VOLUME 3, ISSUE 2

SEPTEMBER, 2010

An online newsletter of the
Association of Asian-Pacific Occupational Therapists in America (AAPOTA)

The SPOTLIGHT

By 2017-
*We envision that **occupational therapy is** a powerful, **widely recognized**, **science-driven**, and **evidence-based** profession with a **globally connected** and **diverse workforce** meeting society's occupational needs.*

AOTA
Centennial Vision
(2006)

Inside this issue:

Letter from the President...

Dear AAPOTA Members:

Our organization continues to grow in membership and activity. This past month, we welcomed Bill Wong, OTS as Chair of our Student Committee. His enthusiasm and energy will hopefully give a boost to AAPOTA student membership.

To encourage student membership and participation, we will be having a Student Essay Contest which will have a deadline in January or February 2011. This will be open to all AAPOTA student members. Please watch the Spotlight for details.

My gratitude and thanks to Joe Wells, who has served as the Spotlight editor for the past 2 years. Under his leadership, the Spotlight went electronic and we have been able to reach many more members and readers. He has decided to relinquish the editorship in order to move in other professional directions. I will miss his gentle, patient, and calming presence on our monthly Board conference calls. We are in need of a new Spotlight Newsletter editor. If you are willing, please let a Board member know of your interest. The Spotlight has been our most important way of communicating with our members and the electronic aspect has helped to make it timely and efficient. I hope you will consider filling this opening.

Finally, we will be having our annual AAPOTA elections in the fall for the positions of President, Treasurer , Representative for Canada, and two regional representatives (in the US). If you are interested in running for either of these positions, please contact Joe Wells, who will be managing the election process.

Chana Hiranaka

Chair, AAPOTA

OT Community Mourns the Loss of Dr. Kielhofner

Sept.2, 2010:

It is with deep sadness that we communicate to you the passing of our colleague, mentor, and friend Dr. Gary Kielhofner.

Gary Kielhofner was a remarkable man, a visionary, a passionate scholar. As a beginning scholar, over 30 years ago, he had a dream of advancing the field of occupational therapy in order to assist individuals with chronic health conditions and disability live fulfilling and satisfying lives. His dream became a reality when he crafted the Model of Human Occupation, also known as MOHO.

Read more: http://www.aota.org/News/Consumer/Gary-Kielhofner.aspx

The Spotlight is on...

AAPOTA member, Dr. Ricardo Carrasco, was recently conferred with AOTA's highest award for 2010– The Award of Merit!

Dr. Carrasco has been devoted to living and promoting the tenets of occupational therapy. He has provided service to the community, taught through universities and continuing education, conducted research, and developed a variety of service delivery programs, all with the focus of the "power of doing." While his audiences are sometimes clients or occupational therapists, they have just as often been business people, public or governmental officials, school teachers, other health care disciplines, and family caregivers.

Dr. Carrasco's reach has been local, national, and international. He has worked as an educator, researcher, or consultant, but moved beyond those roles, always maintaining the posture and activity of an occupational therapist serving the community. He has served in numerous volunteer leadership roles.

Dr. Carrasco has used purposeful occupation and participation in communities to help individuals and groups achieve goals, improve skills, overcome challenges, and pursue wellness. His occupational therapy pathways have included a Head Start program, Ikebana—the art of Japanese flower arranging, a church wellness ministry, a sheltered workshop, a Very Special Arts Festival in Manila, and a program on gourmet food preparation for business executives.

Dr. Carrasco has knocked on big and small, familiar and unfamiliar doors. He has embraced the spirit of the Centennial Vision to make occupational therapy widely recognized, science-driven, globally connected, and meeting society's occupational needs.

AAPOTA member, Ms. Asha Asher, MA, OTR/L, was inducted in 2010 AOTA Roster of Fellows. She currently serves AOTA as the Chair of the Developmental Disabilities Special Interest Section.

Ms. Asher has provided pediatric therapy services in four countries (the United States, Canada, Belgium, and India) and currently works with the Sycamore Community Schools in Cincinnati, Ohio. Previously, Asher was an adjunct faculty member with occupational therapy and occupational therapy assistant programs in Cincinnati, addressing topics of autism, sensory integration, and cultural diversity.

In 2003, Asher was honored as "Affiliated Faculty of the Year" at Xavier University.

