Nebraska Credentialing Review for the Profession of

OCCUPATIONAL THERAPY

Application Date: October 30, 2024

Submitted to the
Nebraska Department of Health and Human Services
By the Nebraska Occupational Therapy Association

1) **Provide the following information for the applicant group:**
This application is submitted by the Nebraska Occupational Therapy Association, Inc. on behalf of its member occupational therapists, occupational therapy assistants, occupational therapy students, and occupational therapy assistant students. .

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American Occupational Therapy Association, Inc.
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The Nebraska Occupational Therapy Association is the professional association representing occupational therapy professionals (occupational therapists, occupational therapy assistants, and students at both licensure levels) in Nebraska. The organization consists of 261 active members as of July 29, 2024.

2) **Identify by title, address, telephone number, e-mail address, and website of any other groups, associations, or organizations in Nebraska whose membership consists of any of the following:**
   a. **members of the same occupation or profession as that of the applicant group;** None the applicant group is aware of.
   b. **members of the occupation dealt with in the application;** None the applicant group is aware of.
   c. **employers of the occupation dealt with in the application;** None the applicant group is aware of.
   d. **practitioners of the occupations similar to or working closely with members of the occupation dealt with in the application;**
      i. American Physical Therapy Association Nebraska Chapter
      PO Box 24133
      Omaha, NE 68134
      info@aptane.org
      ii. Nebraska Speech, Language, and Hearing Association
      8700 Executive Woods Dr. #400
      Lincoln, NE 68512
      (402)476-1528
      info@nslha.org
      iii. Nebraska Medical Association

233 S. 13th St. Ste. 1200
Lincoln, NE 68508
(402) 474-4472
https://www.nebmed.org

iv. Nebraska Hospital Association
3255 Salt Creek Circle Ste. 100
Lincoln, NE 68504
(402) 742-8140
info@nebraskahospitals.org

v. Nebraska Nurses Association
3340 American Ave. St. F
Jefferson City, MO 65109
(888) 885-7025
info@nebraskanurses.org

vi. Nebraska Nurse Practitioners
4941 S. 91st St.
Omaha, NE 68127
wemaster@nebraskanp.com

vii. Nebraska Athletic Trainers Association
https://www.nsata.org/about-us/

viii. Nebraska Chiropractic Physicians Association
13215 Birch Dr, Omaha, NE 68164
https://nebraskachiropractic.org/

ix. Nebraska Association for Behavioral Analysis
NEABA (Steven Taylor)
5911 Newport Ave.
Omaha, NE 68116
nebraskaaba@gmail.com

e. **educators or trainers of prospective members of the occupation dealt with in the application;**

i. Nebraska Methodist College OTM
720 North 87th. St
Omaha, NE 68114
(402) 354-7000
jill.cuff@methodistcollege.edu

ii. Creighton University OTD
2500 California Plz
Omaha, NE 68178
(402) 280-2700
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iii. University of Nebraska Medical Center OTD
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(402) 559-6673
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iv. College of Saint Mary OTD
7000 Mercy Rd
Omaha, NE 68106
(402) 399-2400
truppert@csm.edu

v. Union College OTA-A
3800 South 48th St.
Lincoln, NE 68506
(402) 486-2640
erumery@ucollege.edu

vi. Central Community College OTA-A
3234 W. Hwy 34
Grand Island, NE 68802
(800) 729-2682
calliewatson@cccneb.edu

f. **Citizens familiar with or utilizing the services of the occupation dealt with in the application (e.g., advocacy groups, patient rights groups, volunteer agencies for particular diseases or conditions, etc.);**
   i. Brain Injury Alliance of Nebraska
   ii. NE Down Syndrome Alliance
   iii. Autism Society of Nebraska
   iv. NE Stroke Task Force
   v. NE MS Association
   vi. NE Parkinson's Association
   vii. PTI Nebraska
   viii. NE Appleseed
   ix. NAMI Family Support Group
   x. NE Cancer Coalition

g. **any other group that would have an interest in the application.**

3) Provide the current scope of practice of this occupation as set forth in state statutes. If a change in this scope of practice is being requested, identify that change. This description of the desired scope of practice constitutes the proposal. The application comprises the documentation and other materials that are provided in support of the proposal. (insert summary of and location of current statutes document here)

Occupational therapy is currently defined in state statutes as:

1. Occupational therapy means the use of purposeful activity with individuals who are limited by physical injury or illness, psychosocial dysfunction, developmental or learning disabilities, or the aging process in order to maximize independent function, prevent further disability, and achieve and maintain health and productivity.

