intervention Planning and Implementation
7. Management of Pediatric Occupational Therapy Services
8. Assistive Technology

The survey tool is lengthy due to comprehensive needs of the assessment of the content. The survey is designed for ease of reading, scoring of the items and each content area located so natural breaks could occur between sections. For the ease of reference, the first page could be torn away from the survey.

#### Data Collection

In the development of the *Guidelines for Pediatric Curriculum Content for Occupational Therapy Education*, program directors and occupational therapy faculty



were surveyed using data from pediatric practitioners from 1988 (Giuffrida & Battaglia, 1997) thus the guidelines are educationally based versus practice based. In developing the current research survey used in this study for occupational therapy assistant pediatric curriculum content, the population sample indicates diversity from faculty, occupational therapists and certified occupational therapy assistants from rural and urban areas throughout the nation. The program director of the OTA program was to select practitioners with pediatric experience assuring individuals with a pediatric background would complete the survey.

A cover letter indicating a brief history of the development of the guidelines for pediatric curriculum content, purpose of the survey and the intentions of the task force were written. Completing and returning the survey indicated that the subjects were giving their consent to use the information for research (Appendix C). The program director was responsible for the return of all three surveys by March 7, 2000. In actuality, numerous practitioners sent the surveys directly, bypassing the program director.

Two reminders to program directors in regards to collecting the surveys and returning them was sent via email list serve through AOTA, once prior to the March 7<sup>th</sup> deadline, the second was at the end of March. By March 28<sup>th</sup> 146 surveys were returned. On April 7, 2000 a reminder was sent by mail to program directors who programs did not sent back at least one survey (Appendix D). Nine schools requested additional copies of the survey as well as additional time after the third reminder. Surveys were accepted up to May 30<sup>th</sup>, 2000. A total of 177 surveys were received.

## Data Analysis

Data analysis took place during June and July of 2000. Descriptive statistics and cross-tabulations were used to analyze the data. Percents that are reported are the total sample received unless otherwise noted. The data collected focuses on the research objectives:

1. To identify treatment skills, competencies and educational needs of occupational therapy assistants for school based and pediatric practice.
2. To identify current trends of practice for the occupational therapy assistant in pediatric practice arena.
3. To determine guidelines that would provide consistency of the provision of pediatric education across the nation in preparing students for school-based, entry-level, pediatric practice.

Upon completion of the data analysis, a draft of the emerging guidelines will be developed. Copies of the draft will be sent to both OTA and OT educational programs for review. Upon review, educational programs may comment on the proposed guidelines. Comments from the programs in reference to the draft will be considered prior to the establishment of the final draft of the Guidelines for Pediatric OTA Curriculum Content. The final draft will be presented to the Commission of Education for Occupational Therapy Education for possible adoption. If the Commission of Education adopts the guidelines, the American Occupational Therapy Association will distribute the guidelines to existing and developing programs.

## CHAPTER IV

### Results and Discussion

The survey was designed to examine which of the *Guidelines for Pediatric Content for Occupational Therapy Education* were appropriate for occupational therapy assistant education. The survey also examined the extent of the knowledge base, skills that may be needed and if a competency level may be required upon entry into the occupational therapy practice.

In determining what level of academic preparation and the expectations of competency for fieldwork education, the category with the highest percentage was considered. The survey results guide the level of education in regards to the content entry-level occupational therapy assistants need. The levels of education were identified as being not applicable for entry-level, general awareness of the content area, experience using the content, and demonstration of service competency. Appendix E has a summary of the number of content areas with the highest percentage in each of the survey categories. Tables 1-3, which are located in Appendix F, refer to the total of the percentages of each category for each content area surveyed.

#### I. Typical and Atypical Development: Birth to 18 Years

The research indicates that nine out the eleven (82%) content areas in academic preparation demonstrate a need for experience upon entry into the field of occupational therapy (Appendix E). General awareness was indicated for the knowledge base of the models proposed by NAGI and/or the World Health Organization. In this content area, 18.7% of the respondents were unsure if this content area was needed. A demonstration of competency (45.6%) was indicated for the sequence in the development of daily living skills, work and play/leisure skills (Table 1).

Respondents indicate that Level I Fieldwork should provide experience in the demonstration of knowledge to life tasks and roles (42.4%) and the evaluation and

treatment of children (43.5%). In the three basic content areas regarding Level II Fieldwork, respondents indicate that competency is desired in all three areas (Table 1). The skills desired involve the interpretation of the developmental status of children, therapeutic approaches to facilitate development and assisting with adaptations for family and child.

## II. Family Issues

In academic preparation, 67% (8/12) of the content areas had the largest percentage in the category of experience. General awareness of the content was desired in 33% (4/12) of the identified areas (Appendix E).

During Level I Fieldwork education, 41.5% state a general awareness of identifying the treatment contexts for family centered therapy versus child-centered therapy was needed. Establishing rapport was deemed as a competency by 40.3% of the respondents and 39.8% of the respondents state entry-level practitioners should have experience in this area (Table 2). In observing child performance, 46.9% state experience is required. In Level II Fieldwork two of the content areas demonstrate that experience should be achieved whereas the other two content areas competency is desired (Table 2).

## III. Pediatric Diagnoses and Their Impact on Occupational Performance

Based on therapeutic interaction with a child with specific diagnoses in regards to performance areas and components, 64% of the content areas indicated a need for experience. Five of the content areas (36%) demonstrate the need for competency skills (Appendix E). The areas of competency are the most common diagnosis the profession encounters as well as medical/educational interventions and precautions (Table 3).

In Level I Fieldwork education, 49.4% of the respondents indicate that the implementation of methods and strategies information gathering should be experienced. In Level I Fieldwork, competency is expected in two of the content areas. The third content area involving the interpretation of the diagnoses and it's impact of life had close

percentages in the competency (41.6%) and experience (42.8%) categories (Table 3).

In close analysis of this content area, it was noted that the OTR practitioner place more emphasis on the competency level (58.5%) than the COTAs and educators. The COTAs and educators had a higher respondent rate in the experience category at 43.9% and 49.3% respectfully.

#### IV. The Occupational Performance Assessment and Intervention Process: Approaches

In this section, 15 of the 16 content areas for academic preparation are represented in Appendix E. Item number 57 which includes compensatory intervention in relation to adapted equipment, environment and use of assistive technology had 45.2% in both of the experience and competency categories. This item will be considered separately from the other content areas. Of the other 15 content areas, 80% demonstrated higher percentages in the category of experience in using the content. Competency levels are demonstrated in 20% of the content areas (Appendix E).

Experience received the highest percentage (47.2%) regarding observation and application of basic approaches. Competency was the respondents' choice for the two content areas in Level II Fieldwork experience (Table 4).

#### V. The Occupational Performance Evaluation and Intervention Process: Evaluation

The academic preparation of this section encompasses norm-referenced and criterion-referenced assessments as well as inventories, checklists, interviews and observations in regards to assessments and evaluation processes. A total of 67 content items were surveyed. Respondents indicate that 55 of the content areas (82%) required general knowledge of the material. Experience in twelve of the content areas (18%) was indicated by higher percentages (Appendix E).

Respondent results for Level I Fieldwork were not as clearly defined as in the academic preparation. The percentages were significantly close in the categories of not being applicable, general awareness and demonstration of experience in each of the five

content areas surveyed (Table 5). These areas will need to be analyzed by the entire task force and reconsidered before determining the base of knowledge needed.

Discrepancies were also noted for Level II Fieldwork education. In the selection of assessments, 39.5% of the respondents stated experience is needed. A wide spread distribution was noted throughout the categories in this area (Table 5) thus this may need to be reconsidered. A close distribution was noted in written and oral findings, item 147, in the categories of experience (37.4%) and competency (39.2%).

#### VI. The Occupational Performance Assessment and Intervention Process:

##### Intervention Planning and Implementation

Occupational therapy assistants focus has traditionally been in the area of treatment and intervention. This was strongly indicated in this section. Thirteen of fourteen content areas (93%) indicated the entry-level practitioner should have experience in the academic preparation. (Appendix E). Item 149 which is the knowledge base of age-appropriate performance areas, components and context had 39% in both of the categories of experience and competency thus was not included in the above stated data (Table 6). Only one content area, respondents suggested general awareness. This area involved the knowledge of family-centered practice and service delivery. This appears to be consistent with the knowledge base for education in the Family Issues section.

Respondents indicated that Level I Fieldwork education should provide experience in regards to intervention techniques according to a child's function status, age and disability (Table 6). The seven content areas regarding Level II Fieldwork demonstrate that competency is required (Table 6). Only one area displayed lowered percentage rates, 42.9% compared with the rest of the content areas. This content area, item 172, dealt with the termination of treatment, which is traditionally done in collaboration with the OTR. This may account for the lowered percentage compared to

the other content areas in this section.

## VII. Management of Pediatric Occupational Therapy Services

In the academic preparation for management, respondents indicated that 42% of the content area required general awareness where as 47% requires experience (Appendix E). Two of the content areas, OT/OTA role responsibilities and supervisory relationship of the OT and OTA in regards to pediatric services demonstrate competency levels (Table 7).

