



Ohio Occupational Therapy, Physical Therapy,
and Athletic Trainers Board

*Occupational Therapy Section
November 13, 2014
9:00 a.m.*

Members Present

Beth Ann Ball, OTR/L, Secretary
Rebecca Finni, OTR/L, Chair
Jean Halpin, OTR/L (arrived @ 9:31 am)
Mary Beth Lavey, COTA/L
Kimberly Lawler, OTR/L
Trevor Vessels, Public Member

Staff

Diane Moore, Executive Assistant
Jeffrey Rosa, Executive Director

Guests

Jacquelyn Chamberlin, OOTA
Stacy Schumacher

Legal Counsel

Melissa Wilburn, AAG

Call to Order

Rebecca Finni, Section Chair called the meeting to order at 9:13 a.m.

The Section began the meeting by reading the vision statement.

The Occupational Therapy Section is committed to proactively:

- Provide Education to the Consumers of Occupational Therapy Services;
- Enforce Practice Standards for the Protection of the Consumer of Occupational Therapy Services;
- Regulate the Profession of Occupational Therapy in an Ever-Changing Environment;
- Regulate Ethical and Multicultural Competency in the Practice of Occupational Therapy;
- Regulate the Practice of Occupational Therapy in all Current and Emerging Areas of Service Delivery.

Approval of Minutes

Action: Rebecca Finni moved that the minutes from the September 11, 2014 meeting be approved as submitted. Mary Beth Lavey seconded the motion. Kimberly Lawler was absent for the vote due to the Enforcement Review Panel. Jean Halpin was absent for the vote. The motion carried.

Executive Director's Report

- The Executive Director informed that Section that the Ohio Department of Administrative Services is concerned that the new licensing system may not be viable due to vendor issues. The State is moving along as if the project will be viable. The new go live date is late February 2015.

The formal Executive Director's report is attached to the minutes for reference.

Discussion of Law and Rule Changes

The Executive Director presented the 2015 Five Year Rules to the Section. The Section will send out a 1-minute survey regarding potential impact of eliminating the supervisory ratio.

Administrative Reports

Licensure Report

Action: Rebecca Finni moved that the Occupational Therapy Section ratify, as submitted, the occupational therapist and occupational therapy assistant licenses issued by examination, endorsement, reinstatement, and restoration by the Ohio Occupational Therapy, Physical Therapy, and Athletic Trainers Board from September 11, 2014 through November 13, 2014, taking into account those licenses subject to discipline, surrender, or non-renewal. Beth Ann Ball seconded the motion. Kimberly Lawler was absent for the vote due to the Enforcement Review Panel. Jean Halpin was absent for the vote. The motion carried.

Occupational Therapist – Examination

Ashley, Meagan	Baik, Seonhee	Cheek, Roland
Cianciola, Christina	Cowgill, Brittany	Cox, Brittany
English, Brooke	Ford, Blake	Gilbert, Kareen
Hartmann, Victoria	Ingraham, Scott	Iorio, Beth
Jaggers, Jessica	Konzen, Hope	Monroe, Elizabeth
Papania, Paige	Phlipot, Michelle	Plymesser, Julia
Salus, Debbie	Schnipke, Bethany	Schueth, Allison
Schweikert, Joann	Steele, Kimberly	Story, Julia
Travis, Carmen	Vitale, Kayla	Zimmerman, Kevin

Occupational Therapy Assistant – Examination

Adams, Brigid	Ady, Jessica	Balderson, Chester
Bates, Amy	Boatman, Brittany	Boyer, Alissa
Brown, Darcy	Burkett, Denise	Butti, Susan
Callihan, Danielle	Campbell, Jennifer	Cardaman, Theresa
Carter, Julie	Coates, Michelle	Corbitt, Tyler
Cruz, Bianca	Dolbow, Mariah	Dravecky, Andrea
Dunlap, Katie	Eastham, Jennifer	Edie, Amy Beth
Geier, Trudy	Godec, Shelley	Grope, Steven
Hanna, Randall	Hastings, Rebekah	Hewitt, Krystal
Johnson, Shandi	Jung, Tryna	Kiernan-Croucher, Elizabeth
Klegg, Kevin	Korpi, Sabrina-Lee	Lay, Brooke
Leu, Tonya	Martindale, Teylor	McArthur, Katie
McKenrick, Melissa	Misner, Crystal	Mullenger, Laura
Nichols, Judy	Peavley, Michelle	Poppenhouse, Donald
Porcase, Brittany	Prater, Kelsey	Reasoner, Christine
Reed, Brittany	Rivera, Devin	Robson, Ciara
Sharp, Austin	Shaw, Lisa	Stennett, Shannon
Strohl, Sara	Studebaker, Tara	Weissenberger, Emily
Wendorff, Elizabeth	Whiting, Tayler	Williamson, Breanna
Zamolo, Lori Sonia	Zengel, Cassandra	

Occupational Therapist – Endorsement

Anderson, Jacob	Budzyn, Meghan	Creech, Brandon
Dinkelacker, Danielle	Gerstenhaber, Michelle	Gohel, Sonal
Hobart, Kelli	Houseman, Jordan	Jamiolkowski, Audrey
Kaur-Kang, Sandeep	Kremer, Victoria	Mason, Elyssa
Richards, Emily	Smith, Chelsea	Snell, Courtney