2. Occupational therapy encompasses evaluation, treatment, and consultation and may include
    a. remediation or restoration of performance abilities that are limited due to impairment in biological, physiological, psychological, or neurological processes
    b. adaptation of task, process, or the environment, or the teaching of compensatory techniques, in order to enhance performance,
    c. disability prevention methods and techniques which facilitate the development or safe application of performance skills, and
    d. health promotion strategies and practices which enhance performance abilities. 2 Source: Laws 2007, LB463, § 850.

Based upon AOTAs Model Practice Act (2022), the applicant group is proposing updated language to more accurately reflect modern occupational therapy practice:

1. “The Practice of Occupational Therapy” means the therapeutic use of everyday life occupations with persons, groups, or populations (clients) to support occupational performance and participation. Occupational therapy practice includes clinical reasoning and professional judgment to evaluate, analyze, and diagnose occupational challenges (e.g., issues with client factors, performance patterns, and performance skills) and provide occupation-based interventions to address them.
2. Occupational therapy services include habilitation, rehabilitation, and the promotion of physical and mental health and wellness for clients with all levels of ability-related needs. These services are provided for clients who have or are at risk for developing an illness, injury, disease, disorder, condition, impairment, disability, activity limitation, or participation restriction.
3. Through the provision of skilled services and engagement in everyday activities, occupational therapy promotes physical and mental health and well-being by supporting occupational performance in people with, or at risk of experiencing, a range of developmental, physical, and mental health disorders.
4. The practice of occupational therapy includes the following components:
    a. Evaluation of factors affecting activities of daily living (ADLs), instrumental activities of daily living (IADLs), health management, rest and sleep, education, work, play, leisure, and social participation, including
        i. Context (environmental and personal factors) and occupational and activity demands that affect performance
        ii. Performance patterns including habits, routines, roles, and rituals
        iii. Performance skills, including motor skills (e.g., moving oneself or moving and interacting with objects), process skills (e.g., actions related to selecting, interacting with, and using tangible task objects), and social interaction skills (e.g., using verbal and nonverbal skills to communicate)
        iv. Client factors, including body functions (e.g., neuromuscular, sensory, visual, mental, psychosocial, cognitive, pain factors), body structures (e.g., cardiovascular, digestive, nervous, integumentary, and genitourinary systems; structures related to movement), values, and spirituality
    b. Methods or approaches to identify and select interventions, such a
        i. Establishment, remediation, or restoration of a skill or ability that has not yet developed, is impaired, or is in decline
        ii. Compensation, modification, or adaptation of occupations, activities and contexts to improve or enhance performance

iii. Maintenance of capabilities to prevent decline in performance in everyday life occupations
iv. Health promotion and wellness to enable or enhance performance in everyday life activities and quality of life
v. Prevention of occurrence or emergence of barriers to performance and participation, including injury and disability prevention

c. Interventions and procedures to promote or enhance safety and performance in ADLs, IADLs, health management, rest and sleep, education, work, play, leisure, and social participation, for example:
i. Therapeutic use of occupations and activities
ii. Training in self-care, self-management, health management (e.g., medication management, health routines), home management, community/work integration, school activities, and work performance
iii. Identification, development, remediation, or compensation of physical, neuromusculoskeletal, sensory–perceptual, emotional regulation, visual, mental, and cognitive functions; pain tolerance and management; praxis; developmental skills; and behavioral skills
iv. Education and training of persons, including family members, caregivers, groups, populations, and others
v. Care coordination, case management, and transition services
vi. Consultative services to persons, groups, populations, programs, organizations, and communities
vii. Virtual interventions (e.g., simulated, real-time, and near-time technologies, including telehealth and mobile technology)
viii. Modification of contexts (environmental and personal factors in settings such as home, work, school, and community) and adaptation of processes, including the application of ergonomic principles
ix. Assessment, design, fabrication, application, fitting, and training in seating and positioning, assistive technology, adaptive devices, and orthotic devices, and training in the use of prosthetic devices
x. Assessment, recommendation, and training in techniques to enhance functional mobility, including fitting and management of wheelchairs and other mobility devices
Exercises, including tasks and methods to increase motion, strength, and endurance for occupational participation
xi. Remediation of and compensation for visual deficits, including low vision rehabilitation
xii. Driver rehabilitation and community mobility
xiii. Management of feeding, eating, and swallowing to enable eating and feeding performance
xiv. Application of physical agent and mechanical modalities and use of a range of specific therapeutic procedures (e.g., wound care management; techniques to enhance sensory, motor, perceptual, and cognitive processing; manual therapy techniques) to enhance performance skills
xv. Facilitating the occupational participation of persons, groups, or populations through modification of contexts (environmental and personal) and adaptation of processes
xvi. Efforts directed toward promoting occupational justice and empowering clients to seek and obtain resources to fully participate in their everyday life occupations
xvii. Group interventions (e.g., use of dynamics of group and social interaction

to facilitate learning and skill acquisition across the life course).