Fieldwork education for Level I demonstrated that experience should be provided in regards to the mission, purpose, service delivery model and team model to a specific site (Table 7). Experience in four of the six other content areas was deemed for the entry-level practitioner to gain experience. The other two content areas, effective functioning within a team structure and intervention using appropriate service delivery received 62.1% and 70.5% response in the competency category.

## VIII. Assistive Technology

Assistive Technology content areas are an area that rapidly changes due to the technology in computers and assistive devices available on the market. Percentages suggest that nine of the thirteen content areas require general awareness (Table 8). Experience should be gained in four of the areas in the academic preparation. Line items 203, 205, 207, and 213 demonstrate close variation between two or three of the categories (Table 8).

Experience in developing familiarity with assistive technology was the category of choice by 44.3%. Level II Fieldwork education recommends experience in two of the content areas and competency in the area of team interaction (Table 8).

The above data identify the educational levels, competencies and treatment skills required of the entry-level occupational therapy assistant. Identification of these levels will assist in the development of guidelines as well as provide programs with a

“checklist” to compare their program with.

In reviewing the data there were ten content areas that demonstrated a discrepancy with the traditional beliefs of the skills of the occupational therapy assistant within the occupational therapy profession. I have termed these discrepancies as evolving trends. These trends were identified with either close variation between two categories that were not expected to. Other trends were noted in the interpretation or assessment decisions. Evaluations, selection of evaluations and interpretation of evaluative data are traditionally the responsibility of the occupational therapist. The occupational therapy assistant usually is required to demonstrate service competency prior to receiving particular responsibilities involving assessments and interpretation of needs. Practitioners in this survey indicated that some of those responsibilities were changing. The line items noting evolving trends are noted in Appendix G.

The task force will complete the actual Guidelines Pediatric Curriculum Content for Occupational Therapy Assistant Education in the fall of 2000. The raw data and summary of the data will be used to determine which guidelines will be appropriate. The guidelines will more than likely state which category of academic preparation will be required utilizing the data gathered from the survey. The survey data will also strengthen need to develop competency and experience in specific areas of pediatric service within Level I and Level II Fieldwork education.



## CHAPTER V

### Summary, Conclusions and Recommendations

The purpose of this study was to obtain information to assist in the development of pediatric curriculum guidelines for occupational therapy assistant education. Guidelines for the professional level of education for occupational therapy exists but appeared not to be appropriate for the occupational therapy assistant's education. Programs have expressed interest in the development of the guidelines, as has the profession. The guidelines provide consistency within the profession in regards to entry-level practice assuring that employees have somewhat equal skills upon entrance to the field. The information gained from the survey will assist the task force with justification that will influence the development of the guidelines. This information will also assist programs with a document they can compare with their curriculum, which may influence curriculum revisions.

Three major research objectives were established to facilitate the investigative process. The first objective of the research was to identify treatment skills, competencies and educational needs of the occupational therapy assistants for school based and pediatric practice. The second objective was to identify current trend of practice for the occupational therapy assistant in the pediatric practice arena. The third objective was to determine guidelines that would provide consistency of the provision of pediatric education across the nation in preparing students for school-based, entry-level, pediatric practice.

The process began with a pilot study held in the state of Wisconsin with program directors and task force members. The survey used in the study used the same

terminology as the *Guidelines for Pediatric Occupational Therapy Education*. A survey tool was devised using data from the survey, which was easier to read, consumer friendly, shorter and terminology geared toward practitioners. The surveys were sent to program directors of occupational therapy assistant programs around the nation. The program directors were to disseminate the surveys to a faculty member, occupational therapist and occupational therapy assistant who have pediatric experience.

Data gathered from each line item on the survey were tabulated on individual tables with percentages within five categories and three respondent categories. Total percentages within the categories were tabulated on tables for ease of visualization and organization. The results of the data will allow the task force to develop guidelines, identify trends occurring in the practice in the United States and the level of educational needs for entry-level occupational therapy assistants in pediatric practice.

### Conclusions

The conclusions drawn from the findings of the survey indicate that one item (.5%) was not applicable for entry-level practice. Content areas that should provide a general awareness was at 38% or 81 out of 214 items. Experience in using the content areas was at 45.5% or 98 out of 214 items. Competency in the academic preparation and/or fieldwork was at 16 % or 34 out of 214 items (see total in Appendix E). Two items were not included in the above count due to percentages being equal I two of the categories. Those items will need to be studied further.

The study also suggest that there are ten content areas in which the responsibilities of the occupational therapy assistant have changed from the traditional

roles of an entry level practitioner. The task force will further study these content areas in order to determine how the trends can be encompassed in the pediatric curriculum.

The data will assist in establishing the Guidelines for Occupational Therapy Assistant Curriculum Content. The task force will closely scrutinize the data during the fall of 2000. A rough draft of the guidelines will be written by November of 2000. The Commission of Education for Occupational Therapy Education will review the guidelines prior to possible adoption and distribution to Occupational Therapy Assistant Programs.

#### Recommendations

It is recommended that the data be utilized in two other areas that was not part of the study but noted during the analysis of the data. There were eight content areas in which a distinct discrepancy was noted between the occupational therapist and occupational therapy assistant. Seven of those areas, the occupational therapists ranked the content areas higher in experience or competency level. This may suggest that the occupational therapist has higher expectations of the occupational therapy assistant than the occupational therapy assistant has.

It is also recommended to conduct a study on the expectations of the experienced practitioner in regards to the entry-level occupational therapy assistants. There were 16 areas in which a distinct discrepancy was noted between the expectation levels of the educators to that of the practitioners. These recommendations will be discussed with the task force at a later date.

The data collected in this survey will be utilized for the development of pediatric guidelines. This valuable information will impact curriculum development and revisions

throughout the country once the guidelines are established. Most importantly the public in which the occupational therapy profession serves will experience the impact of quality and consistent treatment.

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**Appendix A**

DATE: August 24, 1998

TO: Wisconsin Professional and Technical Program Directors  
Task Force Members

FROM: Doreen Olson, OTR and Peggy Martin, MS, OTR  
Co-Chairs Task force for *Guidelines for Pediatric  
Curriculum Content for Occupational Therapy Assistants*

SUBJECT: Questionnaire for *OTA Guidelines for Pediatric Curriculum*

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The COE/WISCOUCIL Task Force *OTA Guidelines for Pediatric Curriculum Content* is requesting you input regarding the relevancy of the enclosed document for OTA education in the area of pediatrics. Do not feel that you must be totally familiar of practice. Feel free to seek input from others in selecting your responses.

The results of the questionnaire will be shared at the SISS/Program Director's Meeting in Boston in November. Thus we are asking for a short turn around time for the return of the questionnaire so the results can be reviewed at the October 16<sup>th</sup> WISCOUCIL meeting in La Crosse. Please return the questionnaire to Toni Walski by September 10<sup>th</sup>.



## Appendix B

### PEDIATRIC CURRICULUM CONTENT SURVEY

**OTA Program Name/State:**

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**Respondent Category** (check appropriate one):  Academic pediatric educator  
 COTA pediatric fieldwork educator  
 OTR pediatric fieldwork educator

**BACKGROUND:** The following (I-VIII) is based on curriculum content for the OT in the newly revised AOTA document "Review of the Guidelines for Pediatric Curriculum Content" (1998). COE has requested that companion curriculum content for the OTA team member be enumerated. Your perspective as a pediatric specialist is being solicited so that relevant education is provided in this important area of practice. Your support through completion of this instrument will provide quality data for this WISCOUNCIL task force and hopefully allow you as a specialist to reflect on the content of your current academic and/or fieldwork curriculum provisions. Data collected from the survey will be submitted to AOTA COE for consideration for national pediatric guidelines for OTA programs.

**INSTRUCTIONS:** Considering the BEST PRACTICE for the ENTRY-LEVEL COTA, rate OTA education content by placing an "X" over your answer using the following codes:

**0** = Not applicable for entry-level

**1** = General awareness of content area

**2** = Experience in using content

**3** = Demonstrated service competency in academic and/or fieldwork setting

**?** = Not sure

NOTE: The above information may be removed for ease of scoring the survey. Please reattach to the original document upon completion of the survey.

## I. TYPICAL AND ATYPICAL DEVELOPMENT: BIRTH TO 18 YEARS

### A. Academic Preparation content should include:

0 1 2 3 ? 1. Concepts and theories of child development with emphasis on the development of occupations.

❖ Behaviors, stages, and tasks in development from birth to adolescence of:

0 1 2 3 ? 2. Sensorimotor (sensory, neuromuscular, and motor) and cognitive components.

0 1 2 3 ? 3. Psychosocial and psychological components.

0 1 2 3 ? 4. Sequences in the development of daily living, work, and play or leisure.

0 1 2 3 ? 5. Interaction of performance components including sensorimotor, cognitive, psychosocial, and psychological processes in function and dysfunction.

0 1 2 3 ? 6. The impact of different performance contexts. ( AOTA Uniform Terminology.)

❖ Interaction of critical variables that influence development:

0 1 2 3 ? 7. Dysfunctional processes, including prematurity.

0 1 2 3 ? 8. Biological maturation in childhood and adolescence.

0 1 2 3 ? 9. Social and cultural awareness and expectations, including the development of dependence/independence appropriate to chronological age.

0 1 2 3 ? 10. Anatomy and physiology of development in humans and the impact on structures during development when affected by disease or teratogens.