Since 2002, Asher has given multiple presentations at the American Occupational Therapy Association Annual Conference on a variety of topics including handwriting, the inclusion of students with disabilities in mainstream programs and activities, the emergency evacuation of students with disabilities, transitioning to work, and tools to facilitate the employment of individuals with disabilities.

She also has served on the editorial boards of *The American Journal of Occupational Therapy* since 2004, and the *Journal of Occupational Therapy, Schools & Early Intervention* since 2008. In addition to chairing AOTA's Developmental Disabilities Special Interest Section, Asher previously served on its standing committee as the education and research liaison from 1999–2002.

Asher received her occupational therapy degree from Seth GS Medical College in Mumbai, India, and has a master's degree from the University of Southern California. Additionally, she has a master's degree in special education from the SNDT University, in Mumbai, India.

Heartiest congratulations to other 2010 awardees…

The following members received the **2010 AOTA Service Commendations**: Jyothi Gupta, PhD, OTR/L; Meena Iyer, PhD, OTR/L, and Jayanthi Subramanian, MHS, OTR/L.

*The following members received **AAPOTA awards**:*

Outstanding Achievement Award: Meena Iyer, PhD, OTR/L

Distinguished Lectureship Award: Jyothi Gupta, PhD, OTR/L

Service Awards: Chana Hiranaka, MEd, OTR/L; K. Kshepakaran, OTR; Bhagwan Sharma, MS, OTR/L; Madhav Kulkarni, PhD, OTR (retd.); Razak Buddha, OTR/L

A Letter from India...

We are pleased to inform that Department of Occupational Therapy, Manipal University, India is offering a unique opportunity for OTs and OT students across the globe with flexible options to experience the Indian Occupational Therapy practice, which is extremely rich in its clinical content. It will be a great idea for OTs travelling to this part of the world to embark on an *Education Tourism*.

With a team of finest professionals and infrastructural facility it has turned into one of the best centre of OT Education and exemplary clinical services. It is attached with 1500 Manipal University Hospital and the campus of Manipal University plays the host for 20,000 students from 55 countries. The Dept. of Occupational Therapy offers 4½ years full time Bachelors Program in Occupational Therapy; 2 years full time post professional Masters Program in Occupational Therapy; one month certificate program in Hand Splinting; Clinical Placement for overseas students & upgrading the professional qualification of overseas students.

Over the years the Dept. has become the sought after destination for graduate students from Universities in Canada, Australia, England, Norway, Denmark, Germany, Austria to do their international clinical placement. The Dept. is also involved in upgrading the professional qualification of OTs in developing countries across the globe, currently a batch of students from Federal School of Occupational Therapy, Lagos, Nigeria are undergoing the program and negotiations with Srilanka & Malaysia is in the pipeline. The Dept. of Occupational Therapy is also in the process of facilitating the setting up of OT Programs in countries like Oman & Malaysia. The Hand Splinting Program, the one and the only program of its kind in entire Asia – Pacific region is to empower OTs in the art of splinting and convert it into a small scale industry, has not only become popular amongst OTs in India but also internationally like France, Greece, Oman, Uganda & Nigeria.

The Dept. also is the recipient of OT Resource materials through a project titled "Gift for Education" by AOTA & Maine Occupational Therapy Association for two consecutive years, a unique distinction. This is the only Dept. where faculties are extensively involved in WFOT & WHO Projects, and collaborative projects with other universities, the current one been with Governors State University, Illinois.

"Indian OTs go out to the world, OTs all over the world come to Manipal"

Contact:

Shovan Saha, BOT, MOT
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Dept. of Occup. Therapy
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Mr. Shovan Saha is also the Honorary Secretary of the All India OT Association. He recently participated in a 35-member WFOT project titled " Diversity Matters: Guiding Principles on Diversity and Culture" that was presented at the 2010 WFOT Conference at Santiago.