The Nebraska Statutes Pertaining to Occupational Therapy Practice Act can be found here: https://dhhs.ne.gov/licensure/Documents/Occupational%20Therapy.pdf and are **attached** to this proposal.

This document describes the minimum education and competency required for licensed occupational therapists and occupational therapy assistants in the state. The document defines the levels of professional education, as well as the occupational therapy aide. The document identifies the services authorized to be performed by an occupational therapist in a manner that is accurate, but incomplete. While this information is accurate, it is not reflective of the Occupational Therapy Practice Framework, which is the current language of the profession. The current statutes were based on a previous version of occupational therapy practice language called Uniform Terminology. The profession is now on the fourth version of the Occupational Therapy Practice Framework (OTPF-4). The OTPF has guided the profession since its publication in 2002, and Uniform Terminology has not been used since 2002. **The OTPF-4 is attached.** It is the guiding document for all occupational therapy education at accredited programs across the state of Nebraska and beyond.

The American Occupational Therapy Association published a Model Practice Act to help states better align their practice acts with the current professional language in 2022. This was released to members in 2023, and informs the proposed language changes you see today. This Model Practice Act is **attached**. **The majority of the proposed changes are updates to align the practice act with this national document and current educational standards and preparation.** As this document has guided the profession for 22 years, it is past time to update the language.

Changes have also occurred in entry level education of both the occupational therapist and the occupational therapy assistant since the development of the current statute. The current statute describes additional training required for occupational therapists to utilize physical agent modalities in the state. Please see the **attached** PAMS chart provided by AOTA State Affairs to see the restrictions across the United States. **We propose language to remove the requirement of additional training beyond entry-level practice for the occupational therapist, and to open a pathway for additional training and use by trained occupational therapy assistants, who are currently limited to only the use of superficial thermal modalities**. The proposed changes are supported by the review of national language, current entry-level practice, and AOTA Policy E.18. published in 2024 regarding the profession's use of physical agent and instrument-assisted modalities.

In regards to the position on instrument-assisted modalities and greater referrals from physicians for the use of dry needling in occupational therapy, **the association desires to open a pathway for occupational therapists to obtain additional training in and demonstrate competency with instrument-assisted modalities to respond to current evidence and**

ensure the best outcomes for recipients of services. As instrument-assisted modalities are not part of entry-level practice, the proposed language includes requirements for additional training and certification beyond entry-level education. The entry-level accreditation standards for the occupational therapist and occupational therapy assistant are also **attached**.

The requests above are aligned with the typical function of the entry-level profession according to the most recent AOTA Model Practice Act (2022).

5) Describe in detail the functions typically performed by practitioners of this occupation, and identify what if any specific statutory limitations have been placed on these functions.

Occupational therapy (OT) is a healthcare profession focused on helping individuals of all ages perform the activities that they need and want to do in their daily lives. This can include tasks at home, work, school, and in the community. Occupational therapists work with people who have physical, mental, or cognitive impairments to develop, recover, or maintain the skills necessary for daily living and working. Occupational therapy professionals include occupational therapists, occupational therapy assistants, and occupational therapy aides.

Occupational therapy can be beneficial for a wide range of conditions, including but not limited to:

- Physical injuries or disabilities
- Developmental disorders
- Mental health conditions
- Cognitive impairments
- Chronic illnesses
- Aging-related challenges

Specific interventions used by occupational therapy professionals are listed in the modernized definition of occupational therapy practice above, and are included again here:

5. The practice of occupational therapy includes the following components:
    a. Evaluation of factors affecting activities of daily living (ADLs), instrumental activities of daily living (IADLs), health management, rest and sleep, education, work, play, leisure, and social participation, including
        i. Context (environmental and personal factors) and occupational and activity demands that affect performance
        ii. Performance patterns including habits, routines, roles, and rituals
        iii. Performance skills, including motor skills (e.g., moving oneself or moving and interacting with objects), process skills (e.g., actions related to selecting, interacting with, and using tangible task objects), and social interaction skills (e.g., using verbal and nonverbal skills to communicate)
        iv. Client factors, including body functions (e.g., neuromuscular, sensory, visual, mental, psychosocial, cognitive, pain factors), body structures (e.g., cardiovascular, digestive, nervous, integumentary, and genitourinary