❖ Note: A prerequisite course in developmental psychology is highly desirable, though not sufficient to cover essential information for pediatric practice.

0 1 2 3 ? 11. Knowledge of the models of disablement as proposed by NAGI and/or the World Health Organization and their relationship to typical and atypical developmental processes and function.

### B. Level I Fieldwork should provide opportunities for:

0 1 2 3 ? 12. Demonstration of knowledge of typical and atypical development of occupations in relation to appropriate life tasks and roles.

0 1 2 3 ? 13. Demonstration of knowledge of typical and atypical development of occupations in evaluation and treatment of the infant, toddler, child, or youth (adolescent).

### C. Level II Fieldwork (for entry-level practice) should facilitate the development of these abilities:

0 1 2 3 ? 14. Interpretations of information related to the developmental status of the infant, toddler, child, or youth to coworkers and parents/care givers.

0 1 2 3 ? 15. Development of therapeutic approaches to be used to facilitate normal development and development of occupations across different settings.

0 1 2 3 ? 16. Provision of assistance to family/care givers in making adaptations appropriate to the developmental stage of the infant, toddler, child, or youth.

## II. FAMILY ISSUES

### A. Academic Preparation content should include:

- 0 1 2 3 ? 17. Family systems theory: how families operate as units; impact of diverse cultures/child rearing patterns on family life; differences in child rearing.
- 0 1 2 3 ? 18. Family life cycle: critical stages of family life; stages of parenting.
- 0 1 2 3 ? 19. Family ecology: how family systems operate within society, including their immediate community, state, and federal systems.
- 0 1 2 3 ? 20. The emotional and social impact of the infant's, toddler's, child's, or youth's disability on parents, on significant others, and on family life.
- 0 1 2 3 ? 21. The impact of dysfunctional families and environments on an infant, toddler, child, or youth.
- 0 1 2 3 ? 22. The OT's role in helping and collaborating with the family to determine their needs and priorities for intervention; knowledge of self-report instruments.
- 0 1 2 3 ? 23. Knowledge of effective interventions with families who are challenged by a child's disability (e.g., parents who have children with cerebral palsy, developmental disabilities, or autism).
- 0 1 2 3 ? 24. Knowledge of communication styles that enable and encourage appropriate family functioning and positive family interaction.
- 0 1 2 3 ? 25. Knowledge of sociocultural concerns that impact parenting styles and skills.
- 0 1 2 3 ? 26. The OT's role in advocating for families and appropriate OT services.
- 0 1 2 3 ? 27. Knowledge of resources for families available in the community, state, and nationally to support, network, and intervene for children with special needs.
- 0 1 2 3 ? 28. Knowledge of the collaborative process in provision of services for children with special needs and their families.

### B. Level I Fieldwork should provide opportunities for:

- 0 1 2 3 ? 29. Identification of family-centered therapy versus child-centered therapy and appropriate contexts for each.
- 0 1 2 3 ? 30. Establish rapport with care givers and demonstrate an understanding of the OTA's role as a partner in treatment.
- 0 1 2 3 ? 31. Observation of child's performance and peer performance in multiple natural contexts.

### C. Level II Fieldwork (for entry-level practice) should facilitate the development of these abilities:

- 0 1 2 3 ? 32. Development of rapport with care givers, while conducting evaluations based on family concerns and goals, demonstrating the OT's role as a partner in intervention planning.
- 0 1 2 3 ? 33. Engagement in collaborative consultation with the development of the individualized family service plan (IFSP) or the individualized education program (IEP).
- 0 1 2 3 ? 34. Engagement in multiple service delivery patterns in different natural contexts.
- 0 1 2 3 ? 35. Effective intervention with families from diverse cultural or socioeconomic backgrounds.

### III. PEDIATRIC DIAGNOSES AND THEIR IMPACT ON OCCUPATIONAL PERFORMANCE (MEDICAL AND EDUCATIONAL DISTINCTIONS)

#### A. Academic Preparation content should include:

- ❖ Diagnoses most frequently seen in pediatric OT are to be understood relative to their interaction with the child's occupational performance areas and components.

Diagnoses are:

- 0 1 2 3 ? 36. Cerebral Palsy
  - 0 1 2 3 ? 37. Mental Retardation (Down Syndrome)/Developmental Delay
  - 0 1 2 3 ? 38. Learning Disabilities/Attention Deficit Disorder
  - 0 1 2 3 ? 39. Pervasive Developmental Disorders
  - 0 1 2 3 ? 40. Emotional Disturbance/Behavior Problems
  - 0 1 2 3 ? 41. Other diagnoses: Spina bifida, muscular dystrophy, traumatic brain injury, autism, genetic disorders, multiple handicaps or dual diagnoses, AIDS, Developmental Coordination Disorder.
- ❖ For the common diagnosis, students should demonstrate knowledge of:
    - 0 1 2 3 ? 42. Etiology; sub-classifications and variations.
    - 0 1 2 3 ? 43. Potential impact of the disorder on performance of occupational tasks (activities of daily living, work and productive activities, and play or leisure) and acquisition and performance of occupational roles.
    - 0 1 2 3 ? 44. Characteristics across the life span of different performance components including sensorimotor, cognitive integration and cognitive components, psychosocial skills, and psychological components, changes and consequences.
    - 0 1 2 3 ? 45. Principles of medical/educational intervention; precautions.
    - 0 1 2 3 ? 46. Principles of OT assessment/intervention related to therapy service delivery.
    - 0 1 2 3 ? 47. Develop and use methods and strategies for gaining the above information (as needed) for other frequently encountered diagnoses.
    - 0 1 2 3 ? 48. Beginning understanding of the multiple etiologies possible for a variety of presenting problems, interaction of diagnoses, exceptions in characteristics of diagnoses, and subtle symptoms of various diagnoses.
    - 0 1 2 3 ? 49. Projection of how diagnosis and development may interact and influence the occupational performance status in a particular child over time.

#### B. Level I Fieldwork should provide opportunities for:

- 0 1 2 3 ? 50. Implementing methods and strategies for gaining information (as needed) on atypical diagnoses.

#### C. Level II Fieldwork (for entry-level practice) should facilitate the development of these abilities:

- 0 1 2 3 ? 51. Recognition and identification of characteristics of common diagnoses in specific children.
- 0 1 2 3 ? 52. Use of appropriate resources to determine characteristics of different diagnoses of an infant, toddler, child, or youth.
- 0 1 2 3 ? 53. Interpretation, when given characteristics of diagnoses, of their impact on life stages and occupational performance.

#### IV. THE OCCUPATIONAL PERFORMANCE ASSESSMENT AND INTERVENTION PROCESS:

##### A. Academic Preparation content should include:

❖ The commonly used approaches and relevant aspects for entry-level practice:

- 0 1 2 3 ? 54. Developmental approaches: Planning activities in an appropriate sequence of development.
- 0 1 2 3 ? 55. Sensorimotor approaches for the improvement of gross motor, fine motor, and visual motor skills.
- 0 1 2 3 ? 56. Behavioral management approaches.
- 0 1 2 3 ? 57. Compensatory interventions: Adapted equipment, adapted environment, use of assistive technology.
- 0 1 2 3 ? 58. Biomechanical approaches: Application to seating, splinting, etc.
- 0 1 2 3 ? 59. Occupational behavior/Human occupation: Acquisition of occupational roles.
- 0 1 2 3 ? 60. Motor learning and motor control approaches (i.e., Rood, PNF, contemporary task-oriented approach).
- 0 1 2 3 ? 61. Cognitive approaches: Play behaviors, developmentally appropriate function (Piaget, Vgotsky).
- 0 1 2 3 ? 62. Therapeutic use of self in pediatric context.
- 0 1 2 3 ? 63. Ecological approaches incorporating environmental affordances.

❖ Introduction to advanced approaches with selected specific entry-level techniques for skill development:

- 0 1 2 3 ? 64. Neurodevelopment treatment (NDT): Basic positioning and handling; basic oral motor techniques.
- 0 1 2 3 ? 65. Behavioral approach: Use of strategies (e.g. prompts, backward chaining) and reinforcers both for developing skills and eliminating undesirable behaviors.
- 0 1 2 3 ? 66. Psychodynamics: Promoting self-esteem, interaction with peers and adults.
- 0 1 2 3 ? 67. Sensory integration (SI): Introduction to the concept of providing sensory input to facilitate adaptive motor or behavior responses.
- 0 1 2 3 ? 68. Contemporary motor learning and control concepts and their impact on traditional motor learning approaches with regard to function.
- 0 1 2 3 ? 69. Application of the above approaches to activity analysis and intervention.

##### B. Level I Fieldwork should provide opportunities for:

- 0 1 2 3 ? 70. Observation and guided application of approaches basic to entry-level practice.

##### C. Level II Fieldwork (for entry-level practice) should facilitate the development of these abilities:

- 0 1 2 3 ? 71. Selection of appropriate occupational performance approaches, given a specific case and taking into account the child's age, diagnosis, course of disability, sociocultural background, context, environment, and family priorities.
- 0 1 2 3 ? 72. Application of basic and advanced occupational performance approaches with specific entry-level procedures and techniques given a specific case.