Occupational Therapy Assistant – Endorsement

Blethen, Molly	Cooper, Nichole	Gowen, Andrew
Kibbey, Darren	Matthews, Steven	Moore, Emily
Neil, Freda	Osborne, Martha	Reed, Heidi

Occupational Therapist – Reinstatement

Amrhein, Valerie	Eten, Constance	Henning, Deborah
Lester, Stephanie	Moneer, James	Stone, Elizabeth
Williams, Lisa		

Occupational Therapy Assistant – Reinstatement

Carr, Jeffrey	Coe, Terri	Favor, Stephen
Galvin, Shannon	Hammond, Michele	Jone,s Cheryl
Kaplansky, Jody	Stull, Tiffany	Thomas, Anita

Occupational Therapist – Restoration

None

Occupational Therapy Assistant Restoration

None

Limited License Agreements

Jean Halpin recommended that, pursuant to rule 4755-3-12 (D)(2) of the Administrative Code, the Section offer a limited license agreement to occupational therapist reinstatement applicant #5409015 based on the documentation provided. **Action:** Rebecca Finni moved that Section grant a limited occupational therapist license agreement to occupational therapist restoration applicant #5409015 based on the documentation provided. Kimberly Lawler seconded the motion. Jean Halpin abstained from voting. The motion carried. The Section granted a limited license agreement to Marla Zingales.

Continuing Education Report

Action: Mary Beth Lavey moved that the Section approve 62 applications for contact hour approval. Rebecca Finni seconded the motion. Kimberly Lawler was absent for the vote due to the Enforcement Review Panel. Jean Halpin was absent for the vote. The motion carried.

Assistant Attorney General's Report

Melissa Wilburn, AAG, gave a brief report.

Case Review Liaison Report

Kimberly Lawler reported that the Enforcement Division opened eight cases and closed six cases since the September 11, 2014 meeting. There are currently ten cases open. There are zero consent agreements and one adjudication order being monitored.

Enforcement Actions

Kimberly Lawler recommended that a notice of opportunity for hearing be issued for case OT- FY15-005 for failure to document occupational therapy services. **Action:** Rebecca Finni moved that the Section issue a notice of opportunity for hearing for case OT-FY15-005 for failure to document occupational therapy services. Beth Ann Ball seconded the motion. Kimberly Lawler abstained from voting. Jean Halpin was absent for the vote. The motion carried.

Correspondence

1. **Tara Bycroft. OTR/L:** Ms. Bycroft asked the Section questions regarding serving students in a school setting under the Response to Intervention program. **Reply:** According to rule 4755-7-02 (A) of the Administrative Code, the occupational therapist shall assume professional responsibility for the following activities, **which shall not be wholly delegated, regardless of the setting in which the services are provided:** (1) Interpretation of referrals or prescriptions for occupational therapy services; (2) Interpretation and analysis for evaluation purposes; (3) Development, interpretation, and modification of the treatment/intervention plan and the discharge plan. The licensee shall demonstrate concern for the well-being of the client. Failure to comply with paragraphs (C)(1) to (C)(17) of this rule may be grounds for disciplinary action pursuant to section 4755.11 of the Revised Code and in accordance with Chapter 119. of the Revised Code. (1) A licensee shall adhere to the minimal standards of acceptable prevailing practice. Failure to adhere to minimal standards of practice, whether or not actual injury to a client occurred, includes, but is not limited to: (a) **Failing to assess and evaluate a client's status or establishing an occupational therapy intervention plan prior to commencing treatment/intervention of an individual client.** If you are providing a consultative model for a group of students and not direct treatment to an individual, an individual plan of care is not needed. However, if **direct service** is being provided to an individual, whether it is as an identified student under special education, or as an individual student who is being served under RTI, the above rule applies. Direct service requires an evaluation, interpretation of the results and development of a plan of care. The Section recommends contacting Cathy Csanyi, the OT/PT Specialty Consultant with the Ohio Department of Education, Office of Exceptional Children at (419) 747-2806 or via email at cathy.csanyi@ode.state.oh.us for additional information. The Ohio Occupational Therapy Association's pediatrics member support group may also be able to assist you with your questions

regarding school-based practice. You can contact the Ohio Occupational Therapy Association at www.oota.org.