systems; structures related to movement), values, and spirituality

b. Methods or approaches to identify and select interventions, such a
    i. Establishment, remediation, or restoration of a skill or ability that has not yet developed, is impaired, or is in decline
    ii. Compensation, modification, or adaptation of occupations, activities and contexts to improve or enhance performance
    iii. Maintenance of capabilities to prevent decline in performance in everyday life occupations
    iv. Health promotion and wellness to enable or enhance performance in everyday life activities and quality of life
    v. Prevention of occurrence or emergence of barriers to performance and participation, including injury and disability prevention
c. Interventions and procedures to promote or enhance safety and performance in ADLs, IADLs, health management, rest and sleep, education, work, play, leisure, and social participation, for example:
    i. Therapeutic use of occupations and activities
    ii. Training in self-care, self-management, health management (e.g., medication management, health routines), home management, community/work integration, school activities, and work performance
    iii. Identification, development, remediation, or compensation of physical, neuromusculoskeletal, sensory–perceptual, emotional regulation, visual, mental, and cognitive functions; pain tolerance and management; praxis; developmental skills; and behavioral skills
    iv. Education and training of persons, including family members, caregivers, groups, populations, and others
    v. Care coordination, case management, and transition services
    vi. Consultative services to persons, groups, populations, programs, organizations, and communities
    vii. Virtual interventions (e.g., simulated, real-time, and near-time technologies, including telehealth and mobile technology)
    viii. Modification of contexts (environmental and personal factors in settings such as home, work, school, and community) and adaptation of processes, including the application of ergonomic principles
    ix. Assessment, design, fabrication, application, fitting, and training in seating and positioning, assistive technology, adaptive devices, and orthotic devices, and training in the use of prosthetic devices
    x. Assessment, recommendation, and training in techniques to enhance functional mobility, including fitting and management of wheelchairs and other mobility devices
    xi. Exercises, including tasks and methods to increase motion, strength, and endurance for occupational participation
    xii. Remediation of and compensation for visual deficits, including low vision rehabilitation
    xiii. Driver rehabilitation and community mobility
    xiv. Management of feeding, eating, and swallowing to enable eating and feeding performance
    xv. Application of physical agent and mechanical modalities and use of a range of specific therapeutic procedures (e.g., wound care management; techniques to enhance sensory, motor, perceptual, and cognitive processing; manual therapy techniques) to enhance performance skills
    xvi. Facilitating the occupational participation of persons, groups, or

populations through modification of contexts (environmental and personal) and adaptation of processes

xvii. Efforts directed toward promoting occupational justice and empowering clients to seek and obtain resources to fully participate in their everyday life occupations

xviii. Group interventions (e.g., use of dynamics of group and social interaction to facilitate learning and skill acquisition across the life course).

Nebraska currently limits the use of physical agent modalities by occupational therapists to those who have demonstrated additional competency, or who have had their college-level course approved by the state. Occupational therapy assistants are limited to only the use of superficial thermal modalities, regardless of their training.

It has been reported to the association that this restriction was based upon a concern that the use of modalities was not part of entry-level practice at the time. Physical agent modalities have been a component of entry-level education for the occupational therapist since 2008, utilizing the term “demonstrate” in the most current version of the standards. The standard for accredited programs currently states:

ACOTE Standard B.3.14. (2023):
OTR level- (Doctoral and Masters programs)- The student must be able to demonstrate use and knowledge of safe and effective application of ***superficial thermal agents, deep thermal agents, electrotherapeutic agents, and mechanical devices*** *as a preparatory measure to improve occupational performance. This must include indications, contraindications, and precautions.*

OTA level (Bachelor and Associate’s)-The student must be able to define the safe and effective application of ***superficial thermal agents, deep thermal agents, electrotherapeutic agents, and mechanical devices*** *as a preparatory measure to improve occupational performance. This must include indications, contraindications, and precautions.*

The differences in the use of verbs between the OTR and OTA level educational programs supports the associations desire to open a pathway for OTRs to utilize superficial thermal, deep thermal, electrotherapeutic, and mechanical agents at the point of entry level practice. The Association is proposing the creation of a pathway for the OTA level licensee to demonstrate advanced competency in the use of superficial thermal, deep thermal, electrotherapeutic, and mechanical agents and to utilize in the state after completing advanced training.

No language exists in the state in regards to i**nstrument-assisted modalities**. The Association proposes the creation of language clarifying OTs role in the use of instrument-assisted modalities and the pathway for proof of continued competence in order to use these modalities in the state.

6) Identify other occupations that perform some of the same functions or similar functions.

Physical therapists, physical therapy assistants, speech-language pathologists, applied behavioral analysts, social workers, and behavioral health practitioners are also involved in caring for clients often seen by occupational therapy professionals. However, occupational therapy remains a unique profession that requires an entry-level Master's as the minimum point of entry to the field for occupational therapists, with many occupational therapists holding an entry-level or post-professional doctorate degree. Occupational therapy assistants can enter the field at the associate or baccalaureate levels.