#### V. THE OCCUPATIONAL PERFORMANCE EVALUATION AND INTERVENTION PROCESS: EVALUATION

##### A. Academic Preparation content should include:

- 0 1 2 3 ? 73. Assessment methods/procedures for performance areas, performance components, and performance contexts relevant to infant, toddler, child, and youth. (See Appendix: AOTA Uniform Terminology.)
- 0 1 2 3 ? 74. An understanding of how to evaluate and appropriately choose tools, recognize strengths and limitations of assessment; validity and reliability of standardized, norm-referenced, and criterion-referenced assessments; team-based assessments and sampling techniques so that these instruments can be used appropriately.

## ❖ Basic performance components and performance areas assessed with evaluation tools:

Functional Assessments/Performance Areas Assessments:

0	1	2	3	?	75.	Pediatric Evaluation of Disability Inventory (PEDI)
0	1	2	3	?	76.	Functional Independence Measure for Children (WeeFim)
0	1	2	3	?	77.	Play Assessments (Test of Playfulness; Preschool Play Scale)
0	1	2	3	?	78.	School Function Assessment

Developmental Assessments (Criterion-referenced):

0	1	2	3	?	79.	Hawaii Early Learning Profile (HELP)
0	1	2	3	?	80.	Developmental Programming for Infants and Young Children
0	1	2	3	?	81.	Brigance Inventory and Early Development
0	1	2	3	?	82.	Learning Accomplishment Profile (LAP)

Developmental Screenings/Assessments (Norm-referenced):

0	1	2	3	?	83.	Denver II
0	1	2	3	?	84.	Miller Assessment for Preschoolers (MAP)
0	1	2	3	?	85.	First STEP
0	1	2	3	?	86.	Bayley Scales of Infant Development, 2 <sup>nd</sup> edition (BSID-II)
0	1	2	3	?	87.	Mullen Scales of Learning, AGS edition

Sensorimotor Assessments including aspects of Sensory Awareness, Sensory Processing, and/or Perceptual Processing (Norm-referenced, Criterion-referenced, and Observations):

0	1	2	3	?	88.	Test of Sensory Functions in Infants (TSFI)
0	1	2	3	?	89.	Infant/Toddler Symptom Checklist
0	1	2	3	?	90.	Touch Inventory
0	1	2	3	?	91.	Sensory Profile
0	1	2	3	?	92.	Sensory Integration Post Rotary Nystagmus Test (SCPNT)
0	1	2	3	?	93.	Motor Free Visual Perception Test (MVPT)
0	1	2	3	?	94.	Test of Visual Perceptual Skills (TVPS)
0	1	2	3	?	95.	Developmental Test of Visual Perception II (DTVP-II)
0	1	2	3	?	96.	Sensory Integration and Praxis Tests (SIPT)
0	1	2	3	?	97.	Ayres Clinical Observations

Sensorimotor Assessments including aspects of Neuromusculoskeletal and Motor Performance (Norm-referenced, Criterion-referenced, Observations, Checklists, and Interviews):

0	1	2	3	?	98.	Bruininks-Oseretsky Test of Motor Proficiency (BOTMP)
0	1	2	3	?	99.	Peabody Developmental Motor Scales (PDMS)
0	1	2	3	?	100.	Quick Neurological Screening Test (QNST)
0	1	2	3	?	101.	Movement ABC (previously Henderson's Test of Motor Impairment)
0	1	2	3	?	102.	Erhardt Developmental Prehension Assessment
0	1	2	3	?	103.	Exner In-Hand Manipulation Test
0	1	2	3	?	104.	Toddler and Infant Motor Evaluation (TIME)
0	1	2	3	?	105.	DeGangi-Berk Test of Sensory Integration
0	1	2	3	?	106.	Test of Visual Motor Skills (TVMS)
0	1	2	3	?	107.	Developmental Test of Visual Motor Integration (VMI)
0	1	2	3	?	108.	Reflex testing/postural reactions
0	1	2	3	?	109.	Analysis of positioning needs
0	1	2	3	?	110.	Oral motor assessments
0	1	2	3	?	111.	Evaluation and Treatment of Children's Handwriting (ETCH)
0	1	2	3	?	112.	Denver Handwriting Analysis
0	1	2	3	?	113.	Loops and Groups

Psychosocial and Psychological Assessments:

- 0 1 2 3 ? 114. Burke's Behavior Rating Scale
- 0 1 2 3 ? 115. Piers-Harris Children's Self-Concept Scale
- 0 1 2 3 ? 116. Harter Self-Concept Scale
- 0 1 2 3 ? 117. Early Coping Inventory
- 0 1 2 3 ? 118. Carey Infant Temperament Scale
- 0 1 2 3 ? 119. Tennessee Self-Concept Scale, Revised (TSCS)

Performance Contexts including Temporal and Environmental Aspects:

(Instruments for use in helping families assess their own needs and priorities for intervention):

- 0 1 2 3 ? 120. Jacobs Pre-Vocational Assessment (JPVA)
- 0 1 2 3 ? 121. McCarron-Dial System (MDS)
- 0 1 2 3 ? 122. Assessment of Home Environments
- 0 1 2 3 ? 123. The Home Observation for Measurement of the Environment (HOME)
- 0 1 2 3 ? 124. School Observation

❖ Appropriate use of at least one test that is norm- or criterion-referenced in each of the following areas:

- 0 1 2 3 ? 125. Developmental assessment or Functional assessment
- 0 1 2 3 ? 126. Sensorimotor
- 0 1 2 3 ? 127. Psychosocial and Psychological
- 0 1 2 3 ? 128. Environmental contexts

❖ Appropriate use of at least one check list or inventory in each of the following areas:

- 0 1 2 3 ? 129. Developmental assessment or Functional assessment
- 0 1 2 3 ? 130. Sensorimotor
- 0 1 2 3 ? 131. Psychosocial and Psychological
- 0 1 2 3 ? 132. Environmental contexts
- 0 1 2 3 ? 133. Administer and score selected assessments (most commonly used by OT).
- 0 1 2 3 ? 134. Ways of manipulating the environment to engage the infant, toddler, child, or youth in the evaluation process.
- 0 1 2 3 ? 135. The effects of the infant, toddler, child, or youth's behavior on test results.
- 0 1 2 3 ? 136. Interpretation and organization of results.
- 0 1 2 3 ? 137. Implication of the results of the evaluation to functional performance and to intervention planning.
- 0 1 2 3 ? 138. Factors to be considered when administering standardized tests.
- 0 1 2 3 ? 139. Familiarity with interview process with parents and significant others.

B. Level I Fieldwork should provide opportunities to:

❖ Appropriately administer and score at least one checklist, inventory, or standardized assessment tool in one of the following areas:

- 0 1 2 3 ? 140. Developmental assessment or Functional assessment
- 0 1 2 3 ? 141. Sensorimotor
- 0 1 2 3 ? 142. Psychosocial and Psychological
- 0 1 2 3 ? 143. Environmental contexts
- 0 1 2 3 ? 144. Interpret and organize results in writing obtained through one assessment.

C. **Level II Fieldwork** (for entry-level practice) should facilitate the development of these abilities:

- 0 1 2 3 ? 145. Selection of assessments, in collaboration with primary care givers and professionals, for a specific infant, toddler, child, or youth, considering occupational performance problems, diagnosis, age, presenting problem, resources, and setting.
- 0 1 2 3 ? 146. Administer an appropriate test for each performance component, performance area, and contexts in the OT assessment domain.
- 0 1 2 3 ? 147. Reporting of findings (orally and in writing) in language that is understandable to all care givers and sensitive to cultural values.
- 0 1 2 3 ? 148. Selection and use of appropriate techniques for systematic documentation of progress.

## VI. THE OCCUPATIONAL PERFORMANCE ASSESSMENT AND INTERVENTION PROCESS: INTERVENTION PLANNING AND IMPLEMENTATION

A. **Academic Preparation** content should include:

- 0 1 2 3 ? 149. Knowledge of age-appropriate occupational performance areas, performance components, and contexts that are in the domain of pediatric occupational therapy.
- 0 1 2 3 ? 150. Knowledge of approaches and activities, including technology that would be used to intervene in the client's occupational performance areas, components, and/or contexts.
  - ❖ Given information about age and disability:
    - 0 1 2 3 ? 151. Identification of occupational performance areas, components, and contexts that should be addressed.
    - 0 1 2 3 ? 152. Identification of appropriate occupational performance approaches, techniques, and activities specific to each approach.
    - 0 1 2 3 ? 153. The interrelationships of factors (i.e., age, disability, family issues, service delivery model, setting, team goals) and how they impact on or change occupational performance and treatment goals.
    - 0 1 2 3 ? 154. Knowledge of different professional roles, team formation, collaboration, and communication.
  - ❖ Given a complete outcome-based case study of an infant, toddler, child, or youth:
    - 0 1 2 3 ? 155. Identification of functional limitations and assets along with the performance components involved.
    - 0 1 2 3 ? 156. Identification and prioritization of occupational performance needs based on information presented in the case/outcome study.
    - 0 1 2 3 ? 157. Identification of constraints as well as opportunities indicated by factors presented in the case/outcome study.
    - 0 1 2 3 ? 158. Determination of possible targeted outcomes defined by the team (including family members and the child or youth, when appropriate).
    - 0 1 2 3 ? 159. Writing relevant measurable occupational performance goals and objectives, including how these will be measured and reviewed to determine the effect of intervention.
    - 0 1 2 3 ? 160. Completing an intervention plan based on the case/outcome study that addresses frames of reference used, related activities, corresponding materials and supplies needed, rationale for frame(s) of references used, along with classroom, home, and community suggestions, as appropriate.
- 0 1 2 3 ? 161. Implementing the intervention appropriate to the context (i.e., school, home, hospital, early intervention program).
- 0 1 2 3 ? 162. Recommendations of treatment frequency and duration, with rationale for intervention.
- 0 1 2 3 ? 163. Implementing a transition plan appropriate to the client's changes across settings.
- 0 1 2 3 ? 164. Knowledge of family-centered practice and service delivery to multiple consumers.