2. **Karri Cronin, OTA:** Ms. Cronin asked the Section questions regarding whether occupational therapy assistants can upgrade goals. **Reply:** It is the position of the Occupational Therapy Section that the initial plan, long-term goals, and initial short-term goals must be written by the occupational therapist. The occupational therapist may collaborate with the occupational therapy assistant in the development of these items. **Once the initial treatment/intervention plan and goals are established, the occupational therapy assistant may update short-term goals in collaboration with the occupational therapist.** Please review rule 4755-7-02 of the Administrative Code for additional information on the roles and responsibilities of the occupational therapist and occupational therapy assistant. **If your question is regarding IEP goals, IEP goals and objectives are written by the educational team and do not constitute the occupational therapy treatment/intervention plan.** According to rule 4755-7-02 (A) of the Administrative Code, occupational therapist shall assume professional responsibility for the following activities, which shall not be wholly delegated, regardless of the setting in which the services are provided: (1) Interpretation of referrals or prescriptions for occupational therapy services; (2) Interpretation and analysis for evaluation purposes; (3) Development, interpretation, and modification of the treatment/intervention plan and the discharge plan. The Section recommends contacting Cathy Csanyi, the OT/PT Specialty Consultant with the Ohio Department of Education, Office of Exceptional Children at (419) 747-2806 or via email at cathy.csanyi@ode.state.oh.us for additional information. The Ohio Occupational Therapy Association's pediatrics member support group may also be able to assist you with your questions regarding school-based practice. You can contact the Ohio Occupational Therapy Association at www.oota.org.
3. **Holly Broach, OT/L:** Ms. Broach asked the Section questions regarding caseloads in the school setting. **Reply:** The Ohio Occupational Therapy Practice Act only establishes ratios for the number of occupational therapy assistants (OTA) an occupational therapist (OT) may supervise and **does not regulate caseload levels**. Ratios establishing the number of students that an occupational therapist may serve are located in administrative rules adopted by the **Ohio Department of Education**. Rule 3301-51-09 (I)(3)(c) & (e) of the Ohio Department of Education's Operating Standards states that an OT shall provide services to no more than 50 school-age students or 40 preschool students. The Ohio Department of Education interprets this as the number of students to whom the therapist provides direct service. Paragraph (I)(1) of rule 3301-51-09 also states that determination of the appropriate ratio for an individual therapist must take into consideration the following: The severity of each eligible child's needs; The level and frequency of services necessary for the children to attain IEP goals/objectives; Time required for planning services; Time required for evaluations including classroom observations; Time required for coordination of the IEP services; Time required for staff development; Time required for follow up; and Travel time required for the number of building served. Services provided to students without disabilities must also be considered in determination of therapist/student ratio. This includes screenings, assessments, consultation, and counseling with families and professionals. Attending Intervention Assistance Team (IAT) meetings, participating in Response to Intervention (RTI) programs, and training education professionals as a part of these programs also must be considered when determining the therapist/student ratio. All students served by an OTA are part of the supervising therapist's caseload. In accordance with ODE's Operating Standards, as well as the Ohio Occupational Therapy Practice Act, OTAs do not have their own caseloads separate from that of the supervising therapist. It is the position of the Occupational Therapy Section that all responsibilities of the OT and OTA, including both direct and indirect service to students, must be considered when determining an appropriate therapist caseload. The number of students to whom the supervising therapist provides direct service must be reduced as the number of assistants a therapist supervises expands, since this increases the number of students for whom the therapist is responsible. The therapist must ensure provision of appropriate services and must not serve and/or supervise service for more students than he/she can provide skilled care, including informed direction of all aspects of the service provided for students by the assistant. The code of ethical conduct requires licensees, regardless of practice setting, to maintain the ability to make independent judgments and strive to effect changes that benefit the client (4755-7-08 (B)(9)). It is the duty of the Occupational Therapy Section to protect the consumers of occupational therapy services and ensure that students receive care consistent with safe and ethical practices. To this end, licensees are required to report to their licensing board any entity that places them in a position of compromise with the code of ethical conduct as stated in rule 4755-7-08 (B)(12) of the Administrative Code. Please refer to the Board's

website (<http://otptat.ohio.gov>) to review the *Determination of Appropriate Caseload for School-Based Occupational Therapy and Physical Therapy Practice Position Paper* and the *Comparison of Responsibilities of Occupational Therapy Practitioners in School-Based Practice Chart* documents. The Section recommends contacting Cathy Csanyi, the OT/PT Specialty Consultant with the Ohio Department of Education, Office for Exceptional Children at (419) 747-2806 or via email at cathy.csanyi@ode.state.oh.us. The Ohio Occupational Therapy Association's pediatrics member support group chair may be able to assist you with many of your questions regarding school based practice. You can contact the Ohio Occupational Therapy Association at www.oota.org.