7) What functions are unique to this occupation? What distinguishes this occupation from those identified in question 6?

The most unique attribute of the profession of occupational therapy is the focus on occupational performance. The following passage is taken directly from the American Occupational Therapy Associations 4th Edition of the Occupational Therapy Practice Framework (OTPF-4).

The OTPF-4 defines the term "occupation" as are everyday activities that people do to fill their time and give their lives meaning and purpose. They can be done as individuals, in families, or with communities, and can include things people need to, want to, or are expected to do. Occupations are central to a client's health, identity, and sense of competence, and have particular meaning and value to them.

The OTPF-4 categorizes occupations into a broad range of categories, including:

- Activities of daily living (ADLs)
- Instrumental activities of daily living (IADLs)
- Health management
- Rest and sleep
- Education
- Work
- Play
- Leisure
- Social participation

Evidence-based occupational therapy services use a variety of approaches to remediate, restore, compensate for, or obtain skills related to occupational performance. Whether using preparatory, purposeful, or occupation-based activities during treatment, all occupational therapy treatment is focused on helping someone achieve their goals related to completing those daily activities that are meaningful and necessary in their daily lives (AOTA, 2020).

8) Identify other occupations whose members regularly supervise members of this occupation, as well as other occupations whose members are regularly supervised by

this occupation. Describe the nature of the supervision that occurs in each of these practice situations.

Occupational therapists do not require supervision, however may accept referrals from primary service providers such as physicians, physician assistants, nurse practitioners, or others with the ability to refer to occupational therapy. At times, payer sources may require a physician signature to endorse a plan of care or letter of medical necessity, for example. However, that is not the requirement of the state. **The public has direct access to occupational therapy services in the state. There are no changes being proposed to the referrals or direct access section of the statute.**

Occupational therapy assistant: *38-2527. Occupational therapy assistant; supervision required. An occupational therapy assistant may deliver occupational therapy services enumerated in section 38-2526 in collaboration with and under the supervision of an occupational therapist. Source: Laws 2004, LB 1005, § 125; R.S.Supp.,2006, § 71-6119; Laws 2007, LB463, § 867.* **There are no changes being proposed to the supervision of occupational therapy assistants.**

Occupational therapy aide: *38-2525. Occupational therapy aide; supervision requirements. An occupational therapy aide shall function under the guidance and responsibility of an occupational therapist and may be supervised by an occupational therapist or an occupational therapy assistant for specifically selected routine tasks for which the aide has been trained and has demonstrated competence. The aide shall comply with supervision requirements developed by the board. The board shall develop supervision requirements for aides which are consistent with prevailing professional standards. Source: Laws 2004, LB 1005, § 123; R.S.Supp.,2006, § 71-6117; Laws 2007, LB463, § 865* **There are no changes being proposed to the supervision of occupational therapy aides. There are changes being proposed to ensure this section is reflective of the variety of position titles that may be functioning as an aide to an occupational therapist or occupational therapy assistant.**

9) What actions, judgments, and procedures of this occupation can typically be carried out without supervision or orders? To what extent is this occupation, or portions of its practice, autonomous?

Occupational therapists, once licensed, are autonomous practitioners who can provide occupational therapy services without supervision by another health care provider. An occupational therapist interacts with the client to use their clinical reasoning to administer tests and measure functional abilities, and then determine treatment goals bearing in mind the client's occupations (everyday activities that are important to the client). Occupational therapy assistants, once licensed, are, by contrast, not autonomous practitioners and are required to provide services under the supervision of a licensed occupational therapist. The level, frequency and nature of the required supervision varies by state and may be tailored to the client's specific needs or to the occupational therapy assistant's experience and training. In Nebraska, it is specified in regulation 172 NAC 114.005. Supervision is defined in regulation as "The process

by which the quantity and quality of work of an occupational therapy assistant is monitored. Supervision means the directing of the authorized activities of an occupational therapy assistant by a licensed occupational therapist and will not be construed to require the physical presence of the supervisor when carrying out assigned duties.” (172 NAC 114.002). An occupational therapy assistant may perform only the duties and responsibilities for which they have been trained and are qualified to perform (see 172 NAC 114.005.01(E)).

It is important to note that some payer sources have greater requirements for supervision that those outlined in Nebraska State Statute. Occupational therapy professionals at all levels adhere to these requirements in accordance with payer guidelines.

10) Approximately how many people are performing the functions of this occupation in Nebraska, or are presenting themselves as members of this occupation? To what extent are these people credentialed in Nebraska?