B. **Level I Fieldwork** should provide opportunities to:

- ❖ Given information about a specific child's functional status, age, and disability:
  - 0 1 2 3 ? 165. Student will be able to identify occupational performance areas, components, and contexts that should be addressed.
  - 0 1 2 3 ? 166. Student will identify appropriate techniques and activities specific to each approach.

C. **Level II Fieldwork** (for entry-level practice) should facilitate the development of these abilities:

- 0 1 2 3 ? 167. Performance of a complete case study given a specific infant, toddler, child, or youth and under direct supervision.
- 0 1 2 3 ? 168. Implementation of intervention strategies under supervision of clinical supervision
- 0 1 2 3 ? 169. Adaptation of intervention activities based on responses of the infant, toddler, child, or youth within and across settings.
- 0 1 2 3 ? 170. Documentation of/reporting intervention in a manner appropriate to the setting.
- 0 1 2 3 ? 171. Recognition of the need for outside consultation in complex cases that go beyond the scope of one's knowledge and skills.
- 0 1 2 3 ? 172. Ability to terminate intervention and plan transitional or discharge services when client's goals are met or client is transferred to another agency or model of service delivery.
- 0 1 2 3 ? 173. Observation of safety precautions as needed.

## VII. MANAGEMENT OF PEDIATRIC OCCUPATIONAL THERAPY SERVICES

A. **Academic Preparation** content should include:

- ❖ Primary characteristics of typical service provision settings:
  - 0 1 2 3 ? 174. Medical (e.g., hospital and rehabilitation centers, inpatient and outpatient services)
  - 0 1 2 3 ? 175. Community (e.g., private practice, day care, early intervention program, home health, and family practice)
  - 0 1 2 3 ? 176. Educational (e.g., Head Start Programs, preschools, private schools, public schools)
- ❖ Recognition of similar and unique parameters of service delivery systems:
  - 0 1 2 3 ? 177. Agency mission, purpose
  - 0 1 2 3 ? 178. Administrative structures
  - 0 1 2 3 ? 179. Financial structures and various reimbursement plans for OT services. Outcomes appropriate to each setting.
- ❖ Impact on OT service structure and function:
  - 0 1 2 3 ? 180. Case management, priorities for establishing a caseload and initiating/ terminating services.
  - 0 1 2 3 ? 181. Models of service delivery within education, i.e. direct versus indirect.
- ❖ Recognition of the impact of legislation and reimbursement that affects service provision for infants, toddlers, children, or youths:
  - 0 1 2 3 ? 182. State
  - 0 1 2 3 ? 183. Federal (i.e. IDEA. Title 19 – Medicaid, Section 504, etc)
  - 0 1 2 3 ? 184. Knowledge of team models and interactions used in different settings (multi- disciplinary, interdisciplinary, trans-disciplinary).

- ❖ Knowledge of continuum of service delivery:
- 0 1 2 3 ? 185. Role and relationships of therapists, therapy assistants, school personnel, parents, teachers, and paraprofessionals within the service delivery continuum and how they impact on the quality of services.
  - 0 1 2 3 ? 186. The interaction of the client's needs with an understanding of the continuum of service delivery.
  - 0 1 2 3 ? 187. Principles of effective consultation and monitoring.
  - 0 1 2 3 ? 188. Documentation of intervention according to service delivery model (i.e., IEP's, IFSP's, SOAP notes, Progress notes).
  - 0 1 2 3 ? 189. Knowledge of program monitoring.
  - 0 1 2 3 ? 190. Knowledge of both the occupational therapist's and occupational therapy assistant's roles and responsibilities in the delivery of these services.
  - 0 1 2 3 ? 191. Knowledge of the supervisory relationship of the occupational therapist to the occupational therapy assistant in the delivery of these services.
  - 0 1 2 3 ? 192. Knowledge of volunteer, community agencies, and national and state organization and legislative groups providing resources and policies about families and children (e.g., Easter Seal, Parent Training and Information Centers).

B. **Level I Fieldwork** should provide opportunities to:

- 0 1 2 3 ? 193. Identify site's mission and purpose, service delivery model, and team model as it impacts on occupational therapy practice at the specific site.

C. **Level II Fieldwork** (for entry-level practice) should facilitate the development of these abilities:

- 0 1 2 3 ? 195. Identification of an appropriate match between needs, desired outcomes in a service setting, and therapy service provision for specific infants, toddlers, children, or youths.
- 0 1 2 3 ? 196. Identification of how federal and state legislation and reimbursement may impact intervention planning with a specific infant, toddler, child, or youth and family members.
- 0 1 2 3 ? 197. Effective functioning within the team structure of the fieldwork setting (i.e., multi-disciplinary, interdisciplinary, trans-disciplinary).
- 0 1 2 3 ? 198. Intervention using appropriate therapy service delivery for a particular neonate, infant, toddler, child, or youth.
- 0 1 2 3 ? 199. Ability to identify entrance and exit (discharge) criteria.
- 0 1 2 3 ? 200. Ability to determine case loads based on multiple therapy service delivery options.

## VIII. ASSISTIVE TECHNOLOGY

A. **Academic Preparation** content should include:

- 0 1 2 3 ? 201. Knowledge of federal and state legislation mandating assistive technology devices and services.
- 0 1 2 3 ? 202. Knowledge of funding resources to support assistive technology use.
- 0 1 2 3 ? 203. Knowledge of the relevance of assistive technology and the assistive technology team to the practice of occupational therapy for children.
- 0 1 2 3 ? 204. Knowledge of the components of an assistive technology evaluation.
- 0 1 2 3 ? 205. Knowledge of how developmental status and environmental demands affect recommendations for and use of assistive technology.

- 0 1 2 3 ? 206. Information on availability of software, hardware, and other adaptations.
- 0 1 2 3 ? 207. An understanding of the difference between low technology (i.e., keyboards, key guards, head pointers, communication boards, toys, and switches) and high technology (i.e., environmental control units [ECU]).
- 0 1 2 3 ? 208. Familiarity with augmentative communication devices (i.e., vocal and non-vocal output).
- 0 1 2 3 ? 209. Identification of assistive technology resources for programs, schools, families, and professionals.
- 0 1 2 3 ? 210. Knowledge of basic positioning principles and proper seating requirements necessary for evaluating and recommending use of assistive technology.
- 0 1 2 3 ? 211. Knowledge of basic access methods available for assistive technology and augmentative communication devices (direct selection, indirect selection, and adaptive switches, etc.).
- 0 1 2 3 ? 212. Knowledge of factors to be considered prior to making the decision between power and manual wheelchair mobility for specific individuals.
- 0 1 2 3 ? 213. Knowledge of how to access information using computer technology (internet, Netscape).

B. **Level I Fieldwork** should provide opportunities to:

- 0 1 2 3 ? 214. Develop familiarity with accommodations or assistive technologies for a client.

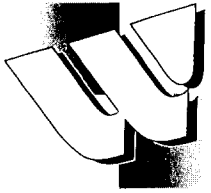
C. **Level II Fieldwork** (for entry-level practice) should facilitate the development of these abilities:

- 0 1 2 3 ? 215. Demonstrate use of or recommend technology appropriate for individual clients in the areas of mobility, communication, self care, play, etc.
- 0 1 2 3 ? 216. Interact with other or additional assistive technology team members (i.e., physical therapist, special educator, rehabilitation engineer, speech pathologist, etc.).
- 0 1 2 3 ? 217. Recommend assistive technology in order to enhance child's performance.

**COMMENTS:** Particularly identify any missing **OTA CURRICULUM** content items.

**OVERALL COMMENTS:**

**THANK YOU FOR YOUR HELP!**



In 1998 the AOTA Commission on Education (COE) adopted revised Guidelines for Pediatric Curriculum Content for Occupational Therapy Programs. This document was initially developed in the 1980's by Anne Henderson, Anita Bundy, Winifred Dunn, Charlotte Exner, Barbara Hanft, Elizabeth Murray, Charlane Pehoski, and Carlyn Harsh, AOTA Liaison. The revised curriculum guidelines reviewers were Clare Giuffrida and Carmela Battaglia.

COE subsequently charged a WISCOUNCIL task force to develop a companion -- Guidelines for Pediatric OTA Curriculum Content. This charge was particularly significant due to the increased job placement of COTAs in pediatric settings and school-based practice (NBCOT Practice Analysis, 1998). Core curriculum guidelines would assist academic programs in cross-referencing their courses with current practice data and providing relevant pediatric educational experiences for OTA students. Also relevant school personnel could use the core pediatric curriculum descriptions in obtaining the educational background of OTA students who are completing fieldwork and later applying for entry-level positions. OT and OTA curriculum guidelines developed in a parallel manner may ultimately assist in comparing and delineating the roles of therapists and assistants in pediatric settings.