4. **Mendi Morrison, COTA/L:** Ms. Morrison asked the Section questions whether occupational therapy assistants can ambulate with patients at a CGA level or whether or not occupational therapy assistants can work on ambulation with a client. **Reply:** There is nothing in the Ohio OT Practice Act that precludes an occupational therapy assistant from working on ambulation provided that it is in the plan of care provided by the supervising occupational therapist. Functional mobility (particularly for ADL and IADL performance) may be addressed under self-care retraining, provided that is a part of the occupational therapy plan of care. This may include documentation of the level of assist provided for functional mobility during a treatment session. Specifics of gait mechanics and training, though, are most typically addressed by physical therapy.
5. **Tracey Cooper, OTR/L:** Ms. Cooper asked the Section questions regarding writing plans of care for home health aides and in a school-based setting. **Reply: In response to your question regarding writing plans of care for home health aides:** There is nothing in the Ohio Occupational Therapy Practice Act that would prohibit an occupational therapist from supervising a home health aide within the home health setting, provided the home health aide would not be providing occupational therapy services. Development of a home health aide care plan is often a natural extension of occupational therapy services, as education and training regarding safety during self-care and home management task performance is typically provided by therapy staff to clients and their caregivers. However, the services provided by the home health aide would have to be clearly separate and distinct from the occupational therapy services provided. You may wish to refer to Medicare and other third party payer policies to determine what they require. Insurer policies and/or federal regulations may be more or less restrictive than the Ohio Occupational Therapy Practice Act. In any situation, licensees should follow the more restrictive policies. **In response to your question regarding writing plans of care in a school-based setting:** IEP goals and objectives are **written by the educational team** and **do not** constitute the occupational therapy treatment/intervention plan. According to rule 4755-7-02 (A) of the Administrative Code, occupational therapist shall assume professional responsibility for the following activities, which shall not be wholly delegated, regardless of the setting in which the services are provided: (1) Interpretation of referrals or prescriptions for occupational therapy services; (2) Interpretation and analysis for evaluation purposes; (3) **Development, interpretation, and modification of the treatment/intervention plan** and the discharge plan. In addition to identifying the IEP goals/objectives to be addressed by the occupational therapy practitioner, the separate occupational therapy treatment/intervention plan should include intervention approaches, types of interventions to be used, outcomes, and any additional occupational therapy goals not listed in the IEP. From your description of the goals that you are contributing to the IEP, it appears that you have understanding of thoroughness in the process. The IEP specifics may be placed into your detailed therapy plan of care. While the Ohio Occupational Therapy Practice Act is not specific about the components of documentation, it is the position of the Occupational Therapy Section that occupational therapy practitioners should follow the American Occupational Therapy Association's *Guidelines for Documentation of Occupational Therapy* (AOTA, 2008) when determining documentation of occupational therapy in any setting. And third party payer policies, such as Medicaid and/or facility policies may be more restrictive than the Ohio Occupational Therapy Practice Act. In addition, please refer to the Board's web site (<http://otptat.ohio.gov>) to review *Comparison of Responsibilities of Occupational Therapy Practitioners in School-Based Practice Chart* documents. The Section recommends that you contact the Ohio Occupational Therapy Association's pediatrics member support group coordinator concerning questions regarding school-based issues at www.oota.org.
6. **Tonya Leu, OTA:** Ms. Leu asked the Section questions regarding whether practicing as an ABA therapist and an occupational therapy assistant with the same children but not simultaneously. **Reply:** There is nothing in the Ohio Occupational Therapy Practice Act prohibiting occupational therapy assistants from

providing additional service to clients distinct from the occupational therapy plan of care. In providing services other than occupational therapy, the occupational therapy assistant must make it clear to the client or family that the occupational therapy assistant is acting only in this other capacity. That is, communication must be done in such a way that if the client or family is asked, he/she could clearly testify in a legal proceeding as to the role of the individual who was providing treatment. You may also wish to note that your professional liability policy (if you have one) would not cover you while acting in any capacity other than as a licensed occupational therapist occupational therapy assistant. The Section recommends that you check with the facility or corporation policies as they may be more restrictive than the Ohio Occupational Therapy Practice Act. If you are representing yourself as an occupational therapy assistant and/or your services as related to your skills as an occupational therapy assistant you must be supervised by an occupational therapist. If your services are represented as occupational therapy, each client would require an evaluation and plan of care overseen by an occupational therapist. You must document your services using your credentials as an OTA. When documenting services as an ABA paraprofessional, the academic degree designation (“AAS in Occupational Therapy Assistant” or “AAS-OTA”) may be utilized at any time for services provided outside of occupational therapy to represent the knowledge and skills acquired as part of that education.

7. **Sally Clements:** Ms. Clements asked the Section questions regarding whether the frequency of supervision for occupational therapy assistants and whether occupational therapists write an order to extend a reassessment. **Reply:** Pursuant to rule 4755-7-01 of the Administrative Code, the evaluating and/or supervising occupational therapist of record must provide supervision at least once per week for all occupational therapy assistants who are in their first year of practice. Occupational therapy assistants beyond their first year of practice must be supervised at least once per month. Evidence must be established, either in the client records or in a separate document (e.g.: collaboration log), that the supervision took place. Supervision is an interactive and collaborative process; simply co-signing client documentation does not meet the minimum level of supervision. Supervision must include a review of the client assessment, reassessment, treatment plan, intervention, and the discontinuation of the intervention. The occupational therapy assistant may not initiate or modify a client’s treatment plan without first consulting with the evaluating and/or supervising occupational therapist of record. Third party payer policies, other regulatory agencies, and/or facility policies may be more restrictive than the Ohio Occupational Therapy Practice Act. In any situation, licensees should follow the more restrictive policies.
8. **Juanita Almond-Davis, OTR/L:** Ms. Almond-Davis asked the Section questions regarding whether there is a listing for billable services for schools and how to join the listserv. **Reply:** The Ohio OT, PT, AT Board does not maintain a list of billable services for schools as the Ohio Occupational Therapy Practice Act does not regulate billing. Your school’s Medicaid Billing Unit should have the information and be able to provide that data for you. You can access the link to join the Board’s listserv(s) at <http://otptat.ohio.gov/Consumers/BoardListservs.aspx>.