AROUND THE WORLD

5th Asia Pacific Occupational Therapy Congress

Nov. 1, 2011
For more information contact:
Suchada Sakornsatian at chadakor@yahoo.co.th

Click on http://www.wfot.org/documents/APOTC[1].pdf

AAPOTA represents occupational therapy practitioners with heritage belonging to some of the following countries:

Australia · Bangladesh

Hong Kong · India

Indonesia Japan · Malaysia

New Zealand ·Pakistan

Philippines · Singapore

Sri Lanka · Taiwan

Thailand

Do you have an interesting article or news to share? If yes, we will like to hear from you. E-mail us at jwells@asian-pacificOT.org

Contribute

by sending us articles, news items, re- views, letters, or any other form of writing that can be printed pertaining to cultural issues and the global practice of OT. Submissions may be edited for length and style. Pictures may be sent via e-mail in .jpg format. Please e-mail your submissions to:

jwells@asian- pacificot.org

MDS 3.0:
Important Changes to Therapy Services – A Brief Overview

By Jayanthi Subramanian, MHS, OTR

Introduction to MDS 3.0 and RUGs IV in Skilled Nursing Facilities (SNF)

Skilled nursing facilities are reimbursed by Medicare for care delivery for a patient's Medicare Part A stay through a system called Prospective Payment System (PPS). PPS was implemented in 1998 with the use of Minimum Data Set (MDS) 2.0 in electronic version. PPS reimbursement was based on case mix methodology used to assess resident care needs. The resident needs are assigned by Resource Utilization Groups (RUGs). Under the current RUGs III system, there are 53 levels and in the future RUGs IV system, there will be 66 levels of reimbursement from highest to lowest. The higher the resident care needs, the higher the reimbursement to the SNF. The MDS is the resource document which scores the components/resources necessary to determine care planning and importantly, the necessary RUG level classification and subsequent reimbursement for the care of the Part A resident. Additionally the MDS is important in:

Developing a patient specific care plan

To reimburse Medicaid services in some states

Quality monitoring activities in the form of quality indicator/measures reports (QI/QM)

Data for surveys and certification processes

Research and policy development

Enabling quality measures at a national level

In July 2009, CMS introduced changes in the Medicare payment system for Skilled Nursing Facilities with the implementation of the 3.0 MDS and RUG IV. The RUG groupings have expanded from 53 to 66 RUG groups.
Highlights of the changes to therapy delivery for Medicare A resident in SNF will be explored with an understanding of upcoming 3.0 MDS implementation beginning on October 1, 2010.

Section I- MDS 3.0 Definition of Therapy Modes of Treatment

Individual-treatment of one resident at a time with the resident receiving the full attention of one therapist/assistant
Concurrent-treatment of two residents at the same time when the residents are performing two different activities regardless of payer source; both in line of site of therapist/assistant
Group-treatment of two-four residents regardless of payer source; are performing similar activities under supervision by one therapist/assistant who are not supervising any other individuals-25%
Definition of group has been modified with the MDS 3.0-patient who are performing "similar activities"
Group defined as treatment with two, three or four residents with one therapist or assistant

Section II-Rehab RUG Levels with No Changes from MDS 2.0 to MDS 3.0

Therapy minutes for each Rehab RUG category remain the same

- Rehab Ultra High (RU) - Minimum of 720 minutes a week with 1 discipline 5/week and 2nd discipline 3/week frequency
- Rehab Very High (RV) - Minimum of 500 minutes a week with 1 discipline 5/week
- Rehab High (RH) - Minimum 325 minutes a week with 1 discipline 5/week
- Rehab Medium (RM) - Minimum 150 minutes with 1 discipline 5/week or a combination of disciplines providing 5 different days of treatment totaling to a minimum of 150 minutes
- Rehab Low (RL) - Minimum 45 minutes a week with 1 discipline 3/week and 2 restorative programs conducted 6/week, each of 15 minutes duration totaling 30 minutes

Regularly scheduled PPS assessments, ARDs, grace days and payment days remain the same for 5, 14, 30 60 and 90 days based on the number of Medicare A days used by patient
Assessment Reference days or ARDs remain the same for regularly scheduled PPS assessments (see below for the table)

Regularly Scheduled Assessment	Assessment Reference Period	Grace Days	Payment Days
5 Day	1-5	6-8	1-14
14 Day	11-14	15-19	15-30
30 Day	21-29	30-34	31-60
60 Day	51-59	60-64	61-90
90 Day	81-89	90-94	91-100

- Evaluation minutes do not count for towards any assessment minutes
- Re-Evaluation minutes do count towards assessment minutes
- Treatment must be at least 15 minutes to count as a day