There are 1591 occupational therapists and 279 occupational therapy assistants in Nebraska. Licensure is required for every person practicing as an occupational therapist or occupational therapy assistant in the state. There are 1014 occupational therapy practitioners licensed to administer superficial thermal modalities, 908 licensed to administer deep thermal agents, and 906 licensed to administer electotherapeutic agents.

To be initially licensed, the following requirements must be met:

Occupational Therapist	Occupational Therapy Assistant
Graduate from an ACOTE accredited occupational therapy program. Programs exist at the entry-level master’s and entry-level doctorate levels.	Graduate from an ACOTE accredited occupational therapy assistant program. Programs exist at the entry-level associates and entry-level baccalaureate levels.
Successful completion of the NBCOT examination for the occupational therapist. Both entry-level master’s and entry-level doctorate graduates take the same NBCOT examination.	Successful completion of the NBCOT examination for the occupational therapy assistant. Both entry-level associate’s and entry-level bachelor’s graduates take the same NBCOT examination.

***An entry-level Masters or above has been required for the occupational therapist since the year 2007. Occupational therapists who graduated prior to 2007 may hold different degrees.*

ACOTE Standards for Entry-Level Practice 2023
NBCOT Initial and Renewal Board Certification

11) Describe the general level of education and training possessed by practitioners of this occupation, including any supervised internship or fieldwork required for credentialing. Typically, how is this education and training acquired?

Occupational therapy practitioners practice at one of two levels of license: the occupational therapist and the occupational therapy assistant. Students must graduate from a program accredited by the Accreditation Council for Occupational Therapy Education (ACOTE). The Accreditation Council for Occupational Therapy Education (ACOTE®) ensures quality occupational therapy education by developing accreditation standards and verifying implementation to support the preparation of competent occupational therapists and occupational therapy assistants (2024).

The Accreditation Council for Occupational Therapy Education (ACOTE®) Standards and Interpretive Guide provides the required elements for educational programs and establishes critical competencies necessary to prepare students to become entry-level occupational therapists (OTs) or occupational therapy assistants (OTAs). The Standards review process is completed every 5 years to ensure that the entry-level educational standards reflect current occupational therapy practice. ACOTE uses a comprehensive review process to ensure participation by all stakeholders and communities of interest (ACOTE, 2023). Programs in occupational therapy must demonstrate their compliance with all aspects of the accreditation standards through the initial and continuing accreditation process.

Occupational therapists who graduate from any of the four degree level options must participate in fieldwork programs that provide the student the opportunity to carry out professional responsibilities under the supervision of qualified personnel serving as a role model (ACOTE, 2023). Fieldwork education is a crucial part of professional preparation and is integrated into accredited program's curricular design, designed to promote professional reasoning and reflective practice.

Programs integrate both Level I and Level II fieldwork into their academic programs. According to ACOTE Standard C.1.11., Level I Fieldwork: *Demonstrate that Level I fieldwork is provided to students and is not substituted for any part of Level II fieldwork. Document mechanisms for formal evaluation of student performance. Level I fieldwork may be met through one or more of the following instructional methods: virtual environments, simulated environments, standardized patients, faculty practice, faculty-led site visits, supervision by a fieldwork educator in a practice environment. Document that all students have similar Level I fieldwork experiences (e.g. learning activities, objectives, assignments, and outcome measures)* (ACOTE, 2023). There are not mandates for the number of hours of Level I fieldwork, however **there are length requirements for Level II fieldwork.**

The goal of Level II fieldwork is to develop competent, entry-level, generalist occupational therapists. Level II fieldwork must be integral to the program's curriculum design and must include an in-depth experience in delivering occupational therapy services to clients, focusing on the application of purposeful and meaningful occupation and research, administration, and

management of occupational therapy services. It is recommended that the student be exposed to a variety of clients across the lifespan and to a variety of settings (ACOTE, 2023).

The required length of Level II fieldwork differs by degree level, and consists of the following:

Doctoral Degree Level Occupational Therapist	Masters Degree Level Occupational Therapist	Baccalaureate Degree Level Occupational Therapy Assistant	Associate Degree Level Occupational Therapy Assistant
24 weeks minimum full time Level II fieldwork	**24 weeks** minimum full time Level II fieldwork	**16 weeks** minimum full time Level II fieldwork	**16 weeks** minimum full time Level II fieldwork

In addition, the doctoral degree level occupational therapist completes a doctoral capstone project that may include additional clinical skill exposure. These are a minimum of 14 weeks and may include clinical skills, research skills, administration, program development and evaluation, advocacy, education, and/ or leadership.

The baccalaureate-level occupational therapy assistant student also completes a capstone that may include advanced level knowledge in clinical skills, administration, advocacy, education, and/ or leadership. There are no requirements for the length of this project.