Joint Correspondence

- JB1. Victoria Ridgway:** Ms. Ridgway asked the Occupational and Physical Therapy Sections questions regarding whether occupational and physical therapy evaluations are required in early intervention settings. **Reply:** It is the opinion of the Occupational Therapy Section that collaborative teamwork, including multidisciplinary, interdisciplinary, and transdisciplinary approaches are appropriate forms of service delivery. Please refer to the *AOTA Practice Advisory on Occupational Therapy in Early Intervention* (AOTA, 2010) at <http://www.aota.org> for discussion of this topic. As in any work setting, an occupational therapist working in Early Intervention would be required to assume the professional responsibilities outlined in rule 4755-7-02 (A) of the Ohio Administrative Code. For example, as a part of the transdisciplinary team, the occupational therapist performs evaluations and analysis of the client and environment; identifies issues and inputs into the development of the ISFP goals and objectives; plans appropriate interventions; and assesses outcomes. An intervention plan (plan of care) is required in the Early Intervention setting. As in any practice setting, appropriate documentation continues to be a requirement. Please refer to the American Occupational Therapy Association’s *Guidelines for Documentation of Occupational Therapy* (AOTA, 2008). An intervention plan might include identification of the IFSP goals and objectives targeted by the occupational therapy practitioner, intervention approaches

and types of interventions, and outcomes. The occupational therapist determines the aspects of the occupational therapy intervention plan that may be carried out by other team members. Instructing team and family members on ways to implement appropriate activities may be part of the intervention plan. Only services provided by an occupational therapist or occupational therapy assistant may be called occupational therapy. In response to your questions, yes a physical therapist would be required to perform a separate physical therapy evaluation to be able to establish a physical therapy plan of care.

JB2. Email Correspondent: The Email Correspondence asked the Occupational and Physical Therapy Sections questions regarding documenting services provided by occupational and physical therapy practitioners. **Reply:** Please be advised that the codes of ethical conduct adopted by both the Occupational Therapy and Physical Therapy Sections address required reporting in certain situations. Rule 4755-7-08 (A)(9) of the Administrative Code states that “licensees shall report to the occupational therapy section any unprofessional, incompetent, or illegal behavior of an occupational therapist or occupational therapy assistant of which the licensee has knowledge.” Rule 4755-27-05 (A)(10) of the Administrative Code contains the same provisions for physical therapy licensees. Rule 4755-27-05 (A) of the Administrative Code also states that “an individual licensed by the physical therapy section has a responsibility to report any organization or entity that provides or holds itself out to deliver physical therapy services that places the licensee in a position of compromise with this code of ethical conduct.” Rule 4755-7-08 (B)(12) contains the same provisions for occupational therapy licensees. In the situation that you describe, deleting services provided due to regulations by an insurance company, in this case Medicare, and your employer, would constitute a violation of the Code of Ethical Conduct and therefore a violation of the Ohio Occupational Therapy and Physical Therapy Practice Acts. Please be advised if this action is performed all occupational therapy and/or physical therapy personnel involved in this patient’s case could be subject to disciplinary action. Rule 4755-27-05 of the Ohio Administrative Code states: (A)(2) A licensee shall exercise sound judgment and act in a trustworthy manner in all aspects of physical therapy practice. Regardless of practice setting, the physical therapist shall maintain the ability to make independent judgments. A licensee shall strive to effect changes that benefit the patient. (A)(3) A licensee shall only seek compensation that is reasonable for the physical therapy services delivered. A licensee shall never place the licensee’s own financial interests above the welfare of the licensee’s patients. A licensee, regardless of the practice setting, shall safeguard the public from unethical and unlawful business practices. (B)(1) A licensee shall adhere to the standards of ethical practice by practicing in a manner that is moral and honorable. A licensee may be disciplined for violating any provision contained in division (A) of section 4755.47 of the Revised Code. (B)(9) A licensee shall not falsify, alter, or destroy patient/client records, medical records, or billing records without authorization. The licensee shall maintain accurate patient and/or billing records. Rule 4755-7-08 of the Ohio Administrative Code states: (B) Professionalism of the licensee includes conforming to the minimal standards of acceptable and prevailing occupational therapy practice, including practicing in a manner that is moral and honorable. . . . Failure to comply with paragraphs (B)(1) to (B)(17) of this rule may be grounds for disciplinary action pursuant to section 4755.11 of the Revised Code. . . . (B)(4) A licensee shall not falsify, alter, or destroy client records, medical records, or billing records without authorization. The licensee shall maintain accurate client and/or billing records. (B)(9) A licensee shall exercise sound judgment and act in a trustworthy manner in all aspects of occupational therapy practice. Regardless of practice setting, the occupational therapy practitioner shall maintain the ability to make independent judgments. A licensee shall strive to effect changes that benefit the client. (B)(14) A licensee shall only seek compensation that is reasonable for the occupational therapy services delivered. A licensee shall never place the licensee’s own financial interests above the welfare of the licensee’s clients. A licensee, regardless of practice setting, shall safeguard the public from unethical and unlawful business practices. The Board recommends that you talk to your compliance department regarding the best possible way to address your concerns. You may also contact your professional organization for additional information regarding this concern.