Section III-Changes Different from MDS 2.0 to MDS 3.0
Therapy minutes are entered in Section O of MDS 3.0 (See below for actual form)

O0400. Therapies

A. Speech-Language Pathology and Audiology Services

Enter Number of Minutes

1. **Individual minutes** - record the total number of minutes this therapy was administered to the resident **individually** in the last 7 days

Enter Number of Minutes

2. **Concurrent minutes** - record the total number of minutes this therapy was administered to the resident **concurrently with one other resident** in the last 7 days

Enter Number of Minutes

3. **Group minutes** - record the total number of minutes this therapy was administered to the resident as **part of a group of residents** in the last 7 days

If the sum of individual, concurrent, and group minutes is zero, → skip to O0400B, Occupational Therapy

Enter Number of Days

4. **Days** - record the **number of days** this therapy was administered for **at least 15 minutes** a day in the last 7 days

5. **Therapy start date** - record the date the most recent therapy regimen (since the most recent entry) started — Month – Day – Year

6. **Therapy end date** - record the date the most recent therapy regimen (since the most recent entry) ended - enter dashes if therapy is ongoing — Month – Day – Year

B. Occupational Therapy

Enter Number of Minutes

1. **Individual minutes** - record the total number of minutes this therapy was administered to the resident **individually** in the last 7 days

Enter Number of Minutes

2. **Concurrent minutes** - record the total number of minutes this therapy was administered to the resident **concurrently with one other resident** in the last 7 days

Enter Number of Minutes

3. **Group minutes** - record the total number of minutes this therapy was administered to the resident as **part of a group of residents** in the last 7 days

If the sum of individual, concurrent, and group minutes is zero, → skip to O0400C, Physical Therapy

Enter Number of Days

4. **Days** - record the **number of days** this therapy was administered for **at least 15 minutes** a day in the last 7 days

5. **Therapy start date** - record the date the most recent therapy regimen (since the most recent entry) started — Month – Day – Year

6. **Therapy end date** - record the date the most recent therapy regimen (since the most recent entry) ended - enter dashes if therapy is ongoing — Month – Day – Year

C. Physical Therapy

Enter Number of Minutes

1. **Individual minutes** - record the total number of minutes this therapy was administered to the resident **individually** in the last 7 days

Enter Number of Minutes

2. **Concurrent minutes** - record the total number of minutes this therapy was administered to the resident **concurrently with one other resident** in the last 7 days

Enter Number of Minutes

3. **Group minutes** - record the total number of minutes this therapy was administered to the resident as **part of a group of residents** in the last 7 days

If the sum of individual, concurrent, and group minutes is zero, → skip to O0400D, Respiratory Therapy

Enter Number of Days

4. **Days** - record the **number of days** this therapy was administered for **at least 15 minutes** a day in the last 7 days

5. **Therapy start date** - record the date the most recent therapy regimen (since the most recent entry) started — Month – Day – Year

6. **Therapy end date** - record the date the most recent therapy regimen (since the most recent entry) ended - enter dashes if therapy is ongoing — Month – Day – Year

O0400 continued on next page

Unlike in MDS 2.0, in MDS 3.0 version, minutes need to be separately tracked as individual, concurrent and group for MDS submission.

- All Individual minutes provided need to be submitted for MDS assessment
- All minutes provided as concurrent, per the above definition, need to be submitted for MDS entry. The MDS grouper software will count 50% of the minutes for use in the RUG calculation
- Example:
- 30 minutes for John Doe
- 30 minutes for Roger Brown
- Therapy submits 30 minutes for John Doe and 30 minutes for Roger Brown
- Grouper software will automatically reduce the 30 concurrent minutes for each patient to half (15 minutes)
- All minutes provided in group mode need to be submitted for MDS assessment, Grouper software will apply the 25% limitation per the above definition. Cap of 25% of total discipline minutes per look-back period remains with the implementation of 3.0

(continued from page 5)

Section IV- Off Cycle MDS Assessments in MDS 3.0

- **Medicare Short Stay Assessment**
- **End of Therapy OMRA**
- **Start of Therapy OMRA**

Medicare Short Stay Assessment

A Short Stay Assessment is one in which the resident must have been discharged from Part A on or before day 8 of the Part A stay and the resident must have completed only 1 to 4 days of therapy with therapy started the last 4 days of the Part A stay. The following 7 conditions must be present to be considered a short stay assessment:

- The Short Stay Assessment must be the start of therapy OMRA (defined below). This assessment may be completed alone or combined with a PPS 5 day or readmission/return assessment. The Short Stay Assessment cannot be combined with a 14 day, 30 day, 60 day or 90 assessments.
- The Short Stay Assessment OMRA should be combined with a discharge assessment when the end of the Part A stay is the result of discharge from the facility, but not combined with a discharge assessment if the resident expires in the facility or is transferred to another payer source in the facility.
- A PPS 5-day assessment or readmission/return assessment has been completed. These assessments can be completed alone or combined with the start of therapy OMRA.
- The ARD must be on or before the 8th day of the Part A Medicare covered stay, 7 days or less of therapy care; day 8 is not a billable day.
- The ARD of the Start of Therapy OMRA must be the last covered Medicare Part A day. The end of the Medicare stay date is the date Part A ended.
- Therapy services of PT, OT and/or speech language pathology services must have started during the last 4 days of the Medicare Part A covered stay including weekends.
- At least one therapy discipline must continue through the last day of the Medicare Part A covered stay. This indicates the resident received therapy up to the end of the covered Medicare stay date.

Short Stay RUG Level Assignment - RUG level will be assigned based on a calculation of the average daily minutes of therapy provided as the following:

15-29 average daily therapy minutes →Rehabilitation Low category RLx

30-64 average daily therapy minutes →Rehabilitation Medium category RMx

65-99 average daily therapy minutes→ Rehabilitation High category RHx

100-143 average daily therapy minutes →Rehabilitation Very High category RVx

144 or greater average daily therapy minutes →Rehabilitation Ultra High category RUx

Impact on payment periods for the Medicare Short Stay assessment is as follows (does not apply to regular assessment):

1. If therapy starts on the day of admission, the rehab RUG rate will be effective from the day of admission through the end of the stay.

2. If therapy starts after the day of admission, the rehab RUG rate will be effective on the start of therapy date. The RUG level for the days prior to the start of therapy will be a Medicare non-therapy RUG.

Example of Short Medicare Stay Assessment:

Physical therapy is started on day 4 and the resident is discharged to the hospital on day 7

- Day 4-25 minutes
- Day 5-35 minutes
- Day 6-33 minutes
- Day 7- 37 minutes

The total days of care = 4; total minutes = 130

Average daily minutes:

130 divided by 4 = 32.5 the RUG level assigned is RM

RM begins on day four through the ARD or the discharge date; days 1-3 are Medicare non-therapy RUG days

End of Therapy OMRA
Completed when the resident was classified into a Rehab RUG category and is discharged from therapy but still has skilled nursing needs for continued stay in the Part A bed.

- This OMRA establishes a new non-therapy or nursing RUG classification and Medicare payment rate which begins the day after the last therapy treatment
- ARD is set on day 1, 2, or 3 after all therapy disciplines have discharged the resident
- The last day in which therapy treatment was provided is considered day 0 when determining the ARD for the End of Therapy OMRA
- Day one is the first day after the last therapy treatment was provided; if therapy is not normally provided on a weekend the days of Saturday and Sunday are skipped in the count; and if Friday was the last day when therapy was provided, then day one would be on Monday
- Nursing RUG is billed until the end of the billing period
- Grouper will create two RUGs: a therapy RUG and a Medical or Nursing RUG

Monday	Tuesday	Wednesday	Thursday	Friday
Therapy provided This date Day 0	ARD or 1st day of Nursing RUG	ARD or 2nd of Nursing RUG	ARD or 3rd of Nursing RUG	

Last day therapy RUG in this case is Monday. Thereafter, reimbursement will be at Nursing RUG levels

Start of Therapy OMRA
For therapy starting in the middle of an assessment period a SNF would have the **option** of completing an OMRA with an Assessment Reference Date (ARD) that is set 5 to 7 days after the first day therapy services are provided. This is for classification of residents into a RUG IV Rehab Extensive or Rehab category only.