The complete ACOTE standards can be found here.

Occupational Therapy Programs:
College of Saint Mary OTD Curriculum
Creighton University OTD Curriculum
Nebraska Methodist College OTM Curriculum
Union Adventist University Master of OT Bridge Program
University of Nebraska Medical Center OTD Curriculum

Occupational Therapy Assistant Programs
Central Community College OTA-A Curriculum

Union Adventist University OTA-A Curriculum

12) Identify the work settings typical of this occupation (e.g., hospitals, private physicians' offices, clinics, etc.) and identify the predominant practice situations of practitioners, including typical employers for practitioners not self-employed (e.g., private physician, dentist, optometrist, etc.).

According to AOTA (2024), occupational therapy services are provided by licensed occupational therapists and occupational therapy assistants, to people of all ages in homes, communities, schools, and healthcare settings. Occupational therapy services may be provided in a client's home, community setting (e.g. community centers, shelters, free clinics), hospitals, nursing homes, outpatient clinics, primary care offices, schools, and many other locations. Occupational therapy practitioners may also work as consultants and experts in health information technology, human centered design, addressing the health of communities, education (e.g. schools, higher education), health promotion programs, driving and community mobility, and many others.

Resource: AOTA "What is OT?"

According to NBCOT (2023), the top five practice areas for currently registered occupational therapists in **Nebraska** include:

1. Adult rehabilitation
2. Older adult
3. Pediatrics
4. Schools
5. Musculoskeletal/ Orthopedics

According to NBCOT (2023), the top five practice areas for currently certified occupational therapy assistants in **Nebraska** include:

1. Older adult
2. Adult rehabilitation
3. Schools
4. Musculoskeletal/ Orthopedics
5. Pediatrics

Additional Education and Training Anticipated Under this Proposal

In addition to the accreditation requirements for licensure and entry-level education in occupational therapy, additional provisions are being recommended related to the specific competencies addressed in this proposal. The proposed additional requirements have been developed after an in-depth analysis of occupational therapy across the United States, with the support of the American Occupational Therapy Association.

The applicant group proposes that licensed occupational therapists take an approved training course for the use of instrument assisted modalities, such as dry needling. Examples of such courses include:

1. Myopain Seminars
2. American Academy of Manipulative Therapy
3. Institute of Clinical Excellence

For the occupational therapy assistant and physical agent modalities, it is recommended a licensed occupational therapy assistant demonstrate competency through one of the following courses:

1. Physical Agent Modalities Practitioner Credentialing Agency, LLC.
2. Exploring Hand Therapy dba Treatment2Go

13) Do practitioners routinely serve members of the general population? Are services frequently restricted to certain segments of the population (e.g., senior citizens, pregnant women, etc.)? If so, please specify the type of population served.

Occupational therapists serve individuals across the lifespan, from birth to death, that demonstrate a limitation in occupational performance capabilities due to a disability, illness, or injury.

14) Identify the typical reasons a person would have for using the services of a practitioner. Are there specific illnesses, conditions or situations that would be likely to require the services of a practitioner? If so, please specify.
Occupational therapy services are designed to help individuals of all ages to develop, recover, improve, or maintain daily living skills. Typical reasons include:
Physical disabilities, such as those resulting from injuries, stroke, or congenital conditions. Mental health issues, such as depression, anxiety, or schizophrenia to manage daily routines and community activities. Developmental disorders in children such as autism spectrum disorder, attention deficit disorder or learning disabilities. Age related issues, typically older adults experience issues such as Alzheimer's disease, physical limitations, parkinson's disease. Recovery from surgery or a serious illness, may need services to regain skills and learn adaptive ways to performing skills. Chronic conditions such as arthritis, multiple sclerosis, chronic obstructive pulmonary disease (COPD) need services to adapt to the environment and lifestyle to manage symptoms more effectively. Work related injuries, occupational therapy can be crucial to regain skills on job or modifications to return to work. Educational and learning challenges, occupational therapy can assist with students struggling with physical, cognitive, or sensory demands of school settings. Occupational therapy uses a variety of techniques to address needs including exercises to enhance motor skills, strategies for memory and organization, adaptations to home and work environments, and meaningful activities and occupations to improve reasoning and social skills.

]15) Identify typical referral patterns to and from members of this occupational group. What are the most common reasons for referral?