JB3. Cathy Selway: Ms. Selway asked the Occupational and Physical Therapy Sections questions regarding whether medication assessment is within the scope of practice for occupational and physical therapy. **Reply:** There is nothing in the Ohio Occupational Therapy Practice Act that prohibits an occupational therapy practitioner from completing medication reconciliation provided that the occupational therapy practitioner has received the appropriate training and demonstrated/documented competence in this activity. This type of reconciliation may be performed as an administrative task by any health care practitioner during the treatment visit. Occupational therapy practitioner may also play a role in medication

management as discussed by the American Occupational Therapy Association in its September 2008 Scope of Practice Issues Update. In this update, AOTA stated: In general practice, health care professionals have focused on teaching (telling patients what their medications do) and compliance or whether they are taking medications as ordered. But OT practitioners have the skills and knowledge to operationalize medication teaching to ensure that it is integrated into the patient's daily routine successfully and correctly. A nursing referral should be made if the patient needs to be taught specific information about a medication that is not provided on written instructions. But if the concern is performance or how the client learns to manage taking their medications and handling the effects of them in the context of their daily activities and routines, that is an unmet need for clients and home care agencies which OT practitioners can address. Reviewing medication information sheets with patients and assessing whether they understand them is an expectation for therapists by CMS and is well within the scope of OT. Using that information, OTs can then assist patients in translating the instructions into their daily routines and habits. For example, medications to control high blood pressure are often diuretics and can make patients need to use the bathroom more often. The OT can discuss timed voiding, simplified clothing fasteners, mobility issues related to accessing the bathroom, especially away from home and other strategies to manage or avoid incontinence. This should increase the patient's compliance with taking the medication as directed. There is nothing in the Physical Therapy Practice Act that prohibits a physical therapist from performing a medication reconciliation that includes interviewing a patient about current medications, comparing those to the list of prescribed medications, and implementing a computerized program or referring the lists to other practitioners to identify suspected drug interactions. This does not include the interpretation of medication verbal orders or interpretation of medication interactions. Even though not part of the physical therapy plan of care, the reconciliation may be performed as an administrative task of any health care professional. Other such administrative tasks that are not part of a physical therapy plan of care but that may be performed by physical therapy personnel include removal of staples, coaguchecks, listening for bowel sounds, and other patient assessments. However, no procedure should be performed by a physical therapist or physical therapist assistant unless the practitioner demonstrates competence in that procedure.

JB4. Lisa Chance, PT: Ms. Chance asked the Occupational and Physical Therapy Sections questions regarding co-signature requirement for documenting missed visits by an occupational therapy assistant or physical therapist assistant. **Reply:** In accordance with rule 4755-7-04 of the Administrative Code, it is the position of the Occupational Therapy Section that if patient/client documentation includes any type of treatment grid, a single co-signature and date of review on the form is sufficient. Co-signature verifies that the supervisor reviewed the document and agrees with its content. It is the position of the Section that for any hand written documentation, the supervising occupational therapist must co-sign each entry into the patient/client medical record with their name, credential, and date. For any electronic documentation, the supervising occupational therapist must co-sign and reference the dates of the entries into the patient/client medical record. If needed, the occupational therapist may make a separate entry, referencing the date of the note(s) that are being reviewed with documentation referencing the review, noting agreement, and/or changes needed in the treatment plan. Yes, all physical therapy documentation by a physical therapist assistant should be co-signed by the physical therapist. You may wish to refer to Medicare and other third party payer policies to determine what they require. Insurer policies and/or federal regulations may be more or less restrictive than the Ohio Occupational and Physical Therapy Practice Acts. In any situation, licensees should follow the more restrictive policies.

JB5. Kim Wood: Ms. Wood asked the Occupational and Physical Therapy Sections questions regarding whether occupational therapy assistants/physical therapist assistants can perform medication reconciliation and update the medication profile/lists. **Reply:** There is nothing in the Ohio Occupational Therapy Practice Act that prohibits an occupational therapy practitioner from completing medication reconciliation provided that the occupational therapy practitioner has received the appropriate training and demonstrated/documented competence in this activity. This type of reconciliation may be performed as an administrative task by any health care practitioner during the treatment visit. Occupational therapy practitioner may also play a role in medication management as discussed by the American Occupational Therapy Association in its September 2008 Scope of Practice Issues Update. In this update, AOTA stated: In general practice, health care professionals have focused on teaching (telling patients what their medications do) and compliance or whether they are taking medications as ordered. But OT practitioners have the skills and knowledge to operationalize medication teaching to ensure that it is integrated into the patient's daily routine successfully and correctly. A nursing referral should be made if the patient needs to

be taught specific information about a medication that is not provided on written instructions. But if the concern is performance or how the client learns to manage taking their medications and handling the effects of them in the context of their daily activities and routines, that is an unmet need for clients and home care agencies which OT practitioners can address. Reviewing medication information sheets with patients and assessing whether they understand them is an expectation for therapists by CMS and is well within the scope of OT. Using that information, OTs can then assist patients in translating the instructions into their daily routines and habits. For example, medications to control high blood pressure are often diuretics and can make patients need to use the bathroom more often. The OT can discuss timed voiding, simplified clothing fasteners, mobility issues related to accessing the bathroom, especially away from home and other strategies to manage or avoid incontinence. This should increase the patient's compliance with taking the medication as directed. The OT role in medication management can include: Recording medication dosages, routes etc. per agency policy when required as part of an assessment. Involving nursing for patient education on new medications if needed. Ensuring that patients know how to take their medications and are, in fact taking them as directed. If not, the OT can explore reasons why they are not being taken or are taken incorrectly. During the assessment, identify when the patient takes medications within their daily routine and have there been disruptions to that routine that interfere. Identifying habits and routines have worked to support appropriate medication management for the patient in the past. How can we work with them vs. changing them? Assessing medication management as part of the patient's overall ADLs so tasks can be accomplished timely, allowing for medications to be taken within the prescribed time frame relative to food, blood sugar etc. Considering how OT skills and knowledge around energy conservation techniques can assist with managing all ADLs. Medication management in home care is a critical part of the patient's ADL, beyond assistance with opening pill bottles and is well within the OT scope of practice. There is nothing in the Physical Therapy Practice Act that prohibits a physical therapist from performing a medication reconciliation that includes interviewing a patient about current medications, comparing those to the list of prescribed medications, and implementing a computerized program or referring the lists to other practitioners to identify suspected drug interactions. This does not include the interpretation of medication verbal orders or interpretation of medication interactions. Even though not part of the physical therapy plan of care, the reconciliation may be performed as an administrative task of any health care professional. However, no procedure should be performed by a physical therapist or physical therapist assistant unless the practitioner demonstrates competence in that procedure.