Criteria required for Start of Therapy OMRA:

- Skilled therapy services must be daily, at least 5 days a week
- Skilled therapy services must be medically necessary
- Establishes a RUG for rehabilitation services and Medicare payment
- The day of the therapy evaluation which may or may not included treatment is the start date of reimbursement for the therapy RUG and would be effective until the end of the billing cycle
- Best ARD would be the day which allows the highest day/minutes and least concurrent minutes

Example of a Start of Therapy OMRA:
John Doe initiated Occupational therapy services on day 9 of his Medicare A stay in SNF. From day 1- 8th, John Doe did not receive any therapy. In this example, MDS nurse has the option to complete a Start of Therapy OMRA on day 13, 14 or 15 and the payment for the RUG level achieved would start from Day 9 instead of from day 15 like it used to be in MDS 2.0

Section V-Therapy Aides and Therapy Students Utilization

Therapy Aides or Therapy Techs
Therapy Aides cannot provide skilled services. Only the time a therapy aide spends on set-up for skilled services preceding individual therapy may be coded on the MDS .The therapy aide must be under direct supervision of the therapist or assistant

Therapy students
Therapy students must provide care in line-of sight of the supervising therapist/assistant -

- When a student is involved in an individual treatment session, to code individual minutes the supervising therapist/assistant may not be engaged in any other activity or treatment and in line of sight
- When a student is involved in a group treatment session, the supervising therapist/assistant must be in line of sight and not treating other individuals; if the supervising therapist/assist is providing group therapy, the student must not be providing treatment to any other resident

Association of Asian Pacific Occupational Therapists in America

Membership Application

A. Membership Status: **New** **Renewal** (membership #: _____)

B. Membership Type: ***Practitioner*** ***Student*** ***Associate Member (non-OT)***
Country of residence: USA Canada Other : _____

For renewals, please complete 1, 12 & 13, and only sections that have changed.
New Applicants- Please complete all sections.

1. Name: _____ Sex: M F
2. Designation (e.g., PhD, OTR, OTA, etc.) _____
3. Employer: _____
4. Job Title: _____
5. If student, university attending_____

6. Contact Information:
   a. Address: _____
   City/ State/ Zip: _____
   b. Phone: Home/ Work/ Mobile: _____
   c. Fax: _____ d. E- Mail: _____

7. Country of origin/ Asian-Pacific heritage (optional) _____

8. Please list your area/s of expertise (*e.g. pediatric OT*):_____

_____

9. Please check the ad-hoc committee/s you are willing to serve on:
____*membership* ____*research* ____*immigrations* ____*student services* ____*newsletter*

10. If selected, are you willing to be featured in AAPOTA's publications (e.g. website, e-newsletter, etc.)? ____Yes ____No

11. Do you give permission for your name and contact information to be listed in AAPOTA directory? ____Yes ____No

Note: AAPOTA may share membership directory with AOTA and other similar professional organizations requesting such information.

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12. a. Check number:_____
    b. Amount enclosed: Membership: $ _____ Donation: $_____ **Total**: $_____

13. a. Signature: _____ b. Date:_____

Membership fee/year (in US Dollars):
***US & Canada*: Practitioner: $20.00 Student: $10.00 Associate member: $20.00**
***Other Countries*: Practitioner: $10.00 Student: $5.00 Associate member: $10.00**

Please make check payable to AAPOTA and mail to:
Bhagwan Sharma, MS, OTR/L. Treasurer, AAPOTA
P.O. Box 450. Palos Heights, IL 60463.
E-Mail: members@asian-pacificot.org Website: www.Asian-PacificOT.org

Points to Ponder 1:
Why we need a diverse workforce….

In its centennial vision AOTA has expressed its commitment to building a workforce that draws on the strengths of all segments of our diverse society. Why is it imperative that we achieve this objective? The answer lies in current demographic trends and in our commitment to providing client-centered care.

Slowly but surely, the U.S. population is becoming increasingly diverse. According to the U.S. Census, today, about 70% of the population is European American. By the year 2050, that number will decrease to 49% while the number of individuals from various racial / ethnic backgrounds is projected to increase from about 30% to 51%. To ensure that future practitioners have the skills to meet the *occupational* needs of people with varying backgrounds, the leaders of our profession have recognized the need for developing a diverse workforce in their centennial vision (http://www.aota.org/News/Centennial/Background/36516.aspx).

The challenge lies in turning this vision to tangible results.