We need your assistance in assuring the relevancy and adequacy of developing the OTA pediatric curriculum guidelines. It is our intent to survey pediatric faculty and OT /OTA pediatric fieldwork educators to reflect their points of view. OT and OTA practitioners will assist in determining what students need to know upon entering the field. **Your critical participation** will ensure that OTA programs such as yours will have updated guidelines for curriculum assessment and development.

We are requesting that you distribute one survey each to your pediatric faculty member, to an OT pediatric fieldwork educator and to an OTA pediatric fieldwork educator of your choice. Be selective to assure the practitioners you recruit will have the commitment to complete the survey. Do not feel, however, that the individuals must be totally familiar with all of the topics to complete the survey, for we are looking for a broad range of responses across the nation. Also remind survey participants to consider "*best practice*" for entry-level OTAs in completing the questionnaire.

The task group has chosen a survey methodology which assures broad review versus a panel of experts approach. The quality of the revised guidelines will correlate directly with the response rate. Please show your support for "Grass Roots" participation studies and help us produce revised OTA Pediatric Guidelines you will be proud to use.

Due to the necessary length of the survey to parallel the OT document and resulting fatigue factor which can affect accuracy of results, we highly recommend that breaks be taken. It may take approximately 35-45 minutes to complete the entire survey. The practitioners and faculty member/s are to return the survey to you. Knowing first hand how hectic things can get for OTA faculty and pediatric therapists, we have tried to set a respectful deadline for we surely need your assistance in developing this document. You are to return the surveys by March 7, 2000 to:

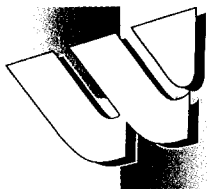
Doreen Olson, OTR  
OTA Program Head  
Western Wisconsin Technical College  
304 Sixth Street N, PO Box C-908  
La Crosse, WI 54602-0908

Due to the various funding sources of this project, the data will be used as a research project for students of University of Wisconsin – La Crosse and Doreen Olson's master's degree. Thus individuals participating in this survey is giving informed consent as a participating volunteer in this study. Participants understand the basic nature of the study and the potential benefits that might be realized from the successful completion of this study. Participants are also aware that the information is being sought in a specific manner so that not identifiers are needed and so that confidentiality is guaranteed. Participants have the right to refuse to participate and the right to withdraw from participation at any time.

Any questions or comments can be directed toward task force co-chairs:

Doreen Olson, OTA Program Head, Western Wisconsin Technical College,  
(608) 789-4757 or [olsond@email.western.tec.wi.us](mailto:olsond@email.western.tec.wi.us)  
Peggy Martin, OT Program Director, University of Wisconsin – La Crosse,  
(608) 785-8303 or [marti\\_pm@mail.uwlax.edu](mailto:marti_pm@mail.uwlax.edu)

Thanks for your help.



## Appendix D

April 7, 2000

RE: Memo for **OTA Pediatric Curriculum Survey**

Dear Colleague:

In January, you received three surveys regarding pediatric curriculum for the Occupational Therapy Assistant whom we requested for you to distribute to an OTA educator OTR Fieldwork educator and COTA fieldwork educator. As of this time we have not received any responses from you institution regarding the survey.

Since we feel that the outcome of the survey may have an impact on the content of pediatric curriculum for occupational therapy assistants, we are requesting that you send the completed surveys even though it is past the requested return date. We realize that schools may have had difficulty with obtaining the survey from the fieldwork educators but we were taking a grassroots approach and desire input from the practitioners. If you only have one or two of the surveys completed, we are requesting that you still send it. We will be continuing to work on this project through May.

Please send completed surveys to:

Doreen Olson, OTR  
Western Wisconsin Technical College  
304 North Sixth St, PO Box C908  
La Crosse, WI 54602-0908

If you have any questions or concerns please feel free to contact Doreen at 608-789-4757 or by email – [olsond@western.tec.wi.us](mailto:olsond@western.tec.wi.us)

Thank you for your time and consideration.

Doreen Olson, OTR  
OTA Program Head  
Western Wisconsin Technical College

Peggy Martin, MS, OTR  
OT Program Director  
University of Wisconsin – La Crosse

## Appendix E

**OTA Pediatric Curriculum Content Survey**

Summary of the number of items with the highest percentage within a category

	NA	General awareness	Experience in content	Demonstrate competency	Not sure
<b>I. Typical and Atypical Development: Birth to 18 Years</b>					
A. Academic Preparation		1 (9%)	9 (82%)	1 (9%)	
B. FWI			2 (100%)		
C. FWII				3 (100%)	
<b>II. Family Issues</b>					
A. Academic Preparation		4 (33 %)	8 (67%)		
B. FWI		1 (33.3%)	1 (33.3%)	1 (33.3%)	
C. FWII			2 (50%)	2 (50%)	
<b>III. Pediatric Diagnosis and their Impact on Occupational Performance</b>					
A. Academic Preparation			9 ((64 %)	5 (36%)	
B. FWI			1 (100%)		
C. FWII			1 (33 %)	2 (67%)	
<b>IV. Occupational Performance Assessment and Intervention Process:</b>					
<b>Approaches</b>					
A. Academic Preparation			12 (80%)	3 (20%)	
B. FWI			1 (100%)		
C. FWII				2 (100%)	
<b>V. Occupational Performance Assessment and Intervention Process:</b>					
<b>Evaluation</b>					
A. Academic Preparation		55 (82%)	12 (18%)		
B. FWI	1 (20%)	2 (40%)	2 (40%)		
C. FWII			2 (50%)	2 (50%)	
<b>VI. Occupational Performance Assessment and Intervention Process:</b>					
<b>Intervention Planning and Implementation</b>					
A. Academic Preparation		1 (7%)	13 (93%)		
B. FWI			2 (100%)		
C. FWI				7 (100%)	

## VII. Management of Pediatric Occupational Therapy Services

A. Academic Preparation	8 (42%)	9 (47%)	2 (11%)
B. FWI		1 (100%)	
C. FWII		4 (67%)	2 (17%)

NA	General awareness	Experience in content	Demonstrate competency	Not sure
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## VIII. Assistive Technology

A. Academic Preparation	9 (69%)	4 (31%)	
B. FWI		1 (100%)	
C. FWII		2 (67%)	1 (33%)

<b>TOTAL</b>	1 (.5%)	81 (38%)	98 (45.5%)	34 (16%)
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## **Appendix F**

Tables 1 through 8

**Table 1**

## Typical and Atypical Development: Birth to 18 Years

	NA %	General awareness %	Experience in content %	Demo. Competency %	Not sure %
<b>A. Academic Preparation</b>					
1. Concepts and Therories	-	26.5	44.1	29.0	-
2. Sensorimotor and cognitive components	-	13.0	45.0	42.0	-
3. Psychosocial and pschological components	-	25.0	45.2	29.8	-
4. Sequences of ADLs	-	15.4	39.1	45.6	-
5. Interaction of performance components	-	13.6	47.9	38.5	-
6. Impact of performance contexts	-	19.2	43.1	34.7	-
7. Dysfunctional processes	-	32.4	44.1	23.5	-
8. Biological maturation	0.6	30.6	45.3	23.5	-
9. Social and cultural awareness	0.0	27.9	49.4	22.9	0.6
10. A & P of development	0.0	28.2	44.7	26.5	0.6
11. Models of NAGI and World Health Org.	11.7	36.3	28.1	5.3	18.7
<b>B. Fieldwork Level I</b>					
12. Knowledge of dev relating to life roles	1.2	28.8	42.4	24.7	2.9
13. Knowledge of eval & treatment	1.8	34.7	43.5	18.2	1.8
<b>C. Fieldwork Level II</b>					
14. Interpretation of developmental status	3.5	10.6	38.2	47.1	0.6
15. Therapuetic approach of normal dev.	0.6	5.3	27.5	66.7	-
16. Assist in adaptations to dev. stages	0.6	8.8	35.1	55	0.6

**Table 2**

## Family Issues

	NA %	General awareness %	Experience in content %	Demo. Competency %	Not sure %
<b>A. Academic Preparation</b>					
17. Family systems theory	1.7	55.1	34.7	5.7	2.8
18. Family life cycle	8.5	52.5	33.9	3.4	1.7
19. Family ecology	7.9	63.3	25.4	1.7	2.3
20. Emotional/social impact of dys on family	0.6	36.2	45.8	16.9	0.6
21. Impact of dysf families on the child	0.6	42.4	43.5	13.6	-
22. OTA's role determining needs/priorities	2.3	20.3	43.5	33.9	-
23. Knowledge of effective interventions	1.7	19.2	46.9	32.2	-
24. Knowledge of communication styles	1.1	26.6	45.8	26.6	-
25. Sociocultural concerns on parenting	2.8	49.7	37.9	9.6	-
26. Advocating for family & services	1.7	27.8	43.2	27.3	-
27. Knowledge of community resources	4	36.2	44.6	14.7	0.6
28. Collaborative process of services	1.1	28.8	40.1	29.9	-
<b>B. Fieldwork Level I</b>					
29. Family-centered vs child-centered therapy	6.8	41.5	37.5	12.5	1.7
30. Establish rapport & OTA role	0.6	18.8	39.8	40.3	0.6
31. Observation of child & peer performance	1.1	14.3	46.9	37.1	0.6
<b>C. Fieldwork Level II</b>					
32. Rapport/OTA role during eval and planning	5.1	7.3	31.1	54.8	1.7
33. Collaborative consult with the IFS/IEP	1.7	9.6	42.4	45.2	1.1
34. Engage in multi service delivery patterns	1.1	18.6	43.5	32.2	4.5
35. Multicultural effective intervention	0.6	15.3	46.3	36.2	1.7