Typical referrals into occupational therapy practice come from:

- Primary service providers who are able to refer under their professions scope of practice who have identified a limitation in occupational performance for their client such as new onset disability, injury, or illness that is preventing the client from engaging in the required activities of their daily life. These referrals occur for clients seen in:
    - Hospitals
    - Inpatient rehabilitation facilities
    - Skilled nursing facilities
    - Nursing homes
    - Outpatient clinics
- School-based referrals: Occupational therapy to support learning and school participation is provided to children from birth to 21 years of age through the public education system. Referrals to these services may come from school psychologists, special or regular education teachers, related service providers, school administrators, early intervention agencies, community-based therapy or medical providers, and parents or guardians.
- Community-based Referrals: Occupational therapy services can receive community referrals from various sources, reflecting the broad scope and integrative approach to OT. Senior or aged care center facilities, mental health facilities, community health centers, insurance companies, family and self referrals, social services and agencies that support people with disabilities, veterans, or those with socioeconomic challenges.
- Occupations are identified by the profession of occupational therapy as work, play, self-care, leisure, rest and sleep, and social participation.
    - An example of a self-care deficit includes a client who experienced a cerebrovascular accident and has limited use of their impaired upper and lower extremity, as well as visual and cognitive deficits.
        - An occupational therapy practitioner would work with this individual to maximize neuroplasticity to regain their ability to or compensate or adapt for deficits necessary to complete the activities of their daily life that they need to do, want to do, and have to do. This may include caring for themselves, caring for others, returning safely to their home environment, engaging in work and leisure tasks, and returning to driving.
    - An example of a play-related deficit includes a child with a diagnosis of Autism Spectrum Disorder whose sensory-seeking and avoiding tendencies limit their ability to participate in the occupation of play, which is essential for a child's development.
        - An occupational therapy practitioner would work with the child and their caregiver(s) to identify strategies to support optimal sensory re-education to reduce the limitations encountered in age-appropriate play activities.

- A school-based occupational therapy practitioner would focus on the child's ability to engage in the occupation of education, which is the "work" of childhood.

*These examples do not reflect the entire depth and breadth of occupational therapy practice, however are provided to help the reader envision common occupational therapy practice environments and strategies.

16) Is a prescription or order from a practitioner of another health occupation necessary in order for services to be provided?

The public has direct access to occupational therapy services. *38-2529. Direct access to services. The public may have direct access to occupational therapy services. Source: Laws 2004, LB 1005, § 127; R.S.Supp.,2006, § 71-6121; Laws 2007, LB463, § 869.*

17) How is continuing competence of credentialed practitioners evaluated?
Licensees are required to engage in qualified continuing education activities as defined in state regulation, obtaining a minimum of twenty hours of qualified continuing education every two-year period. Licensees pay a fee to renew their license and verify continuing education. *38-2522. Applicant for licensure; continuing competency requirements. An applicant for licensure to practice as an occupational therapist who has met the education and examination requirements in section 38-2518 or to practice as an occupational therapy assistant who has met the education and examination requirements in section 38-2519, who passed the examination more than three years prior to the time of application for licensure, and who is not practicing at the time of application for licensure shall present proof satisfactory to the department that he or she has within the three years immediately preceding the application for licensure completed continuing competency requirements approved by the board pursuant to section 38-145. Source: Laws 2007, LB463, § 862.*

Practitioners must also obtain advanced and specialty training and certifications for many areas of practice that are not considered entry-level. It is up to the licensee and their employer to be knowledgeable about entry-level practice versus advanced practice, and to obtain additional certification and training when necessary. At this time, the state of Nebraska identifies the use of physical agent modalities as advanced practice requiring specialty certification. **The proposed language advocates for the occupational therapist to be able to use superficial thermal, deep thermal, and electrotherapeutic modalities at entry-level, consistent with current entry-level educational standards. (ACOTE 2018, ACOTE 2023). The applicant group would like to open a pathway for occupational therapy assistants to use not only superficial thermal modalities, as currently allowed, but also deep thermal and electrotherapeutic under the supervision of an occupational therapist.**

The applicant group is also proposing a pathway be created for occupational therapists to demonstrate competency above entry-level practice in the use of instrument-assisted modalities such as dry needling, and wound care management.

18) What requirements must the practitioner meet before his or her credentials may be renewed?

Practitioners must attest that they have obtained the necessary twenty hours minimum of continuing education in the two-year license period during their application for renewal of licensure.

Renewal of the certification to utilize physical agent modalities is not required by the current statute. Practitioners can be initially certified, then competence is never again assessed. This is another reason the applicant group believes that the certification and additional cost for certification in the use of physical agent modalities is no longer needed in the state.

19) Identify other jurisdictions (states, territories, possessions, or the District of Columbia) wherein this occupation is currently regulated by the government, and the scopes of practice typical for this occupation in these jurisdictions.

OT is a regulated profession in all 50 states, plus Washington, DC, Puerto Rico and Guam. A chart with the licensure requirements of these states and territories is **attached.**