JB6. Caren Maniaci: Ms. Maniaci asked the Occupational and Physical Therapy Sections questions regarding caseload requirements for occupational and physical therapy practitioners. **Reply:** The Ohio Occupational Therapy Practice Act only establishes ratios for the number of occupational therapy assistants (OTA) an occupational therapist (OT) may supervise and does not regulate caseload levels. Ratios establishing the number of students that an occupational therapist may serve are located in administrative rules adopted by the Ohio Department of Education. Rule 3301-51-09 (I)(3)(c) & (e) of the Ohio Department of Education's Operating Standards states that an OT shall provide services to no more than 50 school-age students or 40 preschool students. The Ohio Department of Education interprets this as the number of students to whom the therapist provides direct service. Paragraph (I)(1) of rule 3301-51-09 also states that determination of the appropriate ratio for an individual therapist must take into consideration the following: The severity of each eligible child's needs; The level and frequency of services necessary for the children to attain IEP goals/objectives; Time required for planning services; Time required for evaluations including classroom observations; Time required for coordination of the IEP services; Time required for staff development; Time required for follow up; and Travel time required for the number of building served. Services provided to students without disabilities must also be considered in determination of therapist/student ratio. This includes screenings, assessments, consultation, and counseling with families and professionals. Attending Intervention Assistance Team (IAT) meetings, participating in Response to Intervention (RTI) programs, and training education professionals as a part of these programs also must be considered when determining the therapist/student ratio. All students served by an OTA are part of the supervising therapist's caseload. In accordance with ODE's Operating Standards, as well as the Ohio Occupational Therapy Practice Act, OTAs do not have their own caseloads separate from that of the supervising therapist. It is the position of the Occupational Therapy Section that all responsibilities of the OT and OTA, including both direct and indirect service to students, must be considered when determining an appropriate therapist caseload. The number of students to whom the supervising therapist provides direct service must be reduced as the number of assistants a therapist supervises expands, since this increases the number of students for whom

the therapist is responsible. The therapist must ensure provision of appropriate services and must not serve and/or supervise service for more students than he/she can provide skilled care, including informed direction of all aspects of the service provided for students by the assistant. The code of ethical conduct requires licensees, regardless of practice setting, to maintain the ability to make independent judgments and strive to effect changes that benefit the client (4755-7-08 (B)(9)). Educational agencies following the requirement of rule 3301-51-09 (I)(1), which states that additional factors must be considered when determining the appropriate caseload for a therapist, would bring therapist caseloads closer to a level that is in alignment with the therapist providing service only to the number of students that they can provide skilled care as required by their respective professional practice acts. It is the duty of the Occupational Therapy Section to protect the consumers of occupational therapy services and ensure that students receive care consistent with safe and ethical practices. To this end, licensees are required to report to their licensing board any entity that places them in a position of compromise with the code of ethical conduct as stated in rule 4755-7-08 (B)(12) of the Administrative Code. Please refer to the Board's website (<http://otptat.ohio.gov>) to review the *Determination of Appropriate Caseload for School-Based Occupational Therapy and Physical Therapy Practice Position Paper* and the *Comparison of Responsibilities of Occupational Therapy Practitioners in School-Based Practice Chart* documents. The Ohio Physical Therapy Practice Act is silent on and does not regulate caseload levels. However, the Section requires the physical therapist to ensure appropriate patient management based on the unique needs of the clients, taking into account the complexity of the patient population. The ultimate responsibility for care of the patient lies with the evaluating physical therapist regardless of whether the therapist or physical therapist assistants provide follow-up treatment. In any given period of time, a physical therapist must not provide or supervise care for a higher number of patients than that for which skilled care by licensed practitioners can be delivered. When attempting to determine caseloads, please remember to take into consideration travel time, number of locations, etc. Please refer to the *Determination of Appropriate Caseload for School-Based Occupational Therapy and Physical Therapy Practice Position Paper* and the *Comparison of Responsibilities of Occupational Therapy Practitioners in School-Based Practice Chart* documents on the Physical Therapy Publications page on the Board's website (<http://otptat.ohio.gov>). The Sections recommends contacting Cathy Csanyi, the OT/PT Specialty Consultant with the Ohio Department of Education, Office for Exceptional Children at (419) 747-2806 or via email at cathy.csanyi@ode.state.oh.us. The Ohio Occupational Therapy Association's pediatrics member support group chair may be able to assist you with many of your questions regarding school based practice. You can contact the Ohio Occupational Therapy Association at www.oota.org. You can contact the Ohio Occupational Therapy Association at www.oota.org; the Ohio Chapter or Reimbursement Department of the American Physical Therapy Association; and/or Mark Smith, OMSP Program Coordinator at the Ohio Department of Education at (614) 752-1493 or via email at mark.smith@ode.state.oh.us.