**Table 3****Pediatric Diagnoses and Their Impact on Occupational Performance**

	NA %	General awareness %	Experience in content %	Demo. Competency %	Not sure %
<b>A. Academic Preparation</b>					
36. Cerebral Palsy	-	14.9	37.4	47.7	-
37. Mental retardation/Down's Syndrome	-	12.6	40.2	47.1	-
38. LD/ADD	-	14.9	40.2	44.8	-
39. PDD	-	17.8	41.4	40.8	-
40. ED/BD	-	19.5	48.3	32.2	-
41. Other: Spina Bifida/MD/TBI/AIDS/Autism/etc.	-	21.8	47.7	30.5	-
42. Etiology	1.7	38.5	42	17.2	0.6
43. Impact of disorder on ADLs/performance	-	12.6	44.3	43.1	-
44. Characteristics of Performance Components	1.2	22	46.2	28.9	1.7
45. Medical/education intervention/precautions	0.6	18.5	38.2	42.2	0.6
46. OT assess/intervention related to service	1.1	13.8	41.4	43.7	-
47. Develop/use of methods and strategies	1.7	16.8	42.8	36.4	2.3
48. Possible multi etiologies affecting treatment	4.1	36.8	43.9	14	1.2
49. Projection of status of the diagnosis	2.3	31	49.7	17	-
<b>B. Fieldwork Level I</b>					
50. Implementation of methods/strategies on DX	0.6	24.4	49.4	23.8	1.7
<b>C. Fieldwork Level II</b>					
51. Recognize common DX characteristics					
52. Appropriate resources according to DX	0.6	4	35.8	59.5	-
53. Interpretation of DX on life stages/performance	1.2	11.6	38.7	48	0.6
	2.3	12.7	42.8	41.6	0.6

**Table 4**

The Occupational Performance Assessment and Intervention Process:  
Approaches

	NA %	General awareness %	Experience in content %	Demo. Competency %	Not sure %
<b>A. Academic Preparation</b>					
54. Developmental approaches /planning	-	6.8	34.5	58.8	-
55. Sensorimotor approaches	-	7.3	35	57.1	0.6
56. Behavioral management	-	18.6	50.3	31.1	-
57. Adapted equipment/assistive technology	0.6	9	45.2	45.2	-
58. Biomechanical approaches-seat/splinting	-	14.7	54.8	29.9	0.6
59. Occupational behavior/Human occupation	1.7	29.9	46.6	21.8	-
60. Rood/PNF/Motor control approaches	1.7	29.9	48.6	19.8	-
61. Cognitive approaches: Piaget, play	0.6	27.7	47.5	24.3	-
62. Therapeutic use of self	-	12.4	40.1	46.9	0.6
63. Ecological approaches	5.1	33.5	35.8	17.6	8
64. NDT/postioning/oral motor techniques	0.6	22.6	52.5	23.7	0.6
65. Behavior: Prompts/reinforcers/chaining	-	19.2	53.7	26.6	0.6
66. Prompting self-esteem, interaction	0.6	29	47.2	22.7	0.6
67. Sensory integration/adaptive responses	-	22.7	54.5	22.2	0.6
68. Contemporary motor learning & control	1.1	33.5	48.9	12.5	4
69. Application of above to AA & intervention	-	17.7	51.4	29.7	1.1
<b>B. Fieldwork Level I</b>					
70. Basic observation & application	-	12.5	47.2	39.8	0.6
<b>C. Fieldwork Level II</b>					
71. Selection of appraches to specific cases					
72. Application of basic/advance approaches	1.7	5.6	26.6	65.5	0.6
	1.7	4.5	33.5	58.5	1.7

**Table 5**

The Occupational Performance Assessment and Intervention Process:  
Evaluation

	NA %	General awareness %	Experienc e in content %	Demo. Competency %	Not sure %
<b>A. Academic Preparation</b>					
73. Relevent assess methods/procedures	2.3	28.6	51.4	17.1	0.6
74. Understand assess tools & selection	7.5	41.4	36.8	13.8	0.6
75. PEDI	7	51.5	29.1	2.3	11.1
76. WEEFIM	9.9	50	24.4	2.9	12.8
77. Play assessments	8.8	52	25.1	2.3	11.7
78. School Function Assessment	7	48.5	31	5.8	7.6
79. HELP	8.7	48.8	30.2	5.2	7
80. Dev. Programming for Infants/Children	14.1	47.6	24.1	1.2	12.9
81. Brigance Inventory & Early Dev.	13.5	53.2	18.1	2.3	12.9
82. LAP	15.3	50	19.4	2.4	12.9
83. Denver II	5.8	53.8	26.3	8.2	5.8
84. MAP	7.6	57.3	24	5.3	5.8
85. First STEP	12.4	50.6	17.6	2.9	16.5
86. Bayley Scales of Infant Development II	9.9	16.2	18.1	4.7	7
87. Mullen Scales of Learning - AGS edition	18.9	43.2	13.6	1.8	22.5
88. Test of Sensory Function in Infants	20.9	45.3	12.2	1.7	19.8
89. Infant/Toddler synpton Checklist	19.9	44.4	17	2.3	16.4
90. Touch Inventory	14	54.5	14	1.8	15.8
91. Sensory Profile	11.7	50.9	25.1	5.3	7
92. SI Post Rotary Nystagmus Test	27.1	56.5	8.8	1.8	5.9
93. MVPT	4.1	42.4	35.5	15.1	2.9
94. TVPS	5.8	42.4	34.3	15.1	2.3
95. DTVP-II	8.2	52.6	25.1	8.8	5.3
96. SIPT	22.7	62.2	12.2	-	2.9
97. Ayres Clinical Observations	11	54.1	26.7	3.5	4.7
98. Bruinicks-Oseretsky Test MP	4.7	48.3	35.5	9.3	2.3
99. Peabody Dev Motor Scales	4.7	45.3	37.2	11	1.7
100. Quick Neurological Screening Test	22.1	53.5	50.1	1.2	8.1
101. Movement ABC	25.7	38	7.6	0.6	28.1
102. Erhardt Dev Prehension Assessment	16.3	52.9	16.3	4.7	9.9
103. Exner In-Hand Manipulation Test	21.5	45.3	11.6	2.9	18.6
104. TIME	22.4	48.2	8.2	0.6	20.6
105. Degangi-Berk Test of SI	24	48	15.2	2.3	10.5
106. TVMS	5.9	50.6	27.6	12.4	3.5
107. VMI	3.5	47.7	30.8	15.1	2.9
108. Reflex testing/postural reactions	6.4	41.9	36	12.8	2.9
109. Analysis of positioning needs	5.8	32	43.6	14.5	4.1
110. Oral motor assessments	7	50.6	32	5.8	4.7
111. Eval RX Children's Handwriting (ETCH)	14.6	50.3	19.3	4.7	11.1

	NA %	General awareness %	Experienc e in content %	Demo. Competency %	Not sure %
<b>A. Academic Preparation continued</b>					
112. Denver Handwriting Analysis	21.1	48	10.5	0.6	19.9
113. Loops & Groups	12.8	40.1	30.8	8.1	8.1
114. Burke's Behavior Rating Scale	27.6	36.8	5.2	-	30.5
115. Pier-Harris Child Self-Concept Scale	29.3	37.4	3.4	0.6	29.3
116. Harter Self-Concept Scale	29.9	33.9	2.9	-	33.3
117. Early Coping Inventory	29.9	37.4	5.7	0.6	26.4
118. Carey Infant Temperament Scale	31	34.5	4.6	-	29.9
119. Tenn. Self-Concept Scale Revised	30.5	32.8	2.9	0.6	33.3
120. Jacobs Pre-voc Assessment (JPVA)	26	33.35	5.2	1.2	34.1
121. McCarron-Dial System	25.4	32.4	4.6	-	37.6
122. Assess of Home Environments	20.9	32	21.5	4.7	20.9
123. HOME	24.4	30.8	11.6	2.9	30.2
124. School Observation	12.2	36	27.9	11.6	12.2
125. Dev Assess of Functional Assessment	4.6	33.5	41.6	18.5	1.7
126. Sensorimotor	7.5	35.1	41.4	13.8	2.3
127. Psychosocial/Psychological	13.3	41	31.8	7.5	6.4
128. Environmental Contexts	10.4	39.9	33.5	8.7	7.5
129. Invent-Dev/func assessments	3.4	31.3	45.5	18.8	1.1
130. Invent-Sensorimotor	5.1	32	44	17.7	1.1
131. Invent-Psychosocial/Psychological	10.9	36.6	38.3	10.3	4
132. Invent-Environmental Contexts	8.6	35.1	39.1	13.8	3.4
133. Administer/score selected assessments	14.9	35.4	34.9	14.3	0.6
134. Manipulate enviro to engage child	5.1	26.1	42.6	25.6	0.6
135. Effects of behavior on test results	6.3	37.5	39.8	5.9	0.6
136. Interpretation/organization of results	27.3	34.1	32.4	5.7	0.6
137. Imply results of the eval	12.5	30.7	42.6	13.6	0.6
138. Factors considered during testing	6.8	40.9	36.9	14.8	0.6
139. Familiarity of interview process	3.4	28.4	41.5	26.7	-
<b>B. Fieldwork Level I</b>					
140. Adm/score dev/func assessments	20.8	28.3	35.3	14.5	1.2
141. Adm/score sensorimotor assess	22.2	32.2	35.7	7.6	2.3
142. Adm/score psycho/psycol assess	28.2	35.3	28.2	3.5	4.7
143. Adm/score environmental assess	26.5	35.3	28.2	5.9	4.1
144. Interpret results of 1 assessment	34.1	26.6	27.2	11	1.2
<b>C. Fieldwork Level II</b>					
145. Select appropriate assessment	16.9	22.1	39.5	21.5	-
146. Adm test for component/area/context	9.4	22.8	44.4	22.2	1.2
147. Report finding oral/written	6.4	15.2	36.4	39.2	1.8
148. Select/use OT techn for documentation	3.6	10.2	34.3	51.8	-