Achieving our centennial vision requires an increase in the enrollment and graduation of racial/ethnic minorities, low-income students, and others of diverse backgrounds from Occupational Therapy Programs nationwide. That brings us to the next question - who are the people responsible for increasing diversity in the classrooms? The obvious answer is - the leaders of the academic programs. However, students choose to enter particular educational programs – are these students well-informed of the different career choices? Have they heard about Occupational Therapy? Do they know what an Occupational Therapy career involves? Each one of us can and should advocate for Occupational Therapy as a career choice, particularly among the members of our immediate community. Make that move to inform your neighbors, members of your church, temple, or mosque. Tell them what you do for a living, how you have made a difference in the lives of others, and why perhaps they too might consider or recommend to others Occupational Therapy as a career choice. Help turn the vision of a diverse workforce to a reality.

Submitted by;
Meena Iyer, PhD, OTR/L
Vice-President, AAPOTA
Centennial Vision Commissioner – MDI Representative

MDS 3.0….*(Continued from page 7)*

For a student to code a concurrent treatment session the following must apply:

- When the therapy student is treating one resident, supervising therapist/ assistant treats another, in line of sight
- When the therapy student treats two residents both of whom are in line of sight of the therapist, then the therapist should not treat any patients
- When the therapy student does not treat any residents (observing) but the supervising therapist/assistant treats two residents at the same time, regardless of payer source

[Author: Jayanthi Subramanian, MHS, OTR/L. Ms. Subramanian is a Rehab Consultant with Rehab Care],

Are you an AAPOTA member? If no,

JOIN TODAY!

The benefits of AAPOTA membership:

1. Mentorship opportunities with seasoned professionals
2. Networking opportunities
3. Receive quarterly e-newsletter- "The Spotlight"
4. Receive information on relevant professional global activities
5. Receive support/ guidance in research activities from well known OT academicians and researchers
6. Publishing opportunities in e-newsletter
7. Peer recognition and career support: a) Awards program to be launched in 2010. b) Practitioners/ students featured in "The Spotlight".

Come grow with a growing organization!

The purpose of Association of Asian/ Pacific Occupational Therapists in America (AAPOTA) :

- *Serve as a liaison between occupational therapy practitioners and the American Occupational Therapy Association on Asian/Pacific cultural issues affecting occupational therapy practice.*
- *Promote scholarly activities and research on Asian/Pacific cultural issues affecting occupational therapy practice.*
- *Identify and work to achieve common goals and needs.*
- *Promote and support learning and scholarship.*
- *Support Occupational therapy practitioners emigrating from Asian/Pacific countries with transition and integration into the North American occupational therapy practice.*
- *Promote occupational therapy education and scholarly exchange among Asian/Pacific countries and North America.*

AAPOTA ELECTIONS– 2010

The association will conduct its first official elections in **December, 2010** for the following positions:

1. President
2. Treasurer
3. Regional Representative (Southern states)
4. Regional Representative (Western states)
5. Representative for Canada

For positions 4. and 5., candidates must reside in the stated regions. Mode of elections will be both via electronic and paper media. Only members (practitioners and students) are allowed to hold offices and vote. If not already a member, please consider joining. Membership form is available on page-8 of this newsletter.

Members are strongly urged to submit their names for these vital professional leadership positions. **Last date for submission of names is November 15th, 2010.** You may nominate your self or another member. Names of the nominators will not be disclosed. Based on the nominations, an electoral slate will be declared. Please submit nominations to:

Joe Wells, OTD, OTR/L
AAPOTA Elections

AAPOTA
P.O. Box 450
Palos Heights, IL 60463
E-Mail: jwells@Asian-PacificOT.org

VISIT US ON : WWW.ASIAN-PACIFICOT.ORG

Association Officers

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President/Founding Member

Meenakshi Iyer, PhD, OTR/L
Vice-President

Bhagwan Sharma, MA, OTR/L
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Vijay Suple, MA, PhD, OT (C)
Representative for Canada

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Immigrations Support:
Guru Nam Kaur Khalsa, MOT, OTR

Student Committee:
Bill Wong, MOT (stu.)

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The mission *of the Association of Asian/Pacific Occupational Therapists in America is*

- *to advance a greater understanding of Asian/Pacific cultural issues affecting occupational therapy practice, and*
- *to support career opportunities and advancements in occupational therapy by people of Asian/Pacific heritage.*