JB7. Peggy Chester: Ms. Chester asked the Occupational and Physical Therapy Sections questions regarding whether occupational therapists can provide LE PROM and UE PROM if a physical therapist is not involved. **Reply:** There is nothing in the Occupational Therapy Practice Act that would prohibit an occupational therapist from performing passive range of motion to lower extremities. The occupational therapist must document and demonstrate competency in the technique being administered. Occupational therapy services are defined within the Ohio Revised Code 4755.04 to include methods or strategies selected to direct the process of interventions, including, but not limited to, establishment, remediation, or restoration of a skill or ability that has not yet developed or is impaired and compensation, modification, or adaptation of activity or environment to enhance performance. Provision of services to enable a client to maintain or achieve increased range of motion is within the scope of practice. There is nothing within the Physical Therapy Practice Act that stipulates the physical therapist or physical therapist assistant is the sole provider of passive range of motion to the bilateral lower extremities. However, best practice would be for the practitioner to demonstrate competence in that procedure before it is to be performed.

JB8. Renee Coughlin: Ms. Coughlin asked the Occupational and Physical Therapy Sections questions regarding whether occupational therapy assistants and physical therapist assistants can make updates to short term goals. **Reply:** It is the position of the Occupational Therapy Section that the initial plan, long-term goals, and initial short-term goals must be written by the occupational therapist. The occupational therapist may collaborate with the occupational therapy assistant in the development of these items. The occupational therapy assistant can gather objective information and report observations, with or without the client and/or occupational therapist present. The occupational therapy assistant can document achievement of goals as

part of the updating of short-term goals and progress. It is the responsibility of the occupational therapist to interpret the data gathered by the occupational therapy assistant and collaborate with the occupational therapy assistant to make recommendations. Any collaboration between the occupational therapist and occupational therapy assistant must be reflected in client documentation. In accordance with rule 4755-7-04 of the Administrative Code, it is the position of the Occupational Therapy Section that if patient/client documentation includes any type of treatment grid, a single co-signature and date of review on the form is sufficient. Co-signature verifies that the supervisor reviewed the document and agrees with its content. For any hand written documentation, the supervising occupational therapist must co-sign each entry into the patient/client medical record with their name, credential, and date. Also, it is not within the jurisdiction of the Occupational Therapy Section to render billing and reimbursement advice. The Section recommends that you refer to payer policies for any specific billing and reimbursement requirements in your setting. You might also contact the Ohio Occupational Therapy Association, or the Reimbursement Department of the American Occupational Therapy Association. The physical therapist assistant may assess responses to treatments rendered and make statements about progress toward goals as outlined in the plan of care and document this in the assessment portion of the daily or progress note in the medical record. The physical therapist assistant cannot establish goals or perform physical therapy assessment. Goal modifications may be performed only by a physical therapist and the documentation must clearly reflect the physical therapist's revision(s).

Old Business

Review Aging Limited License Agreements

The Section reviewed the aging limited license agreement report.

Review Draft Language for Supervision of Level I Students

The Section reviewed the proposed changes to rule 4755-9-01.

New Business

Rules Re-Numbering Project

The Executive Director and the Section's Rules Liaison will start doing a comprehensive review of all the rules. The Board will contact OPTA to help identify potential contributors to this project. The Board will hold different subgroups based on the specific content area. The Board anticipates this project will be ready to file in 2016.

Recap of NBCOT State Regulatory Conference

Rebecca Finni gave a brief report to the Section.

Recap of OOTA Conference

Mary Beth Lavey gave a brief report to the Section.

Ethics Training

The Executive Director provided the Section members with written instructions on how to access the mandatory on-line ethics training course. Section members are required to forward a copy of their certificate of completion to the Board office to be kept on file for auditing purposes. The deadline to complete the online ethics education is December 31, 2014.

Open Forum

The Section discussed meeting dates for the 2015 Calendar. The Executive Director will post the official 2015 calendar on the Board's website.

Ohio Occupational Therapy Association (OOTA) Report

Jacquelyn Chamberlin gave a brief report to the Section.

Items for Next Meeting

- Review Survey Results
- Rules Hearing

Next Meeting Date

The next regular meeting date of the Occupational Therapy Section is scheduled for Thursday, January 15, 2015.

Action: Jean Halpin moved to adjourn the meeting. Kimberly Lawler seconded the motion. The motion carried. The meeting adjourned at 12:24 p.m.

Respectfully submitted,
Diane Moore

Rebecca Finni, OTR/L, Chairperson
Ohio Occupational Therapy, Physical Therapy,
and Athletic Trainers Board, OT Section

Beth Ann Ball, OTR/L, Secretary
Ohio Occupational Therapy, Physical Therapy,
and Athletic Trainers Board, OT Section

Jeffrey M. Rosa, Executive Director
Ohio Occupational Therapy, Physical Therapy,
and Athletic Trainers Board

BB:jmr:dm