**Table 6**

The Occupational Performance Assessment and Intervention Process:  
Intervention Planning and Implementation

	NA %	General awareness %	Experience in content %	Demo. Competency %	Not sure %
<b>A. Academic Preparation</b>					
149. Knowledge of age appropriate domains	0.6	21.5	39	39	-
150. Knowledge of approaches within domain	0.6	18.6	44.8	36	-
151. Identify domains to be addressed	-	21.6	47.4	31	-
152. Identify approaches/techniques/act	-	18.1	46.8	35.1	-
153. Interrelationship factors on goals	-	32.2	43.3	24.6	-
154. Roles, team formation, collaboration	-	27.5	37.4	35.1	-
155. Identify func limitations and assessments	1.2	15.9	48.2	33.5	1.2
156. Identify/prioritization of needs	1.8	18.1	48.5	30.4	1.2
157. Identify constraints and opportunities	1.2	21.6	53.2	22.8	1.2
158. Determine outcomes defined by team	1.2	20.7	55.6	17.8	4.7
159. Write measurable goals/how reviewed	1.8	15.2	45	37.4	0.6
160. Complete intervention plan	2.9	16.4	43.9	35.7	1.2
161. Intervention appropriate to context	1.8	15.2	38.6	43.3	1.2
162. Recommend RX freq/duration	11.2	27.1	43.5	17.6	0.6
163. Implementing transition plan	10.1	30.8	44.4	13.6	1.2
164. Knowledge of family-centered practice	2.9	42.4	34.1	17.1	3.5
<b>B. Fieldwork Level I</b>					
165. Identify occup perf area/comp/context	0.6	19	56.3	23.6	0.6
166. Identify techn/activities to approach	1.1	17.2	60.9	20.7	-
<b>C. Fieldwork Level II</b>					
167. Complete case study	1.7	5.7	25.7	65.7	1.1
168. Implement supervised intervention	1.1	3.4	12.6	82.9	-
169. Adapt intervention to child	1.7	2.9	20.6	74.3	0.6
170. Document intervention approach	1.1	1.7	15.4	81.7	-
171. Recognize need for outside consult	4	7.4	28	60.6	-
172. Terminate/DC treatment	7.4	9.7	38.3	42.9	1.7
173. Observe safety precautions as needed	1.1	0.6	8	90.3	-



**Table 7**

## Management of Pediatric Occupational Therapy Services

	NA %	General awareness %	Experience in content %	Demo. Competency %	Not sure %
<b>A. Academic Preparation</b>					
174. Medical services	1.7	37.1	38.9	22.3	-
175. Community services	1.1	36.6	39.4	22.9	-
176. Educational services	0.6	34.3	40.6	24.6	-
177. Agency mission, pupose	6.3	60.2	24.4	7.4	1.7
178. Administrative structures	6.8	59.7	25.6	5.7	2.3
179. Fianicial & reimbursement structures	6.3	58	29	5.7	1.1
180. Case management	7.4	45.5	38.1	8	1.1
181. Models of service - direct/indirect	0.6	40	41.1	17.7	0.6
182. Impact of state reimbursement	2.3	50.6	34.7	11.9	0.6
183. Impace of federal reimfursement	2.3	47.2	34.1	15.9	0.6
184. Team models in different settings	1.7	46.6	30.7	20.5	0.6
185. Roles/impact of diff. team members	-	28	45.1	26.9	-
186. Continuum of services	-	34.1	42.8	22.5	0.6
187. Effective consultation/monitoring	6.3	33.1	48.6	11.4	0.6
188. Documentation of service delivery	0.6	10.4	45.7	43.4	-
189. Knowledge of program monitoring	3.4	38.3	38.9	17.1	2.3
190. OT/OTA role del. in service delivery	0.6	12.1	35.1	52.3	-
191. Supervision relationship of OT/OTR	0.6	11.4	32	56	-
192. Agencies providing resources/services	3.4	52.6	35.3	8	1.7
<b>B. Fieldwork Level I</b>					
193. Identify site's mission/pupose/impact	1.1	32.2	39.1	27	0.6
194 -- error - no Question 194					
<b>C. Fieldwork Level II</b>					
195. Macth between needs and site's mission	2.9	13.8	44.3	34.5	4.6
196. Identify legislat. Reimbursement impact	1.7	32.2	46.6	19	0.6
197. Effective function of team	1.1	9.2	27.6	62.1	-
198. Intervention of appro. therapy service	1.7	5.2	22.5	70.5	-
199. Identify entrance/DC criteria	5.2	14.4	43.7	36.8	-
200. Determine case loads	10.9	24.1	42	19	4

**Table 8**

## Assistive Technology

	NA %	General awareness %	Experience in content %	Demo. Competency %	Not sure %
<b>A. Academic Preparation</b>					
201. Legislative mandates for AT	4.6	56.6	28.6	10.3	-
202. Funding resources for AT	6.9	58.9	29.1	5.1	-
203. Relevance of AT for children	1.1	36	34.9	28	-
204. Components of AT evaluation	7.4	45.1	36	10.3	1.1
205. How dev & enviroment affects AT	3.4	36.6	37.7	21.7	0.6
206. Knowledge of software/hardware/adapt	4	51.7	33.5	10.2	0.6
207. Knowledge of high/low technology	2.3	34.3	37.1	26.3	-
208. Familiarity with augmentative comun.	6.3	52.3	33.5	8	-
209. Identify resources for programs/families	5.7	58.9	25.7	8.6	1.1
210. Positioning/seating knowledge for AT	1.7	22.2	47.2	29	-
211. Basic selection for access/switches/etc	4.6	40.6	36.6	18.3	-
212. Factors for power vs manual wheelchairs	6.8	44.9	39.2	8.5	0.6
213. Access info using internet/netscape/etc	2.3	29.1	32.6	34.9	1.1
<b>B. Fieldwork Level I</b>					
214. Familiarity of AT or accomidations	2.9	36.8	44.3	15.5	0.6
<b>C. Fieldwork Level II</b>					
215. Use/recommend appropriate technology	2.3	14.5	46.5	36.6	-
216. Interact with team members	1.7	14.5	36.6	47.1	-
217. Recommend AT to enhance performance	5.3	21.2	47.1	26.5	-

## Appendix G

### OTA PEDIATRIC CURRICULUM CONTENT

#### EVOLVING TRENDS IN OTA PEDIATRIC SERVICE DELIVERY

Item #	Statement on the survey
4.	Academic preparation content should include: Sequences in the development of daily living, work, and play or leisure.
13.	Level I Fieldwork should provide opportunities for demonstration of knowledge of typical and atypical development of occupations in relation to appropriate life tasks and roles.
14.	Level II Fieldwork should facilitate the development of these abilities: Interpretations of information related to the developmental status of the infant, toddler, child, or youth to co-workers and patents/care givers.
33.	Level II Fieldwork should facilitate the development of these abilities: Engagement in collaborative consultation with the development of the individualized family service plan (IFSP) or the individualized education program (IEP).
53.	Level II fieldwork should facilitate the development of these abilities: Interpretation, when given characteristics of diagnoses, of their impact on life stages and occupational performance.
54.	Academic preparation content should include: Developmental approaches: Planning activities in an appropriate sequence of development.
55.	Academic preparation content should include: Sensorimotor approaches for the improvement of gross motor, fine motor, and visual motor skills.
71.	Level II fieldwork should facilitate the development of these abilities: Selection of appropriate occupational performance approaches, given a specific case and taking into account the child's age, diagnosis, course of disability, sociocultural background, context, environment, and family priorities.
145.	Level II fieldwork should facilitate the development of these abilities: Selection of assessments, in collaboration with primary care givers and professionals, for a specific infant, toddler, child, or youth, considering occupational performance problems, diagnosis, age, presenting problem, resources, and setting.
203.	Academic preparation content should include: Knowledge of the relevance of assistive technology and the assistive technology team to the practice of occupational therapy for children.

